Bradford South & West Commissioning Alliance

Commissioning Plan: 2009 – 2012
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Introduction

As the NHS heads into the most challenging financial climate most of us will have experienced, it seems pertinent to question what role Practice Based Commissioning (PBC) and in particular, our alliance, has to play in meeting that challenge.

Despite pessimistic forecasts PBC remains a central plank of health policy and this seems unlikely to change, even if we have a new party in government in 12 months time.

Primary care teams continue to be responsible for the majority of NHS spending via their referrals, prescriptions, investigations and admissions but for some of these teams, this reality receives scant acknowledgment and we hear the cry of “we’re too busy getting on with the day job!”

At the very least, PBC is about helping all providers of primary medical care to realise that cost-effective clinical decision making is an integral part of their day job.

It is now clearer than ever that, if we wish to see new services continuing to flourish, it will be on the back of continued efficiencies in how we spend our indicative commissioning budgets.

No-one would pretend that PBC has developed at the pace we envisaged three years ago but developed it has and NHS Bradford and Airedale are one of the most supportive primary care trusts in the country in that respect.

It would be easy, at this point, to give up on PBC but that would be a calamitous decision for the NHS and our patients locally. Bradford South and West Commissioning Alliance needs to reflect, focus, persevere and play its part in delivering the highest quality, most cost-effective healthcare that we can.

We continue to believe that PBC is a core mechanism for realising world-class health services in Bradford and Airedale and reducing the unacceptable health inequalities which exist.

Keep the faith!

Dr. Andy McElligott

Dr. Chris Harris
Summary of key commissioning priorities for 2009 - 2012:
Building on the work that was started in 2007, the Alliance will focus on the following commissioning priorities over the next 3 years, 2009 – 2012:

3.1 Reducing health inequalities

3.1.1 Reducing Alcohol intake in adults
Aim: The Alliance will increase the range of services available to support people in reducing their drinking levels or to stop drinking.

3.1.2 Reducing obesity levels in Adults & Children
Aim: The Alliance will improve the range of services available to children, families and adults to support people to eat healthier, exercise more and lose weight.

3.1.3 Improving the health of young people and reducing Teenage pregnancy
Aim: The Alliance will improve the health of young people by ensuring a greater range of services are available and more easily accessibly to young people in the areas of Tong, Wyke & Buttershaw. The services will provide support, information and advice about lifestyle issues and in particular sexual health and deliver health care where appropriate.

3.1.4 Improving the health of older people
Aim: The Alliance will improve the health of vulnerable older people living in a care home and people with dementia living in their own home.

3.1.5 Reducing Infant mortality
Aim: The Alliance will improve antenatal health, child health & development and economic self-sufficiency for mothers and babies in the practice populations of Horton Park, Parklands and the Ridge.

3.1.6 Reducing smoking in the population
Aim: The Alliance will support people to stop smoking by increasing the availability of services that meet local need.

3.1.7 Improving access to welfare advice
Aim: The Alliance will improve the availability of services to enable patients and their families to access welfare advice when they need it.

3.2 Improving community based support to reduce emergency admissions and provide proactive preventative support
Aim: The Alliance will increase the availability of community based services to provide earlier proactive support and reduce the need for people to be admitted to hospital as an emergency.

3.3 Developing more community based alternatives to secondary care
Aim: The Alliance will increase the availability of community based services to provide care closer to home for patients that choose to access them.

3.4 Enhancing community nursing and therapy services
Aim: The Alliance will review and enhance the provision of community nursing and therapy services to develop equitable services based on need.

3.5 Improving medicines management
Aim: The Alliance will support practices to improve medicines management to ensure it is safe, effective and best value.

3.6 Improving access to mental health services
Aim: The Alliance will increase the range of services available to patients to reduce wait times, and support practices in earlier identification of patients with a mental health disorder.
1. Bradford South & West Commissioning Alliance

1.1 Background

The Alliance came into being on 1st October 2006 in order to give member practices a unified and strong voice with regard to major commissioning decisions and service redevelopments. It was also intended to act as a peer support network for the dissemination of PBC related information and to ensure that many existing, quality services were maintained. Effective care pathways have been established for a number of years and there have been extensive developments of services around local diagnostic and treatment centres.

1.2 Aims of the Alliance

The Alliance aims to make commissioning decisions based on a clear understanding of patients’ needs and in conjunction with patients. All commissioning decisions have clinical quality, value for money and a solid evidence base at their heart.

The Alliance recognises that there are both national and local priorities for healthcare and the commissioning decisions will reflect these needs. The Alliance endeavours to work in conjunction with NHS Bradford and Airedale to support these priorities.

The Alliance aims to encourage training and development based around the practice and to facilitate sharing of best practice and expertise across the whole Alliance. The Alliance will engage clinicians in the development of new services, redesign of existing services and the prioritisation of service developments.

1.3 Objectives of the Alliance

- To commission cost-effective services, based on local health needs analyses
- To continue looking at the effectiveness of existing services
- To continue to develop services closer to patients’ homes and to continue to support those which already exist
- To share best practice and clinical knowledge
- To seek best practice from elsewhere and adapt locally
- To explore the development of clinical networks
- To continue development as a commissioning group

1.4 Alliance Principles

- Practices should maintain their own autonomy and identity
- Practices should work together with mutual respect
- The Alliance will work towards service redesign, which will be clinically focussed and will ensure that the services take account of patient needs and suggestions.
- The Alliance will share information and ideas in a fair, open and transparent manner.
- Practices will involve the whole primary care team and other providers of health and social care as well as patients where appropriate.
- Practices should be aware of the importance of workforce planning.
1.5 Membership of the Alliance

Alliance Constitution
Membership and List Sizes

<table>
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<tr>
<th>Practice Code</th>
<th>Name of Practice</th>
<th>List Size (end Dec 2008)</th>
<th>Lead PBC Clinician</th>
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TOTAL LIST Size: 161594

The Alliance is open to all practices in NHS Bradford and Airedale. At the present time practices may opt in or opt out of the Alliance at any time although a degree of commitment in terms of attendance at meetings and a willingness to share and compare practice level data (referral rates, prescribing costs etc) is expected.

1.6 Current Structure

Steering Group (meets monthly)

Andy McElligott (clinical lead),
Chris Harris (clinical lead),
Chris Brennan (practice manager lead),
Caroline Dyson (practice manager lead),
Jacquie White (general manager)
Sharon Barraclough (assistant general manager)
Functions of the Steering Group

- Reviewing PBC activity with individual practices.
- Liaising with NHS Bradford and Airedale re: accurate and timely budgets
- Liaising with NHS Bradford and Airedale re: the other information necessary for effective PBC such as health needs analyses
- Involvement in production of NHS Bradford and Airedale’s prospectus
- Attendance at all PBC related meetings in order to influence local policy development
- Organisation of business and educational meetings
- Analysis and feedback of latest local and national commissioning developments to practices
- Helping to formulate business cases
- Helping to develop local PBC incentive schemes
- Acting as a conduit between NHS Bradford and Airedale and practices for issues such as referral patterns
- Involvement in contract setting with major providers including development of prior approval protocols, pathway design and quality standards
- Involvement in the auditing of agreed contracts
- Performance management of services commissioned by the Alliance.

Business Meetings (meets monthly)

Steering group members
1 GP and practice manager from each practice
Other health and social care workers by invitation

The function of the Alliance business meetings is to bring all constituent practices of the Alliance together to discuss all matters relating to PBC, agree commissioning priorities, develop service specifications, discuss new pathway developments, feedback from meetings with the PCT and to share best practice.

1.7 Future development of the Alliance
The Alliance is currently reviewing its structures reflecting on the achievements and challenges so far and over the next 12 months aims to strengthen its operating processes to become more effective and efficient. In the next 3 years the Alliance aims to have earned autonomy from the PCT working in an organisational model which allows it be the best commissioning group that it can be, in order to deliver the best possible outcomes for the patients it serves. Further details on the process of this are attached as appendix 1.

1.8 Working with others

NHS Bradford and Airedale

The Clinical Leads of the Alliance are members of the Clinical Executive providing a PBC and Alliance perspective to the group and feedback of the issues of relevance to the Alliance. The Alliance managers work with the commissioning leads in the organisation to ensure plans are in line with the strategic direction. Each of the 10 programme boards will have PBC representation which will strengthen alignment of the Alliance priorities, connect Alliance plans to the relevant programme and enable the Alliance to influence district-wide plans.
The Alliance actively participates in the Joint Commissioning Forum, which brings together all 4 Alliances and NHS Bradford and Airedale to discuss the performance of PBCers and the development of PBC across the district.

Providers
The Alliance meets regularly with both its main providers of services, Bradford teaching hospitals foundation trust and BACHS to share plans and priorities, service developments and discuss the delivery of commissioned services.

Local Authority
Regular discussions occur with the Locality Managers for Bradford South and Bradford West in order to review plans and areas of joint working.

The Alliance meets with the Adult Care team for Bradford South & West to review services and closer partnership working.

Other partners
Through the workstreams, the Alliance works with a wide variety of partners to consider areas of improvement and action for all concerned. In particular the Alliance will be working with local schools, care homes and CVS organisations in 2009.

Public engagement
The Alliance links in with residents in the local wards through the locality wardens and with the neighbourhood forums through the Locality Managers to share new developments and gain feedback on areas for improvement.

Practices in the Alliance are currently developing their own patient engagement mechanisms supported by both the PBC incentive scheme for 2009/10 and the National Association for Patient Participation project as well as the Alliance. This work will enable the Alliance to identify various methods to engage patients in service developments at an Alliance level.
2. Summary of the Alliance Profile

The full profile is available on the NHS Bradford and Airedale intranet at: http://practiceprofiles.bradfordairedale-pct.nhs.uk/PracticeReports/Reports_Library/Practice%20Profiles%202008/SandW%20Alliance.doc. The following provides a summary of this and the alliance specific health needs identified within the 2008 JSNA for Bradford and Airedale.

2.1 Population
The population of the Alliance was 161,594 as at December 2008, which is 29% of the Bradford and Airedale population and consists of the following wards:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Main Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bingley Rural</td>
<td>Wilsden</td>
</tr>
<tr>
<td>Bowling and Barkerend</td>
<td>Bowling Hall, Rooley Lane</td>
</tr>
<tr>
<td>City</td>
<td>Gaugine, Bevan House</td>
</tr>
<tr>
<td>Clayton and Fairweather Green</td>
<td>Mayfield, Cowgill</td>
</tr>
<tr>
<td>Great Horton</td>
<td>Horton Bank, Ridge</td>
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<tr>
<td>Heaton</td>
<td>Heaton MP</td>
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<tr>
<td>Queensbury</td>
<td>Willows</td>
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<tr>
<td>Royds</td>
<td>Parklands, Low Moor, Royds</td>
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<tr>
<td>Thornton and Allerton</td>
<td>Grange, Phoenix</td>
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<tr>
<td>Toller</td>
<td>Carlton</td>
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<tr>
<td>Tong</td>
<td>Micallef, Mills</td>
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<tr>
<td>Wibsey</td>
<td>Wibsey &amp; Queensbury, Sinha</td>
</tr>
<tr>
<td>Wyke</td>
<td>Sunnybank</td>
</tr>
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2.2 Services
Primary care services provided in South & West are as follows:
- 22 practices
- 32 Pharmacists
- 16 Dentists
- 12 Optometrists

The main providers and location of hospital and community services are:
- Secondary care – Bradford, Airedale, Leeds & Calderdale hospitals, Bradford Care Trust
- Practitioners with a Special Interest (PwSI) – Westwood park and some practice based services (listed as appendix 2)
- Private providers – Eccleshill ISTC and Yorkshire Clinic
- Community Hospitals – Westwood park, Westbourne Green, St. Luke’s Hospital
• Community services – Community Nursing, Fast response team, Community Mental Health team
• Voluntary and Community services – currently there are 88 services commissioned running across district.

2.3 Summary of health inequalities for the Alliance
• The majority of the population (67%) is in deprivation quintiles 1 & 2 (1=most deprived)
• The population is mostly non south-asian with a small eastern european ethnic group
• SMR<75 are higher than the national average
• Life expectancy for males is the second lowest in the district
• Life expectancy for females is the lowest in the district
• The Alliance has the second highest incidence of mental health disorders
• Obesity rates are higher than average for 5 and 11 year olds
• Infant mortality is significantly high in some of the wards
• The Alliance has the highest percentage of smokers in the district
• Teenage pregnancies are higher than the national average particularly in the wards of Tong and Wyke
• The Alliance has the lowest coverage of immunisations in 5 year olds (MMR) in the district
• The 3 wards with the highest percentage of young people not in employment, education or training (NEET) are in the Bradford South area – Tong 13.3%, Royds 12.5%, Wyke 11.6%
(Source: South & West Alliance Profile 2008, Bradford JSNA August 2008)

2.4 Social marketing profile of the Alliance
• Majority of the population is deprived or disadvantaged
• High proportion of families (often single parent), and pensioners
• High proportion of the population has a lack of physical activity, sedentary lifestyles, poor diet, are smokers, and obese
• Severe health issues exist in the population
• 3 main existing health problems:
  - older people with LTC, deprived and disadvantaged neighbourhoods with poor diet, smoking
• 2 main future health problems:
  - single parent families with poor lifestyle and ill health, - people living in estates with lack of physical activity and poor diet
(Source: CACI data 2008)
### 2.4 Breakdown of PBC activity & expenditure

<table>
<thead>
<tr>
<th>Main Specialty</th>
<th>Sub Specialty</th>
<th>Non-Elective Inpatient Spells</th>
<th>Outpatient Firsts</th>
<th>Outpatient Follow-Ups</th>
<th>% Change</th>
<th>2008 - 09</th>
<th>% Change</th>
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<td>Accident &amp; Emergency (A&amp;E)</td>
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<td>£49,141</td>
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<tr>
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<th>Sub Specialty</th>
<th>Non-Elective Inpatient Spells</th>
<th>Outpatient Firsts</th>
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<td>£193,191</td>
<td>0.0%</td>
<td>£1,001</td>
<td>£1,001</td>
</tr>
<tr>
<td>General Medicine</td>
<td></td>
<td>£193,191</td>
<td>£193,191</td>
<td>£193,191</td>
<td>0.0%</td>
<td>£1,001</td>
<td>£1,001</td>
</tr>
<tr>
<td>GU</td>
<td></td>
<td>£193,191</td>
<td>£193,191</td>
<td>£193,191</td>
<td>0.0%</td>
<td>£1,001</td>
<td>£1,001</td>
</tr>
<tr>
<td>GU</td>
<td></td>
<td>£193,191</td>
<td>£193,191</td>
<td>£193,191</td>
<td>0.0%</td>
<td>£1,001</td>
<td>£1,001</td>
</tr>
<tr>
<td>Neurology</td>
<td></td>
<td>£193,191</td>
<td>£193,191</td>
<td>£193,191</td>
<td>0.0%</td>
<td>£1,001</td>
<td>£1,001</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td></td>
<td>£193,191</td>
<td>£193,191</td>
<td>£193,191</td>
<td>0.0%</td>
<td>£1,001</td>
<td>£1,001</td>
</tr>
<tr>
<td>Other Specialist Paediatrics</td>
<td></td>
<td>£193,191</td>
<td>£193,191</td>
<td>£193,191</td>
<td>0.0%</td>
<td>£1,001</td>
<td>£1,001</td>
</tr>
<tr>
<td>Paediatric Surgery</td>
<td>MEDICAL: Paediatrics</td>
<td>£193,191</td>
<td>£193,191</td>
<td>£193,191</td>
<td>0.0%</td>
<td>£1,001</td>
<td>£1,001</td>
</tr>
<tr>
<td>Paediatrics</td>
<td></td>
<td>£193,191</td>
<td>£193,191</td>
<td>£193,191</td>
<td>0.0%</td>
<td>£1,001</td>
<td>£1,001</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td></td>
<td>£193,191</td>
<td>£193,191</td>
<td>£193,191</td>
<td>0.0%</td>
<td>£1,001</td>
<td>£1,001</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td></td>
<td>£193,191</td>
<td>£193,191</td>
<td>£193,191</td>
<td>0.0%</td>
<td>£1,001</td>
<td>£1,001</td>
</tr>
<tr>
<td>Urology</td>
<td></td>
<td>£193,191</td>
<td>£193,191</td>
<td>£193,191</td>
<td>0.0%</td>
<td>£1,001</td>
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</tr>
</tbody>
</table>
### 10 Highest Cost Non-Elective Inpatient Specialties

<table>
<thead>
<tr>
<th>Specialties</th>
<th>0708 Cost</th>
<th>0809 Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL: General Medicine</td>
<td>£5,905,908</td>
<td>£6,237,384</td>
</tr>
<tr>
<td>MEDICAL: Geriatric Medicine</td>
<td>£4,923,994</td>
<td>£6,052,218</td>
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<tr>
<td>MEDICAL: Obstetrics</td>
<td>£3,830,832</td>
<td>£4,230,302</td>
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<tr>
<td>SURGICAL: General Surgery</td>
<td>£3,533,167</td>
<td>£3,696,400</td>
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<tr>
<td>Orthopaedics</td>
<td>£2,915,456</td>
<td>£3,181,756</td>
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<tr>
<td>MEDICAL: Paediatrics</td>
<td>£1,908,676</td>
<td>£2,265,782</td>
</tr>
<tr>
<td>MEDICAL: Cardiology</td>
<td>£1,078,122</td>
<td>£1,268,881</td>
</tr>
<tr>
<td>MEDICAL: Gynaecology</td>
<td>£706,412</td>
<td>£957,148</td>
</tr>
<tr>
<td>SURGICAL: Plastic Surgery</td>
<td>£690,605</td>
<td>£881,899</td>
</tr>
<tr>
<td>SURGICAL: Urology</td>
<td>£613,665</td>
<td>£773,039</td>
</tr>
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</table>

### 10 Highest Cost Outpatient Specialties (Firsts)

<table>
<thead>
<tr>
<th>Specialties</th>
<th>0708 Cost</th>
<th>0809 Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURGICAL: Trauma &amp; Orthopaedics</td>
<td>£716,060</td>
<td>MEDICAL: Paediatrics</td>
</tr>
<tr>
<td>MEDICAL: Paediatrics</td>
<td>£691,472</td>
<td>SURGICAL: Trauma &amp; Orthopaedics</td>
</tr>
<tr>
<td>SURGICAL: Breast Surgery</td>
<td>£459,967</td>
<td>SURGICAL: Breast Surgery</td>
</tr>
<tr>
<td>MEDICAL: Obstetrics</td>
<td>£387,258</td>
<td>SURGICAL: Colorectal Surgery</td>
</tr>
<tr>
<td>SURGICAL: Colorectal Surgery</td>
<td>£347,404</td>
<td>SURGICAL: Ophthalmology</td>
</tr>
<tr>
<td>SURGICAL: Ophthalmology</td>
<td>£342,215</td>
<td>MEDICAL: General Medicine</td>
</tr>
<tr>
<td>SURGICAL: ENT</td>
<td>£283,728</td>
<td>MEDICAL: Obstetrics</td>
</tr>
<tr>
<td>MEDICAL: Cardiology</td>
<td>£227,159</td>
<td>SURGICAL: ENT</td>
</tr>
<tr>
<td>MEDICAL: Gynaecology</td>
<td>£238,872</td>
<td>MEDICAL: Cardiology</td>
</tr>
<tr>
<td>MEDICAL: Clinical Haematology</td>
<td>£182,763</td>
<td>SURGICAL: Gynaecology</td>
</tr>
</tbody>
</table>

### 10 Highest Cost Outpatient Specialties (Follow-Ups)

<table>
<thead>
<tr>
<th>Specialties</th>
<th>0708 Cost</th>
<th>0809 Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL: Clinical Haematology</td>
<td>£737,056</td>
<td>MEDICAL: Clinical Haematology</td>
</tr>
<tr>
<td>SURGICAL: Trauma &amp; Orthopaedics</td>
<td>£641,970</td>
<td>SURGICAL: Trauma &amp; Orthopaedics</td>
</tr>
<tr>
<td>SURGICAL: Ophthalmology</td>
<td>£415,593</td>
<td>MEDICAL: Paediatrics</td>
</tr>
<tr>
<td>MEDICAL: Paediatrics</td>
<td>£394,172</td>
<td>SURGICAL: Ophthalmology</td>
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<tr>
<td>MEDICAL: Obstetrics</td>
<td>£347,072</td>
<td>MEDICAL: Dermatology</td>
</tr>
<tr>
<td>MEDICAL: Dermatology</td>
<td>£283,587</td>
<td>MEDICAL: Obstetrics</td>
</tr>
<tr>
<td>MEDICAL: Medical Oncology</td>
<td>£267,731</td>
<td>SURGICAL: ENT</td>
</tr>
<tr>
<td>SURGICAL: Vascular Surgery</td>
<td>£255,359</td>
<td>MEDICAL: Cardiology</td>
</tr>
<tr>
<td>SURGICAL: ENT</td>
<td>£231,862</td>
<td>SURGICAL: General Surgery</td>
</tr>
<tr>
<td>SURGICAL: General Surgery</td>
<td>£196,856</td>
<td>MEDICAL: Medical Oncology</td>
</tr>
</tbody>
</table>
### 2.5 Financial profile

The Alliance has a budget of £106,406,919, 31% of the total budget for the district. 6 practices are moving to fair share budgets over the next 3 years.

<table>
<thead>
<tr>
<th>Practice Code</th>
<th>Practice</th>
<th>OP First</th>
<th>OP Fup</th>
<th>ISTC Diag</th>
<th>Elective</th>
<th>Emergency / Acute Care</th>
<th>A&amp;E Attendances</th>
<th>Pharmacy</th>
<th>GPsWU Services</th>
<th>Distric Nursing</th>
<th>Health Visitor</th>
<th>Community Hospital</th>
<th>Primary Care MH Team</th>
<th>Prescribing</th>
<th>Contingency</th>
<th>Total Other Budgets</th>
<th>Fair Share Movement Yr 1</th>
<th>Total POC Budget</th>
</tr>
</thead>
</table>

Building on the work that was started in 2007, the Alliance will focus on the following commissioning priorities over the next 3 years, 2009 – 2012:

3.1 Reducing health inequalities

3.1.1 Reducing Alcohol intake in adults:

Aim: The Alliance will increase the range of services available to support people in reducing their drinking levels or to stop drinking.

The Alliance has the highest levels of patients drinking above the recommended limits, the highest levels of hazardous and harmful drinking behaviours and the highest numbers of acute admissions due to alcohol. In 2006/07 the cost of acute admissions due to alcohol was £801,702 (data for 08/09 is currently unavailable). Additionally the alliance has the highest demand for detoxification services.

<table>
<thead>
<tr>
<th>Alliance</th>
<th>% of patient population with consumption recorded</th>
<th>% of patients with consumption identified as drinking above recommended limits</th>
<th>% of patient population recorded as drinking above recommended limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airedale &amp; Wharfedale</td>
<td>20%</td>
<td>17%</td>
<td>3.4%</td>
</tr>
<tr>
<td>BANCA</td>
<td>18%</td>
<td>17%</td>
<td>3%</td>
</tr>
<tr>
<td>Citycare</td>
<td>10%</td>
<td>10%</td>
<td>1%</td>
</tr>
<tr>
<td>South and West</td>
<td>30%</td>
<td>13%</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alliance</th>
<th>No of spells 2006/7</th>
<th>Total cost (£)</th>
<th>Approx % of total burden</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airedale &amp; Wharfedale</td>
<td>271</td>
<td>310,818</td>
<td>20</td>
</tr>
<tr>
<td>BANCA</td>
<td>366</td>
<td>501,115</td>
<td>20</td>
</tr>
<tr>
<td>Citycare</td>
<td>333</td>
<td>486,536</td>
<td>20</td>
</tr>
<tr>
<td>South and West</td>
<td>544</td>
<td>801,702</td>
<td>40</td>
</tr>
</tbody>
</table>

At a district-wide level around 30 planned in-patient detoxifications take place each year in Lynfield Mount. A further, estimated, 60-70 community detoxifications are carried out per year, the majority by the Bradford and Airedale Community Drug and Alcohol teams and a small number by local GP practices with a special interest. A far great number of ‘unplanned’ inpatient detoxifications take place when patients dependent on alcohol are admitted to BRI or Airedale. The Clinical Nurse Specialist at BRI from 8th September 08 to January 09 received 253 referrals. Of these 41% were from South & West.

A number of patients who undergo ‘unplanned’ detoxification in BRI could be discharged at an earlier stage if support for their ongoing detoxification were available in the community. Widespread screening and identification of problematic
drinkers is likely to add to this unmet demand for community detoxification in the medium term, by uncovering a group of moderately dependent drinkers previously unknown to services. The Alliance represents approximately 40% of the demand for detoxification services. For community detoxification this would equate to 207 patients.

3.1.2 Reducing obesity levels in Adults & Children

**Aim:** The Alliance will improve the range of services available to children, families and adults to support people to eat healthier, exercise more and lose weight.

Tackling obesity has been identified as a priority due to the increasing prevalence in both adults and children. South & West has the highest prevalence of obesity in the district, based on the latest available data there are potentially 26,739 adults with a BMI > 30. The Alliance has the highest prevalence of obesity in Year 6 children (21.6%). Some trends are beginning to emerge from the National Child Measurement Programme (NCMP) e.g. for Year 6 obesity prevalence Wibsey ward (25%) is consistently in the highest fifth. In terms of Reception Year obesity prevalence Thornton and Allerton (13.5% over 2 years) are in the highest fifth (i.e. hotspots). The full alliance obesity strategy is attached as appendix 3.

3.1.3 Improving the health of young people and reducing Teenage pregnancy

**Aim:** The Alliance will improve the health of young people by ensuring a greater range of services are available and more easily accessible to young people in the areas of Tong, Wyke & Buttershaw. The services will provide support, information and advice about lifestyle issues and in particular sexual health and deliver health care where appropriate.

**Objectives**
- Improve the support available to teenagers/young people to feel better about themselves
- Improve the sexual health outcomes in the 3 areas by providing the best possible support and areas of best practice/excellence in all 3 areas
- Improve/build the trust and confidence of young people in local services
- Improve awareness and branding of what’s available
- Ensure better integration, communication and joined up working between organisations and with other lifestyle support services e.g. obesity, alcohol, smoking, drugs
- Strengthen links with schools and community services/organisations e.g. between school nurses and practices etc.

Bradford South constituency has the highest rate of teenage pregnancy, with 57 per 1,000 conceptions under the age of 18. The areas with the highest rates and the riskiest behaviours are Tong, Wyke and Buttershaw. During the period 2004-6, 1 in every 12 teenage girls in Tong had a baby that was conceived under the age of 18 years. This compares to 1 in 24 in England. Tong must reduce the annual number of teenage pregnancies by 11 per year from the 2006 figure in order to meet the national target.
A recent evaluation of the Brook Sexual Health outreach service in schools concluded that school based services had a positive impact and should be developed further including out of school hours. The report also identified the need for efficient links and relationships with primary care, CASH and young people’s services. Youth workers were seen as having a crucial role in encouraging young people to use such services. Young people want accessible, local and friendly services. Bradford has the lowest take up of services in schools across the country. The full alliance strategy for improving the health of young people is attached as appendix 4.

3.1.4 Improving the health of older people

**Aim:** The Alliance will improve the health of vulnerable older people living in a care home and people with dementia living in their own home.

As at March 2009, the alliance had 21,398 patients registered over the age of 65. In 2008 – 09 there were 5818 acute admissions costing £13,297,812 for people over the age of 65. The Alliance has patients residing in 40 care homes. Currently, the recording of patients living in a care home is poor in practices. A search of SystmOne practices in May found 77 patients coded as living in a care home. The actual numbers of patients in care homes for the Alliance is 879. Patients in care homes are shown to have a higher rate of acute admissions with a slightly higher percentage of 0 or 1 night stays. As at 07/08 national QOF data, the Alliance had 760 patients with a diagnosis of dementia this compares to an expected prevalence of 1,578 for the population of S&W Alliance.

These cohorts of patients are deemed to be more vulnerable in terms of their health than the general population of over 65s, however, are often only seen for a particular element of their health at any one time. The acute illnesses are often preventable, and when they do occur could be managed within the patient’s home (whether that be their own home or the care home they live in) with the appropriate care plan and support to enact that care plan.

**Anticipated benefits of improving the health of this cohort of patients**
- Improved relations/communications with care homes
- Early identification of health problems/risks
- Standardised processes (quality care)
- Falls prevention
- Reduction poly pharmacy
- Reduced emergency admissions
- Reduced A+E attendances
- Improved patient safety
- Improved patient care/quality of care
- Multidisciplinary working
- Increased support care homes
- Identified unmet need
- Improved evidence based practice (inc. NICE)

The full alliance strategy for improving the health of older people is attached as appendix 5.
3.1.5 Reducing Infant mortality

Aim: The Alliance will improve antenatal health, child health & development and economic self-sufficiency for mothers and babies in the practice populations of Horton Park, Parklands and the Ridge.

The infant mortality rates for 2004 – 2006 (latest available) indicate Great Horton, Little Horton and the City wards as having some of the highest rates of infant mortality across the district. In attributing this data to practices, the highest rates for the Alliance fell within the 3 practices identified above. The demographics for these patients indicate that there is a mix of south asian women, young white women, and with high levels of deprivation. The causes of mortality are mainly due to genetic disorders and low birth weight. The full alliance strategy for reducing infant mortality is attached as appendix 6.

3.1.6 Reducing smoking in the population

Aim: The Alliance will support people to stop smoking by increasing the availability of services that meet local need.

As outlined in section 2, the Alliance has the highest levels of smoking in the district. There are a range of current services available in practices and other community based venues, which have developed over time. The Alliance plans to review the provision of current services and the outcomes achieved to ensure equitable availability based on need and service models that gain the best possible outcomes for patients.

3.1.7 Improving access to welfare advice

Aim: The Alliance will improve the availability of services to enable patients and their families to access welfare advice when they need it.

67% of the Alliance population is in the 2 lowest quintiles of deprivation. The current economic climate means that support for the local population is in even greater demand. There are a range of services currently available, however, these are not necessarily in the areas with the greatest need. The Alliance plans to review the current provision of services and ensure future provision meets the needs of the population.

3.2 Improving community based support to reduce emergency admissions and provide proactive preventative support

Aim: The Alliance will increase the availability of community based services to provide earlier proactive support and reduce the need for people to be admitted to hospital as an emergency.

Over the last 3 years the Alliance has seen an increase in the numbers and cost of people accessing emergency care;

- In A&E 1,472 extra people accessed care and the budget was overspent by £233,446.
• Non-elective admissions rose by 1,445 spells, and the budget was overspent by £4,552,757. However, the budget was reduced in 08/09 by £2,237,429. With the right community based alternatives this area has huge potential to release efficiency gains for reinvestment in other areas.

Particular areas of high activity:

Respiratory conditions: Improving the care of patients with respiratory conditions could release savings assuming proactive case finding and treatment, particularly COPD without complications, lobar, atypical or viral pneumonia without complications and COPD with complications, complex elderly with respiratory diagnosis.

Cardiac conditions: The majority of cardiac episodes are appropriately managed in the acute trust, however, with community support a number of patients could be discharged earlier in order to qualify for the short stay emergency tariff.

Syncope/collapse, which includes in-patients aged 69 years or older, could be an area for potential savings by proactive case finding of patients, who have had a fall. Heart failure and IHD without intervention, in-patients who are 69 years or older may also be patients that could receive support in the community with proactive case finding.

Stoke/TIA: Community Hospitals are well placed to provide stroke rehabilitation, thereby reducing the length of stay in the acute trust.

Fractures: A large number of patients who have fallen and ended up with a fracture could have been identified as being at risk of a hip fracture with subsequent preventative treatment if action had been taken when the patient had a fragility fracture such as a wrist.

Patients with a fracture that are non-weight bearing could be transferred to community hospital for rehabilitation, thereby reducing the length of stay in the acute trust.

DVTs: Better use of the community based DVT service would reduce the need for patients to be admitted to hospital.

UTIs: Better support out of hours for patients at home, and to care homes could dramatically reduce these admissions.

3.3 Developing more community based alternatives to secondary care

Aim: The Alliance will increase the availability of community based services to provide care closer to home for patients that choose to access them.

The Alliance has seen an increasing demand for hospital based planned care. In 08/09 1st outpatient attendances rose by 8,370 at a cost of £1,772,504. This is due to many factors including the impact of 18 weeks which has dramatically improved access for patients. The choose and book system in the Alliance changed in 2008, resulting in more referrals being made to secondary care due to a lack of awareness...
and confidence in other alternatives. The current range of practice and community based services is listed at appendix 2.

The Alliance is keen to increase the range of community based services available by making more efficient use of existing services that meet the needs of patients and developing new services that support care closer to home for patients. The Alliance plans to increase the range of diagnostics available in the community, and increase the number of outreach clinics and same day procedures performed in community facilities.

3.4 Enhancing community nursing and therapy services

**Aim:** The Alliance will review and enhance the provision of community nursing and therapy services to develop equitable services based on need.

Community nursing services in the Alliance are varied both in terms of skill-mix, staffing levels and the range of services provided. The Alliance plans to review the provision of services in each practice and participate in the district-wide review of District Nursing and Health Visiting services to ensure a more equitable service is available across the Alliance and which allows for flexibility to meet the needs of local populations.

Currently there are some practice based physiotherapy services available in the Alliance that have been set up as a result of historical arrangements. Rapid access to therapy services is vital to prevent patients experiencing chronic problems, and availability of a range of different therapy services ensures patients are able to access the right support at the right time to increase the likelihood of as full a recovery as possible. The Alliance plans to review the provision of community based therapy services to ensure equitable access for patients based on need.

3.5 Improving medicines management

**Aim:** The Alliance will support practices to improve medicines management to ensure it is safe, effective and best value.

Improving medicines management will benefit patients by helping them to make the best possible use of medicines. Cost-effective prescribing ensures best use of the resources available. Reducing prescribing risk is essential to the governance of medicines management and will help GP Practices to identify and update medicines policies and procedures for the benefit of patient safety.

Poor medicines management within and across organisations can lead to low public confidence in health services, unaddressed health needs and unsatisfactory patient outcomes. For example, poor medicines management can cause unscheduled emergency admissions or failure to maintain independence leading to re-admission to hospital/care homes.
3.6 Improving access to mental health services

**Aim:** The Alliance will increase the range of services available to patients to reduce wait times, and support practices in earlier identification of patients with a mental health disorder.

Improving the support in primary care for patients with mental health problems has been identified by the Alliance as a priority area due to the lack of available services for some patients, the wait times for patients to access services that are available and a lack of identification of some patients that need mental health services. As highlighted in section 2, the alliance has the second highest incidence of mental health disorders.

Within the Alliance locality mental health services are provided by the primary care mental health team (PCMHT). The PCMHT essentially provide therapeutic approaches to clients in primary care settings with mild, moderate and intermediate mental health needs not requiring or accessing secondary care mental health services. Current wait times for the services are 16 weeks for counselling and up to 8 months for CBT. The British Association for Counselling and Psychotherapy (BACP) suggest a ratio of 1.5 hours of counselling per 1000 population. Using this as a generic guide for all primary care mental health services, the requirement for the South & West locality is 249 hours per week. Allowing for annual leave, training and sickness there is a current provision of 179 hours of therapy per week.

The dementia registers for the Alliance practices total 760 patients versus a consensus expected prevalence of 1,578. The total over 65s population of the Alliance is 21,942. Of these 15,844 are aged 65-79 and 6,098 aged 80+. If the more simplistic calculations of 1 in 20 over 65s and 1 in 5 of the over 80s is used the expected prevalence for the Alliance is 1,706. Using either prevalence figures it appears that the registers for the Alliance are under-detecting dementia.

Research indicates that 75% of service uses presenting in general practice have at least 1 psychosocial problem. Given the deprivation levels in the Alliance and the current economic climate demand for psychosocial support is increasing exponentially. Practices are seeing increasing numbers of patient with stress and anxiety and an increasing need for support, advice and signposting to appropriate services.
## 3.1 Reducing health inequalities

| Staying Healthy | Reducing Alcohol intake in adults | \[• Early identification and interventions provided to people with a drinking problem  
\• Reduction in emergency admissions  
\• Increase in those reporting improved self management of their condition  
\• Improving patient experience  
\• Reduction in health inequalities | Commission primary care alcohol support service and community detoxification service across the Alliance.  
\• Primary care alcohol service will provide 27 half day sessions per week to support approx. 400 patients per annum  
\• Community Detoxification service will consist of a Specialist Nurse, a GPwSI and GP prescribing from contracted practices.  
Participate in district-wide tendering process. Performance measures to be agreed. |
|---|---|---|
| Staying Healthy | Reducing obesity levels in Adults & Children | \[• To improve the health and wellbeing of people  
\• Increase in those reporting improved self management of their weight  
\• Improving patient experience  
\• Reduction in health inequalities | Develop an alliance obesity action plan to be led by and jointly delivered with the Obesity Team support worker allocated to the alliance. This will include raising awareness, providing better information and support to practices.  
As many of the current commissioning options are pilots that are undergoing evaluation for the next 12 months expand the weight management referral scheme to all practices that sign up to the obesity plan. This will include the purchase of additional vouchers and the commissioning of brief intervention training for both adult obesity and childhood obesity by the Alliance. |
<table>
<thead>
<tr>
<th>Children &amp; Young people</th>
<th>Improving the health of young people and reducing Teenage pregnancy</th>
<th>Practices will identify an obesity lead within the practice, have regular meetings with the obesity support worker, attend brief intervention training events, and use the assessment tool to refer/signpost patients to appropriate lifestyle services. See appendix 3 for further details.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Improve the support available to teenagers/young people to feel better about themselves</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Improve the sexual health outcomes by providing the best possible support and areas of best practice/excellence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Improve/build the trust and confidence of young people in local services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Improve awareness and branding of what's available</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Ensure better integration, communication and joined up working between organisations and with other lifestyle support services e.g. obesity, alcohol,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establish an Alliance workgroup to review current services available and identify opportunities to develop locally needed services.</td>
<td></td>
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<tr>
<td></td>
<td>Develop an Alliance action plan which will include raising awareness, providing better information and support to young people and service providers.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agree commissioning priorities at July business meeting and action accordingly.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>See appendix 4 for further details.</td>
<td></td>
</tr>
<tr>
<td>Long term conditions, Acute care &amp; End of Life</td>
<td>Improving the health of older people</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------------------------------</td>
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</tr>
<tr>
<td></td>
<td>• Improve the quality of care provided to patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reduce acute admissions and A&amp;E attendances</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide better proactive support to people to stay well and as independent as possible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establish an Alliance workgroup to review current services available and identify opportunities to develop locally needed services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop an Alliance action plan which will include raising awareness, providing better information and support to older people and service providers.</td>
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</tr>
<tr>
<td></td>
<td>Agree commissioning priorities at July business meeting and action accordingly.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>See appendix 5 for further details.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maternity &amp; new born</th>
<th>Reducing Infant mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Improve the health outcomes of patients and narrow health inequalities among these patients by ensuring services meet the needs of disadvantaged groups</td>
</tr>
<tr>
<td></td>
<td>• Improve ante natal health and good birth outcome</td>
</tr>
<tr>
<td></td>
<td>• Reduce child deaths</td>
</tr>
<tr>
<td></td>
<td>• Improve life outcomes of children and their families as a consequence of the promotion of positive health</td>
</tr>
<tr>
<td></td>
<td>Commission a family support assistant service to work within the existing health visiting teams for the Ridge, Parklands and Horton Park. The service will identify work with, and support vulnerable parents and families from an early stage in pregnancy and for as long as additional support is deemed necessary. The service will have close links with the attached midwife for those practices.</td>
</tr>
<tr>
<td></td>
<td>See appendix 6 for further details.</td>
</tr>
<tr>
<td>Staying Healthy</td>
<td>Reducing smoking in the population</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>• Increase breast feeding rates and delay weaning to reduce the numbers of diabetes, obesity in childhood, • Increase in immunisation rates • Increase in parents self esteem to ensure positive parenting and care of their children • Reduction in child abuse</td>
<td>• Improve the health outcomes of patients and narrow health inequalities among these patients by ensuring services meet the needs of disadvantaged groups • Reduce mortality &amp; morbidity • Reduce the levels of smoking</td>
</tr>
</tbody>
</table>

Review of current services. Re-distribute or increase provision where possible to provide equitable access to services.
### 3.2 Improving community based support to reduce emergency admissions and provide proactive preventative support

<table>
<thead>
<tr>
<th>Acute Care</th>
<th>Enhancing fast response team</th>
<th>Improve patient’s health and quality of life by providing patient-centred, systematic and on-going support.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Ensure that the patient receives the most appropriate care and support delivered in a timely manner.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improve the health outcomes of patients and narrow health inequalities among these patients by ensuring services meet the needs of disadvantaged groups</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduce the reliance on secondary care services and increase the provision of care in a primary, community or home environment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide care closer to home when clinically safe to do so</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduce acute admissions &amp; A&amp;E attendances</td>
</tr>
</tbody>
</table>

| Additional investment funded through alliance pooled FUR for the following: |
| 2 additional support worker posts per night, 7 nights per week, covering 10 hours |
| 1 full time Physiotherapist |
| ½ time OT |
| 1 full time Nurse Practitioner |
| Redesign of present NP cover in community hospital service to provide out of hours NP cover across whole intermediate care services |
| Telecare package for S&W population |
| 4 – 6 extra patients supported per night with planned visits |

| Recruitment still in progress, therapy and support workers still vacant. Action plan to be agreed with Steering Group. |
| No clear outcomes as yet, data monitoring to be provided. Monthly performance meetings ongoing. |
| Education event to be held for practices in Autumn 09 to raise awareness of new service and increase use etc. |
## Long term conditions & Acute Care

**Developing integrated community support teams and the community matron role**

Development of practice based integrated community support teams, development of the Community Matron role and an increase in numbers, joint working with other services including Adult Care services and district nursing as well as each practice clinical team.

- Improve patient’s health and quality of life by providing patient-centred, systematic and on-going support.
- Ensure that the patient receives the most appropriate care and support delivered in a timely manner.
- Improve the health outcomes of patients and narrow health inequalities among these patients by ensuring services meet the needs of disadvantaged groups.
- Reduce the reliance on secondary care services and increase the provision of care in a primary, community or home environment.
- Provide care closer to home when clinically safe to do so.
- Reduce acute admissions & A&E attendances.
- Reduce emergency bed days.

- Redesign existing Community Matron system.

  Funding partly through alliance pooled FUR and partly through PCT additional investment

  9 additional Community Matron posts commissioned (14.8 in total) & 2 Community Support Workers.

  Funding agreed for 1 additional Adult Care team to be co-located with a practice in Autumn 09 (3 co-located teams in total across the Alliance).

  Additional Community Matrons recruited to provide 13.8 Community Matrons in total across S&W so far.

  Further recruitment for 1 remaining post to be progressed.

  Practices and Community Matrons to be supported to work with district nursing teams and social care managers to continue to develop an integrated team approach.

  No clear outcomes as yet, data monitoring to be provided. Monthly performance meetings ongoing.

  Implementation plan for new co-located team to be developed.

## Acute Care

**Reducing acute admissions and A&E attendances**

- Ensure that the patient receives the most appropriate care and participation in A&E media campaign with 2 other alliances funded through FUR. Campaign.

- Review of 08/09 activity to determine priority areas for the Alliance. Consider impact of HRG4 on acute care and the financial implications.

---

Q:\Commissioning\Practice Based Commissioning\South & West Alliance\Jacquie White\Alliance\Bradford South West Alliance - 2009-12 Commissioning Plan.doc
| Support delivered in a timely manner. |
| Reduce the reliance on secondary care services and increase the provision of care in a primary, community or home environment. |
| Provide care closer to home when clinically safe to do so |
| Reduce acute admissions & A&E attendances |
| Reduction in emergency bed days |

| Included posters on buses, radio adverts and newspaper articles. |
| Opportunities available. |
| Participate in district-wide workstream. Establish alliance workgroup to review effectiveness of current services within the Alliance to consider options and action accordingly. |
| Ongoing review and service development as necessary. |

### Long Term Conditions & Acute Care

**Health forecasting for COPD patients**

- Use of automated health forecasting systems supplied by the Met Office to alert patients to times of high risk of exacerbation and support self management to reduce this risk.
- To reduce the exacerbation of patients with COPD
- To improve self-management
- To improve patient experience
- Reduce acute admissions & A&E attendances

| System purchased by PCT. Evaluation in Oct 08, Alliance agreed not to re-commission due to limited impact of service. |
| Plans for COPD support to be included in Alliance acute care plans |

### 3.3 Developing more community based alternatives to secondary care

<table>
<thead>
<tr>
<th>Planned care</th>
<th>Community based diagnostics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure that the patient receives the most appropriate care and</td>
<td></td>
</tr>
<tr>
<td>Practice based services developed for ECGs, 24 hour BP, Spirometry and H-pylori stool</td>
<td></td>
</tr>
</tbody>
</table>

<p>| Review of current services - practice based and Westwood Park. |</p>
<table>
<thead>
<tr>
<th>Planned care</th>
<th>Community based outpatient services</th>
</tr>
</thead>
</table>
|              | support delivered in a timely manner.  
  • Reduce the reliance on secondary care services and increase the provision of care in a primary, community or home environment.  
  • Provide care closer to home when clinically safe to do so. |
|              | testing. |
|              | Practice based services developed in Paediatrics, Minor surgery, Optometry, Audiology, MSK, Sexual Health, Anticoagulation. |
|              | Consider impact of HRG4 on diagnostics and the financial opportunities available.  
  Increase provision where appropriate aiming to make ultrasound and x-ray facilities available in the community. |
|              | Review of current services - practice based and Westwood Park.  
  Consider impact of HRG4 on outpatient services and the financial opportunities available.  
  Increase provision where appropriate aiming to improve pathways of care and the skill mix available to support patients. |
<table>
<thead>
<tr>
<th>Planned care</th>
<th>Community based same day procedures</th>
<th>Ensure that the patient receives the most appropriate care and support delivered in a timely manner.</th>
<th>Review of current services - practice based and Westwood Park. Consider impact of HRG4 on planned same day procedures and the financial opportunities available. Increase provision where appropriate aiming to improve the range of procedures available to patients in the community.</th>
</tr>
</thead>
</table>

3.4 Enhancing community nursing and therapy services

<table>
<thead>
<tr>
<th>Development of Community Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve patient’s health and quality of life by providing patient-centred, systematic and ongoing support.</td>
</tr>
<tr>
<td>Ensure that the patient receives the most appropriate care and support delivered in a timely manner.</td>
</tr>
<tr>
<td>Improve the health outcomes of patients</td>
</tr>
</tbody>
</table>

Alliance wide review of current District Nursing and Health visiting services. Participation in district-wide reviews to influence core service specification and ensure flexibilities to meet local need.
and narrow health inequalities among these patients by ensuring services meet the needs of disadvantaged groups

| Development of community based therapy services | Improve patient’s health and quality of life by providing patient-centred, systematic and on-going support. Ensure that the patient receives the most appropriate care and support delivered in a timely manner. Improve the health outcomes of patients and narrow health inequalities among these patients by ensuring services meet the needs of disadvantaged groups |
| Review of current services - practice based and WWP. Increase practice based therapy where possible to provide more equitable access to services. |

3.5 Improving medicines management

<p>| Enhance the community pharmacy support team | Ensure more cost effective prescribing Reduce prescribing risk Improve safety Identify and update medicines policies |
| Community pharmacy support team set up in practices for 4 hours per week. |
| Participate in district-wide review and tender process. Increase the level of support available to practices based on list size. Support practices to make best use of the service and the financial opportunities available. |</p>
<table>
<thead>
<tr>
<th>MSP</th>
<th>Service area Development</th>
<th>Expected Outcomes</th>
<th>07-09 Achievements</th>
<th>Plan for 09-10</th>
</tr>
</thead>
</table>
| Mental Health| Primary Care Gateway Service                                  | • Improved health and quality of life for patients and feelings of well-being by providing patient-centred, systematic and ongoing support.                                                                                       | Additional investment funded through alliance pooled FUR  
  • Increased capacity for Counselling and therapy  
  • Increase in the number of mental health practitioners  
  • Increased the overall primary care service by 12.5 sessions per week (43 hours)  
  Service fully implemented (April 08). Initial issues around visibility of workers in practices and communication problems are improving.                                                                 | Practice visits to discuss issues and clarify the service as appropriate. No clear outcomes as yet, monthly performance meetings ongoing. |
| Social prescribing Health Trainers | • Improved health and quality of life for patients and feelings of well-being by providing patient-centred, systematic and ongoing support.  
• Improved health outcomes of patients and narrowed health inequalities among these patients by ensuring services meet the needs of disadvantaged groups  
• Reduced reliance on secondary care services and increased provision of care in a primary, community or home environment.  
• Reduced reliance on medication by providing patients with alternative support  
• Improved mental health symptoms  
• Reduced risk of self-harm  
• Increased subjective wellbeing and functionality  
• Reduced referrals to secondary care | Additional investment funded through alliance pooled FUR.  
• 5 WTE support workers covering a population of 25,000 – 30,000 each  
Staff have been recruited and the service has commenced in practices. | No clear outcomes as yet, data monitoring to be provided. Monthly performance meetings ongoing. |

Develop practice based services to improve the mental wellbeing of patients with psychosocial needs.
<table>
<thead>
<tr>
<th>Improving identification and support for patients with Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve practice registers, develop pathways into services and utilise existing services better</td>
</tr>
<tr>
<td>• Improved clinical outcomes for people with dementia</td>
</tr>
<tr>
<td>• Reduction in emergency bed days</td>
</tr>
<tr>
<td>• Reduction in morbidity and mortality</td>
</tr>
<tr>
<td>• Improvement in patient experience</td>
</tr>
<tr>
<td>• Improvement in self management and perceived quality of life</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>well-being and functionality</th>
</tr>
</thead>
</table>

- Improved clinical outcomes for people with dementia
- Reduction in emergency bed days
- Reduction in morbidity and mortality
- Improvement in patient experience
- Improvement in self management and perceived quality of life

Included in Alliance Older People’s development plan.

Further developments will be informed by the recommendations from the district wide commissioning plan currently being developed.
## S&W Alliance Summary of Commissioning Investments

<table>
<thead>
<tr>
<th>MSP</th>
<th>Service development</th>
<th>Funding source</th>
<th>Funding of services 07/08</th>
<th>Funding of services in 08/09</th>
<th>Funding of services in 09/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>Primary Care Mental Health services</td>
<td>FUR for 2 years, then aiming to be self funding through reduction in referrals to secondary care</td>
<td>£87,055</td>
<td>£87,055</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>Social prescribing health trainers</td>
<td>FUR for 2 years, then aiming to be self funding through reduction in referrals to secondary care and prescribing costs</td>
<td></td>
<td>£131,560</td>
<td></td>
</tr>
<tr>
<td>Acute Care</td>
<td>Enhancing fast response team</td>
<td>FUR for 2 years, then aiming to be self funding through reduction in acute admissions and A&amp;E attendances</td>
<td>£268,490</td>
<td>£268,490</td>
<td></td>
</tr>
<tr>
<td>Acute care</td>
<td>A&amp;E media campaign</td>
<td>FUR for 1 year only</td>
<td>£2,669</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long term conditions</td>
<td>Community Matrons</td>
<td>PCT recurrent investment of and FUR for 2 years for the remainder of the cost, then aiming to be self funding through reduction in acute admissions and A&amp;E attendances</td>
<td>£378,577</td>
<td>£378,577</td>
<td></td>
</tr>
<tr>
<td>Staying Healthy</td>
<td>Primary care alcohol support service &amp; community detoxification</td>
<td>Health Inequalities monies – 5 years funding, then aiming to be self funding through reduction in acute admissions</td>
<td></td>
<td>Approx. £150,000</td>
<td></td>
</tr>
<tr>
<td>Staying Healthy</td>
<td>Weight management referral scheme</td>
<td>Health Inequalities monies – 5 years funding</td>
<td></td>
<td>Approx. £45,000</td>
<td></td>
</tr>
<tr>
<td>Maternity &amp; Newborn</td>
<td>Family Support Assistants</td>
<td>Health Inequalities monies – 5 years funding</td>
<td></td>
<td>Approx. £40,000</td>
<td></td>
</tr>
<tr>
<td>Children &amp; Young People</td>
<td>Young people tbc</td>
<td>Health Inequalities monies – 5 years funding</td>
<td></td>
<td>Approx. £45,000</td>
<td></td>
</tr>
<tr>
<td>Acute care, end of life &amp; long term conditions</td>
<td>Older people tbc</td>
<td>Health Inequalities monies – 5 years funding</td>
<td></td>
<td>Approx. £40,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total funding of services</strong></td>
<td></td>
<td></td>
<td>£2,669</td>
<td>£734,122</td>
<td>£866,002</td>
</tr>
</tbody>
</table>
4. Performance monitoring of PBC and performance management of PBCers

The Alliance will adhere to the PBC performance management framework and provide support to practices to adhere to the practice accountability framework. The Alliance will undertake 6-monthly practice visits to discuss plans, and overall progress. Regular data analysis and interpretation of the activity and expenditure at both alliance and individual practice level will identify areas for development and remedial action to take.

In order to improve the management of PBC, the following activities will be undertaken by practices in the Alliance:

<table>
<thead>
<tr>
<th>Area</th>
<th>Objective</th>
<th>Actions</th>
<th>Expected outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice engagement</td>
<td>Regular Clinical &amp; Managerial/Administrative attendance at Alliance PBC meetings</td>
<td>Monthly attendance of PBC lead GP and/or Practice Manager, update to rest of practice in monthly team meetings</td>
<td>Improve engagement in commissioning</td>
</tr>
<tr>
<td>Practice commissioning priorities</td>
<td>Annual practice commissioning plan reflecting local patient needs.</td>
<td>Development of practice plan and commissioning intentions for 2009/10. 6 monthly progress report and review visit.</td>
<td>Improve engagement in commissioning and actions taken</td>
</tr>
<tr>
<td>Resource utilisation</td>
<td>Monthly review of activity and expenditure with action plan for any areas of overtrade.</td>
<td>Monthly analysis of data, discussion in team meetings, notes/actions circulated to team.</td>
<td>Reduce unnecessary referrals to secondary care and unnecessary use of acute services</td>
</tr>
<tr>
<td>Audit of activity and cost</td>
<td>Referral /Admissions Analysis</td>
<td>Audit of the top three areas of 1st out-patient referrals and urgent admissions that occurred in November 2008 and analyse, report and develop an action plan for referrals and an action plan for acute referrals</td>
<td>Improve quality of data and identify areas for service development</td>
</tr>
<tr>
<td>Prescribing</td>
<td>Work with the clinical pharmacy support team to analyse areas of improvement and where possible action recommendations</td>
<td>Audit and discussion in practice meetings Develop support mechanisms for identified patients</td>
<td>Improve the cost effectiveness of prescribing in the practice</td>
</tr>
</tbody>
</table>
Appendix 1: Development of the Alliance

The Alliance currently has an informal arrangement with the group of practices working to an operating framework agreed in 2006. The current arrangements do not allow the Alliance to be as effective or efficient a Commissioner as it could be. Several issues have been identified including long decision making processes, a lack of authority at the Steering Group level, unclear roles & responsibilities of members of the Alliance etc.

It was agreed that the development of the Alliance was a priority in order to be a high performing commissioning group for the benefit of the patients in South & West Bradford Alliance.

An organisational development process was initiated in December 2008.

Process:
1. Practice survey
Practices were asked to complete a questionnaire in December 2008 to provide their views on the alliance. The main themes that were identified from this were weak communication processes, and a lack of clarity on the role of the Steering group.

2. Development workshop 12th May 2009
A first development workshop was held in May 2009. The purpose of this session for Alliance members was to take stock and support the future development of the Alliance, to engage people to develop a shared understanding of the key issues and to seek a shared commitment to address these issues together. The themes identified in the questionnaire were drawn out further in this process.

Participants identified things that they strongly valued about the Alliance, including the opportunity to work collectively on some issues, to network and to increase influence. To build on these strengths, a number of issues were identified that people feel need to be addressed:

<table>
<thead>
<tr>
<th>The key issues in rank order</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Translating ideas into action – too much bureaucracy</td>
<td>84%</td>
</tr>
<tr>
<td>2. Communication from Steering Group and business meetings – not feeling engaged</td>
<td>79%</td>
</tr>
<tr>
<td>3. Decision making processes</td>
<td>78%</td>
</tr>
<tr>
<td>4. Analysis of data and how we use information</td>
<td>77%</td>
</tr>
<tr>
<td>5. Making meetings more effective</td>
<td>68%</td>
</tr>
<tr>
<td>6. Lack of Clarity of Role and Accountability of Steering Group</td>
<td>64%</td>
</tr>
<tr>
<td>7. Use of resources</td>
<td>61%</td>
</tr>
<tr>
<td>8. Clarity of lines of accountability for staff we commission</td>
<td>50%</td>
</tr>
</tbody>
</table>

At the end of the workshop, over 96% of participants felt there had been plenty of opportunities to participate, over 80% felt they had an opportunity to have their say, and the proportion of those feeling ‘pessimistic’ about the future of the Alliance had fallen from 29% to less than 3%.
There was a general feeling that this was the right time to take stock; that there were opportunities to make the Alliance more effective; and that there was a desire and commitment to address these issues together.

3. Options appraisal of the potential structures for the Alliance
A report analysing the potential organisational models the Alliance could adopt commenced in June 2009. This report will look at the in-depth internal and external views of the future of the alliance, a review of the different models that could be adopted and recommendations for the Alliance to consider.

4. 2\textsuperscript{nd} workshop – 21\textsuperscript{st} July 2009
A follow up workshop has been planned in July to look at potential solutions to the issues identified at the 1\textsuperscript{st} workshop and the recommended options available to the Alliance in terms of structures. The results of this workshop will define the OD plan for the Alliance for the next 12 months and potentially 3 years.

Expected outcomes
- Increased engagement in PBC from practices
- Increased commitment to the Alliance
- Better congruence between the Alliance and the 10 programmes
- Increased clinical engagement with more clinical leads identified
- More effective and efficient decision making and commissioning processes
- Wider engagement in the Alliance by other stakeholders
## Appendix 2: GPwSI services available to S&W patients

<table>
<thead>
<tr>
<th>BACHS provided services</th>
<th>Practice provided services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Westwood Park</strong></td>
<td></td>
</tr>
<tr>
<td>24H BP</td>
<td>Avicenna - Anticoagulant *</td>
</tr>
<tr>
<td>24H ECG</td>
<td>Carlton - Cystoscopy *</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Carlton - HP Tests *</td>
</tr>
<tr>
<td>Cystoscopy</td>
<td>Carlton - Sigmoidoscopies *</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Idle Medical Centre - Cystoscopy *</td>
</tr>
<tr>
<td>Dyspepsia (Airedale)</td>
<td>Idle Medical Centre - Dermatology *</td>
</tr>
<tr>
<td>ED</td>
<td>Kilmeny - ENT *</td>
</tr>
<tr>
<td>ENT inc Audiology</td>
<td>Ling House *</td>
</tr>
<tr>
<td>Gastroscopy</td>
<td>Mayfield - Pain Management *</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>Springfield - Dermatology *</td>
</tr>
<tr>
<td>HP Breath Test</td>
<td>Sunnybank - Pain Management *</td>
</tr>
<tr>
<td>Hysteroscopy</td>
<td>The Ridge - Vasectomy *</td>
</tr>
<tr>
<td>Minor Surgery</td>
<td>West Cliffe - Cystoscopy &amp; Urology *</td>
</tr>
<tr>
<td>MSK</td>
<td>West Cliffe - Dermatology *</td>
</tr>
<tr>
<td>Neurology</td>
<td>West Cliffe - General Surgery *</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>West Cliffe - Ophthalmology *</td>
</tr>
<tr>
<td></td>
<td>West Cliffe - Vasectomy *</td>
</tr>
<tr>
<td><strong>Westbourne Green</strong></td>
<td></td>
</tr>
<tr>
<td>24H BP</td>
<td>Westcliffe - Anticoagulant *</td>
</tr>
<tr>
<td>24H ECG</td>
<td>Westcliffe - Plastic Surgery *</td>
</tr>
<tr>
<td>Standard ECG</td>
<td>Wilsden - Ophthalmology *</td>
</tr>
<tr>
<td>Spirometry</td>
<td>Windhill Green - Ophthalmology *</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Windhill Green - SOAP *</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Windhill Green - Vasectomy *</td>
</tr>
<tr>
<td>Women Health</td>
<td></td>
</tr>
<tr>
<td><strong>Eccleshill - GPwSI</strong></td>
<td></td>
</tr>
<tr>
<td>ENT inc Audiology</td>
<td></td>
</tr>
<tr>
<td>Neurology</td>
<td></td>
</tr>
<tr>
<td>MSK</td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td></td>
</tr>
<tr>
<td>Airedale Ophthalmology</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
</tr>
</tbody>
</table>

* Other practices are able to refer patients for these services
Appendix 3: Alliance strategy for reducing obesity in adults & children

Bradford South & West Commissioning Alliance
Health inequalities – Reducing Obesity

1. Introduction

Tackling obesity in adults and children has been identified as a priority by Bradford South & West Commissioning Alliance due to the increasing prevalence in both adults and children. A small workgroup was set up to consider the needs and identify options to recommend to the Alliance Steering group.

Workgroup:
- Yasmin Khan, GP, Willows (YK)
- Nigel Hughes, Public Health Manager (NH)
- Simon Rowlands/Jeannie Smith, Senior Health Improvement Specialist (JS)
- Jacque White (JW)

The workgroup met once on the 12th March to discuss the following.

NB: The PCT Obesity team sits under Bradford and Airedale Community Health Services, who have been commissioned to provide each Alliance with 2 days per week dedicated support to implement Alliance Obesity plans. Jeannie Smith is the support worker for South & West.

2. Vision for S&W

The Alliance will improve the range of services available to children, families and adults to support people to eat healthier, exercise more and lose weight.

3. Assessment of need

Obesity in Adults:
South & West has the highest prevalence of obesity in the district the rates are increasing. Based on the latest available data there are potentially 26,739 adults with a BMI > 30 (data extract from SystmOne extrapolated to include figures for non-SystmOne practices).
Prevalence of obese adults (>16 yrs) by Alliance

<table>
<thead>
<tr>
<th>Alliance</th>
<th>Adult population</th>
<th>Estimated numbers of obese adults</th>
<th>Estimated prevalence of obesity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airedale</td>
<td>74,690</td>
<td>15,765</td>
<td>21.1%</td>
</tr>
<tr>
<td>CityCare</td>
<td>104,348</td>
<td>21,236</td>
<td>20.3%</td>
</tr>
<tr>
<td>S&amp;W</td>
<td>133,169</td>
<td>32,491</td>
<td>24.4%</td>
</tr>
<tr>
<td>YPCA</td>
<td>90,166</td>
<td>18,306</td>
<td>20.3%</td>
</tr>
<tr>
<td>Bradford District</td>
<td>402,373</td>
<td>87,799</td>
<td>21.8%</td>
</tr>
</tbody>
</table>

Health Survey for England (2004-2006): Adult Obesity **23.6%**

**Estimated prevalence (%) of patients in each BMI category by Alliance**

- Between 1995 and 2005 the national prevalence of obesity amongst children aged 2 to 10 years rose from **9.6%** to **16.6% in boys** and **10.3%** to **16.7% in girls**.
- During the same period the proportion of obese adults over 16 years rose from 16% to 24%.
- If these trends were to continue it is estimated that one fifth of all boys, one third of girls, and one third of adults will be obese by 2020.
Obesity in children:

NCMP - Year 6 results by Primary Care Alliance 2007/08

Results from the National Child Measurement Programme 2006/07

<table>
<thead>
<tr>
<th>Former PCT</th>
<th>Underweight</th>
<th>% Children</th>
<th>Normal</th>
<th>Overweight</th>
<th>Obese</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airedale</td>
<td>55</td>
<td>138.2</td>
<td>156</td>
<td>934</td>
<td></td>
<td>1121</td>
</tr>
<tr>
<td>Bradford City</td>
<td>136</td>
<td>232.2</td>
<td>232</td>
<td>1853</td>
<td></td>
<td>2501</td>
</tr>
<tr>
<td>North Bradford</td>
<td>49</td>
<td>215.4</td>
<td>116</td>
<td>157</td>
<td>967</td>
<td>1512</td>
</tr>
<tr>
<td>Bradford South &amp; West</td>
<td>49</td>
<td>313.2</td>
<td>215</td>
<td>1518</td>
<td></td>
<td>1518</td>
</tr>
<tr>
<td>Bradford District</td>
<td>257.2</td>
<td>1907.6</td>
<td>751</td>
<td>5172</td>
<td></td>
<td>7112</td>
</tr>
</tbody>
</table>

Please note that the 5th percentile has been used as a cut off for classifying children as underweight, as opposed to the National Child Measurement Programme website figures that use the 2nd percentile.

- Bradford South and West Alliance has the highest prevalence of obesity in Year 6 children (21.6%).
- Some trends are beginning to emerge from the National Child Measurement Programme (NCMP) e.g. for Year 6 obesity prevalence Wibsey ward (25%) is consistently in the highest fifth.
- In terms of Reception Year obesity prevalence Thornton and Allerton (13.5% over 2 years) are in the highest fifth (i.e. hotspots).
- Within Bradford and Airedale, there is a clear relationship between obesity and deprivation. **Prevalence is 30% higher in school children living in the most deprived fifth of Bradford when compared to the least deprived fifth.**
- National studies have shown Pakistani boys and girls are up to 50% more likely to be overweight than the general population, Afro-Caribbean girls nearly 3 times more likely.

**Overweight children:**

- The relationship between deprivation and overweight children in Bradford and Airedale shows a different pattern, with **the highest prevalence of overweight children being in the least deprived 40% of areas**. This suggests lifestyle interventions may also be needed in more affluent areas to avoid many of these children moving from the overweight to obese category.
- National studies have shown Indian and Pakistani boys are 50% more likely to be overweight than the general population and afro-Caribbean girls 75% more likely (Saxena et al, BMJ, 2009).

4. The B&AtPCT obesity strategy and pathways
Obesity Strategy Vision – Model Based on NICE Guidance

Tier 1
BMI – BMI ≥ 28
all high risk patients (NB BMI is lower for Asian patients to be classified as high risk)

Tier 2
Weight loss assessment clinic

Tier 3
Surgery considered for those with a BMI > 50 – NORCOM Commissioned
BMI ≥ 50
Assume 80% eligible using NICE, F12 National Tariff

Tier 2 Specialist MDT Obesity Service
High risks patient
Ready to manage to change lifestyle
Consider with BMI ≥ 30 (especially with patients with co-morbidities)

Tier 3
Patients would need to be assessed for suitability to lifestyle changes at the assessment clinic to consider the following:
- Bariatric Surgery
- Plastic surgery post bariatric surgery

Tier 2
Weight loss assessment clinic – pt attends and meets with a weight loss trainer who through discussion with pt develops a 3 month personal plan for the individual. This can include some or all of the below:
- Assess readiness to change, Assess BMI/ waist circumference,
- Assess + Manage - CVD co morbidities refer to GP
- Screen and manage CVD risk factors
- Provide patient with dietary advice & skills to eat healthily
- BEEP referral
- Psychological support/counselling
- Drug therapy with appropriate lifestyle intervention support. (NICE guidance)
- Prepare for bariatric surgery
Patient can remain within this supported programme for up to a year.

Tier 1 community wide service looking at prevention
- Tier 1 = advice and signposting appointment (referral proforma assessed to see whether straight to Tier 2)

Health eating including shopping, cooking, eating smart
Physical activity - sign post local physical activity resource
Empower patients - provide skills for health eating & physical activity
All advice given needs to culturally sensitive esp. dietary
Delivered by medical, local authority, third sector, expert patients
Offered community wide – in GP practice, local community venues, workplaces, pharmacies etc. with flexible availability.
Adult pathway:

1. **Does the patient want to lose weight?**
   - **YES**
     - Patient BMI $< 28$ access Tier 1 services
   - **NO**
     - If BMI $\geq 25^*$ follow up in 15 months

2. **Patient BMI $< 28$**
   - Access Tier 1 services
   - Tier 1
     - Basic intervention for prevention
     - Review at practice at 3 months
     - Patient lost $< 5\%$ weight or gained weight
     - Follow-up 6 months
   - Wants to continue / GP feels appropriate to continue?
     - **YES**
       - Tier 2
         - Weight management clinic (BMI $\geq 28$)
         - Review completed by clinic at 3 months and report sent to GP
         - Follow-up at 6 months
     - **NO**

3. **Patient BMI $\geq 28^*$ can access Tier 1 services or consider direct access to Tier 2**
   - Follow-up 6 months

---

*If patient has BMI $\geq 50$ can be referred directly to Tier 3 at any point in pathway (until discussion re national guidance complete across SHA).*
Assessment of weight in children and young people via National Child Measurement Programme

Raise the issue of weight

Child and family ready to change?

Yes

Recommend healthy eating, physical activity, brief behavioural advice and manage co-morbidity and/or underlying causes. Provide your weight, your health booklet.

No

Progress weight loss?

Yes

Maintenance and local support options

No

Provide why weight matters card discuss the value of managing weight; provide contact information for more help/support. Provide information leaflet Top Tips for kids (change4life)

Previous literature provided?

No

Re-evaluate if family/child ready to change Repeat previous options for management or If appropriate and available, consider referral to paediatric endocrinologist for assessment of underlying causes and/or co-morbidities or referral for surgery

Yes

Offer further discussion and future support if/when ready

Refer to specialist weight management programmes ie MEND or Carnegie Weight Management

Refer to specialist weight management programmes ie MEND or Carnegie Weight Management

Q:\Commissioning\Practice Based Commissioning\South & West Alliance\Jacquie White\Alliance\Bradford South West Alliance - 2009-12 Commissioning Plan.doc
5. The services currently provided

5.1 Tier 1 - Adults:

**BEEP Bradford Encouraging Exercising People**
BEEP is the Districts exercise referral scheme. It allows GPs to refer patients for individual advice and support in increasing their physical activity levels. BEEP targets the most inactive adults and signposts to a range of community based exercise programmes ranging from walking and dancing, to gym, swimming and community based classes.

**‘Come and Try’ adult, family and improver cycle sessions**
These pilot Cycle Sessions are aimed at adults who have been encouraged to take part in physical activity and would like to try cycling. These sessions are aimed at adults who have not cycled for many years or have never cycled and would like to build on their skills and confidence. Sessions take place across the District often in local parks and bikes and helmets can be provided.

**Cook and Eat Programme**
Six week courses run in community settings aimed at developing practical cooking skills.

**Healthwise Programme**
Health related physical activity class aimed at populations who are sedentary/inactive and low and medium risk health conditions. A 'springboard' class to enable people to experience physical activity in a supportive enjoyable situation with a view to them becoming independent exercisers in other settings. This is a circuit based exercise class with relaxation and health topic session

**Walking – Volunteer Led Walk Programme**
Organised led walks that are delivered by volunteers that have been on the Natural England Volunteer Walk Leader Programme. The walks are led and organised by the volunteers themselves or the community group they represent.

**Walking – Walk Weight Management Programme**
This programme acts as a springboard for patients to maintain their Physical Activity with the Volunteer Led Walk Programme.

**Health Trainers**
The service tackles health inequalities by providing free and confidential personalised support, based on a coaching model, to encourage and motivate people to make lifestyle changes to improve their health. Individuals and groups from disadvantaged communities are targeted and Health Trainers with a good understanding of the needs of those communities are recruited and trained to work as health trainers. Health trainers come from a variety of backgrounds and many of them speak one or more of the community languages such as Urdu and
Punjabi. Health Trainers work in various accessible settings throughout the district such as community and health centres, education and leisure premises and in the workplace.

**IGT programme**
One to one specialist lifestyle support of patients identified within GP practices with Impaired Glucose Tolerance – initial consultation followed by ongoing patient-centred support to help reduce their chances of developing diabetes.

**5.2 Tier 1 – Children:**

**bactive travel to school scheme (BATS)**
The BATS Programme is in its Pilot Stage and aims to get pupils to actively travel to school. The programme also aims to motivate both the parent and teacher to actively travel and marked areas are put into playgrounds to allow pupils who are unable to actively travel to school (e.g. through disability or distance from home) to be active at school prior to the start of the school day (e.g. 4 laps of the school playground).

**Body, Mind and Soul Programme:**
A 6 week healthy lifestyles programme aimed at teenage girls 14-18 years (identified within schools as those disengaging from PE) - addressing barriers to involvement in physical activity – schools will be identified through the Partnership Development Managers in the five Local Sports Networks across the District.

**Healthy Start**
Provides parents with vouchers that can be exchanged for milk, fresh fruit, vegetables and infant formula milk across registered retail outlets.

**National Standards and Bikeability**
The Obesity Prevention Team and the Council Transport Planning Team have funded 10 places on this Course which will enable them to deliver on road and off road cycle training (Bikeability). This programme is currently being taken into schools.

<table>
<thead>
<tr>
<th>Areas of improvement to Tier 1 support:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Awareness raising of available services within Alliance and to wider community - JS</td>
</tr>
<tr>
<td>• Practice lead to be identified to be point of contact for JS and to keep information up to date – Alliance</td>
</tr>
<tr>
<td>• Briefing pack to be developed for practices – JS</td>
</tr>
<tr>
<td>• Marketing information to be developed – Obesity team</td>
</tr>
<tr>
<td>• Practices to be informed when letters re child weight are sent to parents – JS/Alliance</td>
</tr>
</tbody>
</table>
5.3 Tier 2 – BMI 30-40, Adults:

**Slimming World and Weight Watchers**
Slimming on referral pilot has been established to investigate the feasibility of referring patients to a local commercial slimming organisation (Weight Watchers and Slimming World). Practices offer free membership and 12 weeks attendance at a local group. After the free period, participants are able to continue attending but have to pay their own fees. Currently S&W patients are achieving the highest weight loss, with approximately 54% of patients that complete the programme losing approximately 5% of their weight. 300 more Slimming world/Weight watchers vouchers have been purchased by Public Health and need to be allocated to practices.

**Options**
Options is a pilot run by the Obesity team which offers group support and advice on areas such as nutrition and exercise from a multi-skilled team. The pilot will run for 20 people across the district this year.

5.4 Tier 2 – BMI 30-40, Children:

All the following are pilots, however, they do deliver large scale capacity and all are to be fully evaluated.

**MEND**
A community based programme for obese and overweight children aged 7-13 and their families. MEND is a national, commercial organisation. It combines all the elements known to be vital in training and prevention of overweight and obesity in children, including family involvement, practical education in nutrition, increasing physical activity, and behavioural change. 12 programmes are to be run in Trinity Green accessible for families across the district.

**Mini-MEND Programmes (years 2-5)** to run from 5 Children’s Centres for 80 children, 1 in each constituency.

**Brief interventions training for Childhood Obesity**
3, 1-day child obesity awareness training events for BACHS School nurses and other relevant staff.

**Carnegie Community Club Programme**
One 12 week programme to be delivered for 30 overweight children aged 7-17 and their parents. This programme will be based in Wibsey and available to children from across the district.
Carnegie Day Camp Programme
One two-week programme for 50 overweight children aged 7-17 and their parents will be commencing in a Bradford location within the next 3 months.

Carnegie Programme for 16 – 24 year olds
3 weight management programmes for 16 – 24 year olds to be piloted with Bradford College, 1 for girls, 1 for men and 1 mixed programme. Referrals from practices for the age group to start from September.

Areas of improvement for Tier 2 support:
- Identification of practice obesity lead - Alliance
- Potential development of web-based training tool – NH
- Impact of practice workload for use of vouchers to be considered - Alliance
- Brief intervention materials for practices to be developed and ensure suitable for use in GP consultations – JS
- Relationship/contact between School Nurse and Practices – JS
- Information on the children’s programmes to be disseminated to practices - JS

5.5 Tier 2 – specialist BMI > 40 but prior to surgery, Adults:

Options plus
Options plus is a pilot running in 5 practices across the district (Mayfield & Carlton in S&W). The service offers 1:1 advice and support from a Specialist Nurse in the Obesity Team and has had some positive results. The pilot is being developed this year to offer 12 people per alliance a 12 week programme from the Specialist Nurse and support workers.

5.6 Tier 3 – BMI > 40, Adults

Gastric Surgery as per NICE guidelines

6. Service development options

6.1 Adults:

- Development of obesity assessment service in practices for patients with BMI > 30 that want to loose weight in order to identify which service would be most beneficial. There are 26,739 potential patients in S&W with a BMI 30 – 40 (based on data from SystmOne). Assuming a 10% take up rate (best assumption, no evidence available re. take up rates) this equates to 2,674 patients. Potential costs based on a 30 minute assessment by a band 3 HCA are £5.30 per patient (inc. on costs). For 2,674 patients = £14,172 per annum.
6.2 Children:

- Purchase of additional MEND or Carnegie programmes.

7. Commissioning intentions

The areas for improvement identified within each of the tiers will form an obesity action plan to be led by and jointly delivered with the Obesity Team support worker allocated to the alliance.

In terms of investments to be made, as many of the current options are pilots that are undergoing evaluation the working group recommended that the funding is not committed recurrently in order to consider other options at a later date.

The Alliance will expand the weight management referral scheme to all practices that sign up to an obesity plan. This will include the purchase of additional vouchers and the commissioning of brief intervention training for both adult obesity and childhood obesity. Practices will identify an obesity lead within the practice, have regular meetings with the obesity support worker, attend brief intervention training events, and use the assessment tool to refer/signpost patients to appropriate lifestyle services.
Appendix 4: Alliance strategy for improving the health of young people

Bradford South & West Commissioning Alliance
Health inequalities – Teen Health & Reducing Teenage pregnancy

1. Introduction

Bradford South & West Commissioning Alliance identified improving the health of young people and in particular aiming to reduce teenage pregnancy as a priority area. A small workgroup was set up to consider what the needs were and identify options to recommend to the Alliance Steering Group.

Workgroup:
- Helen Dewhirst, GP, Bowling Hall Medical Practice
- Chris Brennan, Business Manager, Bowling Hall Medical Practice
- Louise Lewis, Nurse Practitioner, Royds Medical Practice
- Cath Bradley, GP, Sunnybank Medical Practice
- Sarah Jowitt, Practice Nurse, Sunnybank Medical Practice
- Anne Connolly, GP, The Ridge Medical Practice & District-wide clinical lead for Sexual Health
- Lucy Clark, GP, Highfield Medical Centre
- Anne Moncrieff, GP, Parklands Medical Practice
- Kathy Carpenter, Nurse Practitioner, Ridge Medical Practice
- Claire Whiteley, Teenage Pregnancy Co-ordinator for LA
- Jeanette Crabbe, Young People's Sexual Health Services Specialist/You're Welcome Lead for NHS Bradford and Airedale
- Mark Anslow – Bradford South Area Manager for Children & Young People
- Jacquie White, General Manager, S&W PBC Alliance

In addition, several providers of local services were invited to attend the 2nd meeting to provide further information on the services and options for development. The representatives were:

- Sharon Rushworth – Highfield Healthy Living Centre
- Liz Robinson – Step 2
- Jan De Villiers - Emerge
- Shelly Summers – Tong Tic Tac

The workgroup met 3 times on the 16th March, the 21st April and the 22nd June.

2. Vision for S&W

The Alliance will improve the health of young people by ensuring a greater range of services are available and more easily accessibly to young people in the areas of Tong, Wyke & Buttershaw. The services will provide support, information and advice about lifestyle issues and in particular sexual health and deliver health care where appropriate.
Objectives

- Improve the support available to teenagers/young people to feel better about themselves
- Improve the sexual health outcomes in the 3 areas by providing the best possible support and areas of best practice/excellence in all 3 areas
- Improve/build the trust and confidence of young people in local services
- Improve awareness and branding of what’s available
- Ensure better integration, communication and joined up working between organisations and with other lifestyle support services e.g. obesity, alcohol, smoking, drugs
- Strengthen links with schools and community services/organisations e.g. between school nurses and practices etc.

Appendix 1 illustrates the flow of services for young people the group feel that should be accessible.

3. Assessment of need

The tPCT strategic priorities are focussed on reducing teenage pregnancy, improving access to terminations of pregnancy (TOP), reducing recurrent TOPs, and improving Chlamydia screening.

A recent health intelligence briefing on Teenage pregnancy in the Bradford District (May 09) presented the latest data and evidence available. Young people who are at risk of becoming teenage parents live lives which often have complex (and often multiple) difficulties including:

- Poor family relationships
- Low self esteem
- Unhappiness at school
- Missing from school
- Early onset of sexual activity
- Poor emotional health and well-being
- Alcohol and substance mis-use
- Low educational attainment
- Lack of Aspirations
- Being looked after

The consequences can be:

- Increased risk of infant mortality (60% higher)
- Poor health outcomes for them and their children
- Limited educational opportunities
- Poor career prospects
- 22% more likely to be living in poverty than mothers giving birth after 24
- Less likely to be employed
- 3 times more likely to suffer from postnatal depression
3 times more likely to smoke throughout pregnancy
50% less likely to breastfeed
children 63% more likely to be born into poverty

Key National Targets
The key national and local targets for teenage pregnancy are to:
• Halve the conception rate by 2010 from the 1998 baseline figure
• Increase to 60% the proportion of teenage parents aged 16-19 in education, employment or training in 2010

Bradford South constituency has the highest rate of teenage pregnancy, with 57 per 1,000 conceptions under the age of 18. During the period 2004-6, 1 in every 12 teenage girls in Tong had a baby that was conceived under the age of 18 years. This compares to 1 in 24 in England. Tong must reduce the annual number of teenage pregnancies by 11 per year from the 2006 figure in order to meet the national target.

Map showing under-18 ward conception rates, 2004-2006
Nationally SRE (Sex and relationships education) is to become a compulsory part of the curriculum by 2011 from the age of 4.

A recent evaluation of the Brook Sexual Health outreach service in schools concluded that school based services had a positive impact and should be developed further including out of school hours. The report also identified the need for efficient links and relationships with primary care, CASH and young people’s services. Youth workers were seen as having a crucial role in encouraging young people to use such services. Young people want accessible, local and friendly services. Bradford has the lowest take up of services in schools across the country although engagement with schools is improving.

4. Current services

<table>
<thead>
<tr>
<th>Service</th>
<th>Tong</th>
<th>Wyke</th>
<th>Buttershaw</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community CASH service</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Practice based level 1 &amp; 2 sexual health services</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Practice led young people’s drop in service</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Pharmacy provided EHC</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Tic Tac</td>
<td>Y</td>
<td>Y (coming soon)</td>
<td>Y (coming soon)</td>
</tr>
<tr>
<td>Step 2</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>APAUSE</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Emerge</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Healthy Living Centre</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>

The group felt that all services worked well on an individual level, but needed better communication and joint working between organisations. The group agreed there was need to link into other lifestyle issues such as obesity. Communication, information, referral routes and signposting between services was vital.

5. Service development options

Specific areas of improvement were identified as follows:

5.1 Sexual Health
- Need to encourage LARC (Long Active Reversible Contraception) provision in the 3 areas
- Access to CASH service in Tong needs reviewing – times, dates and venue may need changing to meet the needs in the locality.
• Information should be provided to practices about Speakeasy which is a training programme for parents to talk to their teenagers about sexual health. The programme runs in Bradford targeting hotspot areas and parents that need support. There are opportunities to become a Speakeasy trainer and run programmes locally.

5.2 Tic Tac
• Learning from the Tong Tic Tac needs to be utilised to inform the development of the Wyke and Buttershaw services. Tong Tic Tac is evaluating the existing young people’s services to understand what’s available, what works, why people do and don’t use them etc. The report will be available by the end of May.
• Tong Tic Tac only runs in school hours currently, it may be possible to deliver the service out of hours and in particular in school holidays depending on available facilities and funding for staff. Other possible venues were suggested e.g. the Healthy Living Centre, Children’s Centre, local VCS facilities etc.
• Practices want to be involved from the outset in the development of the new services in Wyke and Buttershaw (Sunnybank, Low Moor, Parklands, Royds and the Ridge)
• Tong Tic Tac can’t prescribe or provide EHC currently
• Tic Tac in Wyke will be delivered from Childrens centre initially. It will be open after school and possibly on Saturdays, may be possible to deliver the service in school holidays depending on capacity and funding.
• Buttershaw Tic Tac is currently looking at premises and will potentially use the Youth Centre, however, these premises will need improving. Health input is needed to look at this to ensure health services could be provided from the premises.

5.3 EHC (Emergency Hormonal Contraception)
• Pharmacies in the 3 areas need to be encouraged to provide EHC service, the training is being targeted in the hotspot areas.
• PGD (Patient Group Directions) for EHC are available to enable qualified nurses to provide it in the 3 areas.

5.4 APAUSE
• The programme was developed to be jointly delivered by schools and with health professional input. The health input into programmes has been difficult to obtain so far. Each programme needs 3 x 1 hour health input into the sessions in classrooms.
• Practitioners would be trained in how to deliver the session and would use existing materials. It is helpful for health professional to be available after each session for any individual pupil questions or concerns.
• A new SRE programme being piloted in September. for years 9 & 10 and will be rolled out in 2/3 years.
• Practices are keen to be involved with the programme.
5.5 Step 2
- There is the potential to expand the existing Tong service into other localities in particular Wyke due to the lack of other services, which could be run from Childrens centres.
- This would help bring young people into other services.

5.6 E:MERGE
- The organisation focuses on young people’s health and delivers detached work with schools and with local partners out on the streets.
- The workers signpost to other services and offer support for young people to identify and access appropriate services.
- There is a need to strengthen links with other organisations e.g. Healthy Living Centre and Step 2 to help signpost people to a wider range of services.

5.7 Healthy Living Centre
- The Centre works with partners to deliver various services to young people and runs accredited courses.
- The Centre could support the delivery of a wider range of services.

5.8 Youth Workers
- Sexual health is a key priority for the service next year with workers providing support, signposting of service etc. The Youth Workers will carry out teen life checks, deliver sessions around sexual health and relationship, ensure young people have access to up to date info about drugs and substance misuse and the impact on their health and encourage healthy eating and increased physical activity through play by building these into their programmes on offer (indoors and outdoors).
- Clarity regarding the youth workers role and responsibility is needed, the workers should be making contact with local practices to build relationships and raise awareness of services. The workers will need information and training to provide this support.

5.9 Practice led drop in clinics
- Practice led young people’s services were set up as pilots a few years ago with a small amount of non-recurrent funding and based on practice premises.
- The original remit was sexual health however, the young people accessing the services often had a range of support needs i.e. Bullying, Peer pressure, Alcohol and drug worries, puberty and body image concerns, social issues that the staff have to deal with away from clinical interventions.
- The services see a large proportion of non-registered patients who often choose the service to ensure anonymity or through recommendations from friends.
- The services have built up over the last few years and are now established and credible with young people. They ensure a greater choice and accessibility of services for young people.
• The services help to impact on a variety of priority areas for the PCT, the local authority and nationally, e.g. Teenage pregnancy, STIs, smoking cessation, obesity etc. and a wide range on non-health issues such as bullying, self-esteem etc.

• There is no one specification for services, they have developed differently in each of the areas. For instance Bowling Hall work closely with Step 2 to deliver counselling services in their Teentalk service, the Ridge provides a practice staff service, Sunnybank offer a CASH drop in service for all ages and are currently working with the Wyke Tic Tac service.

• Practices have so far offered a range of support to those that access services on the practice premises, however, there are many developments that could be offered with the practice acting as a hub for young people’s services for the local community.

• There is no current funding of these services, practices have been continuing to run them out of good will but are unable to do so in the longer term. This provides a risk for young people in those 3 areas and a potentially negative impact on the relevant PCT targets.

5.10 Misc.

The “HE4T” bus that used to run in Low Moor, Wyke, Buttershaw, Odsal & Bierley evaluated positively and could be considered.

A central point of co-ordination of times and dates of services for young people would be helpful to provide a choice of services, on different days and times.

The sexual health element of the JAR (Joint Area Review) was flagged as needing significant improvement. A joint strategy group is being set up to tackle this, which the work of this group could feed into. The links with schools need to be strengthened and the differences in how schools and their senior management teams work needs to be understood locally.

A Health presence in the localities groups would help link up services and people and support delivery of the strategy and the development of local plans.

Co-ordination of the different contracts with providers would be helpful to understand the length of contracts and the different monitoring requirements and outcomes achieved.

It would be useful for the outcomes of the bHealthy group to be communicated to Alliances.

All services for young people will be asked to work to the You’re welcome criteria. These are being piloted in a few services currently and will roll out to others services later in the year.
6. Potential commissioning options

6.1 Provision of the HE4T Bus

South and West primary care trust (PCT) introduced the Health Education for Teens (HE4T) bus which provided confidential health advice to 13-19 year olds. An evaluation of this in 2007 concluded that the HE4T bus was a successful intervention, but that further improvements, such as clinical services in a new consultation area, and using the bus for general health promotion at other times, were necessary in order to make it successful throughout the whole of Bradford.

The yellow, single decked bus contained a small kitchen area, and a seating area at the back, with a table where youths could discuss issues either on their own, or as part of a group. There were teenage-friendly leaflets, and posters on a range of health issues available around the bus and the youths could also access a free condom scheme. The bus had a regular bus driver, and there were two other members of staff on board, (school nurses, youth worker, or the male health worker). On a Monday and Tuesday night, from 6pm-8pm, the bus visited two different areas of South & West Bradford providing free, confidential advice to 13-19 year olds.

The bus provided an approachable service for teenagers. The criteria for a successful health intervention for young people were well demonstrated with staff displaying good listening skills and flexibility. Confidentiality was adhered to and the bus targeted some marginalised groups, including males. It was a walk-in service that was easily accessible with appropriate opening hours. The coordinator and staff had positive attitudes and displayed strong personal commitment. To further improve the bus it could incorporate other excluded groups such as ethnic minorities, provide additional training for staff and provide a full range of contraceptives, some of which were already a part of the successful Leeds health bus. The bus should be health focused to maximize its potential, possibly with the addition of a GP, and teenage sexual health services provided weekly to additional locations. A private consultation area for confidentiality and clinical applications would also be a valued addition. The improved bus should be well advertised throughout Bradford, informing potential users and educating parents to ensure the bus is welcomed in all areas.

The evaluation report concluded that the HE4T bus, with the recommended improvements, would be a valuable service throughout Bradford.

Cost of pilot 2005 – 2007:

- Royds enterprise bus was commissioned for 8hrs a week from 4pm to 8pm two days for 52 weeks costing £14,000 approx.
- School nurses for 8hrs costing £6,500.
- Health of men worker - time given free as pilot
- Youth worker - time given free as in their patch
- Co-ordinating and running of service was free for the 2 year pilot.
Total cost of pilot = £20,500 per annum for 416 hours on the road

The group agreed that the bus met the need at the time when there were no young people’s services in S&W, however, to be cost effective and obtain the outcomes necessary the service would need to be developed district wide and in partnership with others.

*Therefore the group agreed this should not be funded by the Alliance.*

6.2 Health input into APAUSE programme – Added Power and Understanding in Sex Education

The long-term goal of APAUSE is to promote the positive emotional and physical aspects of relationships. More specifically, the objectives of the programme are to:

- Increase tolerance, respect and mutual understanding;
- Enhance knowledge of risks and counteracting myths;
- Improve effective contraceptive use by teenagers who are already sexually active;
- Provide effective skills to those who wish to resist unwelcome pressure.

The programme is, in brief:

- Curriculum support material for Year 7/8 (aged 11-13)
- 3 Adult-led sessions in Year 9 (aged 13-14)
- 4 peer-led sessions,
- Adult-led sessions in Year 10 (aged 14-15)
- Year 11 (mean age 16 years) Evaluation questionnaire session.

**Overview of programme delivery:**

The Adult-led elements of the programme are delivered to years 9 & 10 and consist of 3, 1 hour sessions per year group. The programme is delivered jointly by a Health professional and a member of school staff, usually a teacher or learning mentor. The same trainers deliver each of the 3 sessions to a class in order to provide consistency. The year 9 programme is delivered throughout the year, the year 10 programme is usually delivered from February onwards.

In total the programme is delivered to approximately 10 year 9 (Y9) classes and 10 year 10 (Y10) classes per academic year, per school. This equates to total delivery time of approximately 60 hours for Tong High School and 60 hours for Buttershaw College of Business & Enterprise. The programmes are generally timetabled a few months in advance, although there are sometimes last minute changes by the Schools. The current programme (name and content) will be changing in the next 2/3 years following the roll out of a pilot that is currently being undertaken. The programme’s format, in terms of number of sessions/delivery commitment for professionals, will remain the same.
Training and support:
A 1 day training course is provided for Health Professionals and teachers to delivering the programme to year 9 and 1 day course to deliver the programme to year 10. This joint training programme fosters relationships at the outset. The SRE Programmes Co-ordinators will provide co-ordination of the programme and ongoing support, for instance people can shadow them (or another experienced health professional) delivering the programme in order to increase confidence. The co-ordinators can arrange team/shared teaching and observed delivery if requested. Access to specific sexual health training can also be provided.

Process:
1. Programme dates will either be circulated at the training course to assess availability or people contacted by the School Nurse.
2. If the health professional is able to deliver all 3 sessions for the programme they arrange a pre-meet with their co-worker from the school. This may be one-to-one or a pre-meeting with the Y9/Y10 delivery ‘team’, arranged by school.
3. A delivery booklet will be provided at the training course and the trainer from the school will have a class pack with all necessary resources for the programme. The school trainer is responsible for providing any information back to the APAUSE co-ordinator, e.g. pupil evaluations.
4. It is useful for the health professional to be available after the session for any pupils that may want to ask further questions. In practice this additional time is never more than a couple of minutes.
5. It is best practice for co-workers to meet at the end of each session to review the process. However, this is sometimes impossible if a teacher has another lesson to teach. Usually an evaluation meeting is organised by the co-ordinator at the end of the year.
6. Health professionals can feed back to the SRE co-ordinator any issues that crop up when delivering the course, so that issues can be addressed with schools where necessary.

Resources:
APAUSE provide training and the opportunity to promote practice services in return for the delivery of programmes.
It is suggested that funding for clinical time could be provided as follows:

£200 per programme based on the agreement to attend 2 training days and deliver a minimum of 3 programmes per year in the practice locality.

It is hoped that practices could deliver training in at least 50% of the programmes, which would mean 10 programmes (30 sessions) delivered in Buttershaw and 10 programmes (30 sessions) in Tong.

Total cost for practice input if all 20 programmes could be delivered by a practice health professional = £4,000
Given the small amount of funding needed, it was agreed that this could be funded by monies available within the teenage pregnancy team until 2011.

*Therefore no funding is needed from the Alliance.*

### 6.3 Step 2 provision in Wyke

Step 2 currently works with young people aged 10 and over in Holmewood and Bierley to:

- raise awareness of health issues
- develop self-confidence, self-determination and self esteem
- involve young people in the planning and the way in which services are provided
- enable young people to make informed choices about their sexual health and emotional well-being needs

Step2 could provide this service in Wyke as per the following:

- Offer support to the newly developed TIC TAC service at Wyke Community and Children’s Centre, offering provision of cover for sessions and other support (also looking at the possibility of renting space in their portakabin to enable Step2 to have a centrally placed base). Advertising the service in other areas of delivery and offering support to users that may need more support.
- Build relationships with the practitioners at Sunny Bank Medical Centre, to support the Young People’s CASH Clinic (mirroring the model used between STEP2 and Bowling Hall Medical Centre - a youth worker and health professional working in partnership to bridge the gap between services and offer a more youth friendly service.
- Link in with Youth Workers - Christian Fellowship Church & Bradford Youth Service to support the work that is currently being delivered, but also to look at the development of new projects e.g. detached/ outreach work on Shirley Manor Estate and St. Marys Estate.
- Link in with the Extended Schools Manager to look at developing work within the local Primary School network, such as friendship, bullying groups, self esteem etc, transition sessions etc.
- To link in with Wyke Manor to look at the delivery of a Protective Behaviours programme. This is a project that works with girls to look at healthy and unhealthy relationships, domestic violence, keeping safe and grooming.
- To review the delivery of Insight (already being delivered within Wyke Manor School), this is a programme looking at mental health, including stress, anger management.
- To look at the further development of Drugs and Alcohol work that is already taking place via the Caleb -Drugs and Alcohol Support Worker by offering a “16+ drop in support session” also linking in with Connexions.
• To look at the development of a young people’s consultation group to identify needs of younger teens.

All of the work above will help prevent unplanned teenage pregnancy and STIs by equipping young people with the skills to enable them to make informed choices about their sexual health and well being. It will promote healthy relationships and keeping safe, self esteem and self awareness and will promote the ‘delay’ message to young people in the area.

The group discussed the need for the range of activities suggested and the responsibility of other partners to fund various elements.

*It was agreed the input into the Tic Tacs in both Wyke and Buttershaw in addition to Tong should be commissioned by the Alliance as well as input into all Practice led young people services.*

6.4 Provision of Tong TIC TAC out of school hours

The Teenage Pregnancy team are going to pilot Tong Tic Tac being run over summer from a variety of locations to suit the local need. This is currently being scoped, the results of the pilot will inform future investment.

*Therefore no funding is needed from the Alliance for this.*

6.5 Wider provision of EHC

EHC is offered at both pharmacists in Wyke. The Asda pharmacy in Tong is currently completing the training. The nearest pharmacist offering EHC for Buttershaw patients is in Wibsey. Both Boots pharmacies in the city centre offer EHC and are open on a Sunday. Pharmacists in the 3 areas are being encouraged to participate in the next round of training. Practices will encourage their local pharmacists to participate.

School Nurses are covered by the existing PGD and could provide a contraceptive service in the 3 areas with the greatest need.

*Therefore no funding is needed from the Alliance for this.*

6.6 Practice led drop in services for Young People

The purpose of providing a teenage health service within practices is a combination of an identified local need and an enthusiasm within the practices to support local teenagers with their ongoing health needs.

There are already Young People’s services provided by 3 practices within the 3 target areas (although not necessarily badged as young people’s services in all 3 practices). These areas have the greatest need in the Alliance to address teenage health issues focussing on sexual health related support and wider
health issues such as smoking, obesity/weight management, behavioural, alcohol support etc.

**Suggested aims of practice services:**

- To provide confidential, friendly, supportive, and accessible health related services to all teenagers aged between 13 and 19 years of age, within the Bradford and Airedale tPCT area.
- To be a ‘centre of excellence’ for teenage services.
- To develop services related to the needs of the teenage population.
- To develop partnerships and network with other local service agencies to provide choice for teenagers to access services.
- To ensure all teenagers accessing the service feel safe and confident to share any issues or concerns they may have.
- To promote the practice as being ‘teenage friendly’
- To work towards addressing the local and national targets applicable to teenagers for example, reducing teenage pregnancies, through education, advice and support.

**Expected outcomes of services:**

- To support young people to make positive lifestyle choices
- To reduce the number of teenage pregnancies
- To reduce the number of terminations of pregnancy
- To improve the uptake of Chlamydia screening
- To reduce the number of young people smoking
- To reduce alcohol intake in young people
- To reduce teenage obesity levels
- To improve self esteem and confidence and overall techniques for behaviour management.

The group agreed that these services are extremely important to retain and could be developed to act as a hub for the locality. It was felt that the Alliance should build on what works rather than invest in new services.

There was an agreed need to develop a service specification that clarified what was expected of these services including required partnership arrangements and performance measurements etc. It was agreed that practices should work with other providers of services that have already been funded to bring in their expertise locally, for instance the smoking cessation service for teenagers could be asked to provide sessions within practices.

It was agreed that the service specification should cover the full service that the Alliance would like to commission. However, given the funding available this would mean certain elements being prioritised until other funding sources were found.

*Therefore it was agreed the Alliance should commission a practice led young peoples service in the 3 areas.*
7. **Action plan**
Various actions have been identified which form an action plan and which will be taken forward by named individuals. The existing work group could be asked to act as the steering group for the workstream and meet again in 6 months to review overall progress against the following identified actions and the final agreed commissioning priorities.

**Actions to take forward:**

7.1 **Communication & Marketing**
- Existing services, including practice services, to be included in the district-wide comms. pack, on the website and as part of the marketing strategy
- Development of flyer/poster/business card of services available in 3 areas
- Times and dates of services to be available to other service providers and young people
- Summary of existing services to be circulated
- Information about Speakeasy programme to be made available to practices along with the option to be a trainer and deliver programmes locally
- Bactive work to be shared with Alliances

7.2 **Current Services**
- The recommendations from the consultation work being done with young people around health service provision and SRE in the Tong area to be considered
- Tong CASH service to be explored to consider whether the dates, times and venue of the current service delivery meet local need
- Outcomes of sexual health pilots run in Owlet & Wrose childrens centres to be considered
- Information for and training of Youth Workers in the services available locally
- Health input into development of Buttershaw Tic Tac
- Counselling needs for practice based young people’s services to be co-ordinated and linked into CAMHS strategy
- Practices are to encourage local pharmacists to participate in the EHC training
- The role of School Nurses in providing contraceptive services for areas with the greatest need to be considered.

7.3 **Partnership working**
- Alliance input into SRE strategy group to be offered to support improvements identified by JAR
- Health presence on locality groups to provide local input to be scoped. Locality meetings should be supported to bring together practices, Schools, Tic Tac, Childrens Centres, Youth workers, CASH services and other local service providers on a regular basis to support partnership working and service developments at a local level.
• Contracts with providers to be reviewed to clarify timescales, expected outcomes and co-ordinate performance measurements.

7.4 Commissioning of services
• The development of the HE4T bus to be discussed at a district-wide level
• Health input into Apause programmes to be commissioned by Teenage pregnancy team
• Tong Tic Tac to be run over summer as a pilot and funded by the Teenage pregnancy team

8. Commissioning intentions

The commissioning intentions are to be agreed at the July meeting of the Alliance. The commissioning of Step 2 to provide support to the Tic Tacs in Buttershaw and Wyke and the practice led young people’s services in all 3 areas will be considered in detail, as will the commissioning of a Practice led Young People’s service in each of the 3 areas.
Flowchart of services in S&W for YOUNG PEOPLE

**TIER 1**

Life Style choices – 
Support, Advice, Information

Current Services:
Practice based drop in teen clinics and SH (sexual health) clinics
Tic Tac
APAUSE
Step 2
Children's centres
Emerge
CASH
Others

**TIER 2**

Health Intervention – 
Diagnosis, Treatment, Support

Current Services:
CASH
GUM
EHC Services
Practiced based sexual health services
Smoking cessation
Drugs and alcohol services

**TIER 3**

Pregnancy & Parenting
Advice, Information, Support Care

Current Services:
Ante natal and post natal – health visitors, midwives, GP
Parenting support
Social Care / Welfare support

Need: Good communication between different service providers
Awareness raising with other professionals
Awareness raising with young people

You’re welcome criteria
Young people actively seeking support

You’re welcome criteria
Young people actively seeking support

You’re welcome criteria
Young people actively seeking support
Appendix 5: Alliance strategy for improving the health of older people

Bradford South & West Commissioning Alliance
Health inequalities – Improving the health of older people

1. Introduction
Bradford South & West Commissioning Alliance identified improving the health of vulnerable older people over the age of 65 as a priority area. A small workgroup was set up to consider what the needs were and identify options to recommend to the Alliance Steering Group.

Workgroup:
- Angela Moulson, GP, Highfield Health Centre - Micallef
- Anne Moncrieff, GP, Parklands Medical Practice
- Anne McAdam, Nurse Partner, Ridge Medical Practice
- Fiona Purdie, Business Manager, Parklands Medical Practice
- Clare Elener, Nurse Practitioner, Carlton Medical Practice
- Carolyn Robinson, Community Matron, Wilsden Medical Practice
- Jacquie White, General Manager, S&W PBC Alliance

The workgroup met once on the 9th April.

2. Vision for S&W
The Alliance will improve the health of vulnerable older people living in a care home and people with dementia living in their own home.

3. Assessment of need
As at March 2009, the alliance had 21,398 patients registered over the age of 65. The following table breaks down the acute activity for this age group.

<table>
<thead>
<tr>
<th>Acute admissions</th>
<th>06/07</th>
<th>07/08</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>5679</td>
<td>5527</td>
<td>5818</td>
</tr>
<tr>
<td>Cost</td>
<td>£13,511,975</td>
<td>£13,144,934</td>
<td>£13,297,812.09</td>
</tr>
<tr>
<td>Rate of admission per 1000 of the over 65 population</td>
<td>262</td>
<td>256</td>
<td>272</td>
</tr>
<tr>
<td>Numbers of 0 or 1 night stays</td>
<td>1694</td>
<td>1843</td>
<td>1956</td>
</tr>
<tr>
<td>% of 0 or 1 night stays</td>
<td>30%</td>
<td>33%</td>
<td>34%</td>
</tr>
</tbody>
</table>
3.1 Care Homes

The Alliance has patients residing in 40 care homes. Currently, the recording of patients living in a care home is poor in practices. A search of SystmOne practices in May found 77 patients coded as living in a care home.

The following table using data from the local authority provides a breakdown of the number and % of patients in a care home for each practice in the Alliance. Overall the Alliance has 4.2% of the over 65s which is comparable to the district wide figure of 4.4%.

### Population Registered as at August 2008, showing count of number in a Care Home

<table>
<thead>
<tr>
<th>Code</th>
<th>Practice Name</th>
<th>Number in Care Home</th>
<th>Total Registered Population</th>
<th>% in Care Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>B83007</td>
<td>The Heaton Medical Pract</td>
<td>62</td>
<td>907</td>
<td>6.8%</td>
</tr>
<tr>
<td>B83009</td>
<td>Sunnybank Medical Centre</td>
<td>4</td>
<td>1267</td>
<td>0.3%</td>
</tr>
<tr>
<td>B83010</td>
<td>Parklands Medical Pract</td>
<td>38</td>
<td>1370</td>
<td>2.8%</td>
</tr>
<tr>
<td>B83012</td>
<td>Carlton Medical Practice</td>
<td>52</td>
<td>834</td>
<td>6.2%</td>
</tr>
<tr>
<td>B83015</td>
<td>Highfield Health Centre</td>
<td>50</td>
<td>695</td>
<td>7.2%</td>
</tr>
<tr>
<td>B83017</td>
<td>Horton Bank Practice</td>
<td>30</td>
<td>980</td>
<td>3.1%</td>
</tr>
<tr>
<td>B83020</td>
<td>The Willows Medical Ctr.</td>
<td>44</td>
<td>920</td>
<td>4.8%</td>
</tr>
<tr>
<td>B83028</td>
<td>Wibsey &amp; Queensbury Med P</td>
<td>62</td>
<td>1641</td>
<td>3.8%</td>
</tr>
<tr>
<td>B83029</td>
<td>Low Moor House</td>
<td>63</td>
<td>1251</td>
<td>5.0%</td>
</tr>
<tr>
<td>B83035</td>
<td>Horton Park Surgery</td>
<td>16</td>
<td>855</td>
<td>1.9%</td>
</tr>
<tr>
<td>B83037</td>
<td>Wilsden Health Centre</td>
<td>37</td>
<td>1664</td>
<td>2.2%</td>
</tr>
<tr>
<td>B83041</td>
<td>Bowling Hall Med Practice</td>
<td>49</td>
<td>688</td>
<td>7.1%</td>
</tr>
<tr>
<td>B83042</td>
<td>Rooley Lane Med. Centre</td>
<td>29</td>
<td>929</td>
<td>3.1%</td>
</tr>
<tr>
<td>B83044</td>
<td>Highfield Health Centre</td>
<td>38</td>
<td>562</td>
<td>6.8%</td>
</tr>
<tr>
<td>B83045</td>
<td>Mayfield Medical Centre</td>
<td>20</td>
<td>770</td>
<td>2.6%</td>
</tr>
<tr>
<td>B83049</td>
<td>Grange Lea</td>
<td>16</td>
<td>695</td>
<td>2.3%</td>
</tr>
<tr>
<td>B83050</td>
<td>The Grange Practice</td>
<td>78</td>
<td>1201</td>
<td>6.5%</td>
</tr>
<tr>
<td>B83055</td>
<td>The Ridge Medical Pract.</td>
<td>97</td>
<td>2448</td>
<td>4.0%</td>
</tr>
<tr>
<td>B83071</td>
<td>Phoenix Medical Practice</td>
<td>77</td>
<td>457</td>
<td>16.8%</td>
</tr>
<tr>
<td>B83619</td>
<td>Sai Medical Centre</td>
<td>13</td>
<td>255</td>
<td>5.1%</td>
</tr>
<tr>
<td>B83647</td>
<td>71 Beacon Road</td>
<td>1</td>
<td>233</td>
<td>0.4%</td>
</tr>
<tr>
<td>B83657</td>
<td>Bevan House</td>
<td>0</td>
<td>17</td>
<td>0.0%</td>
</tr>
<tr>
<td>B83658</td>
<td>Royds Healthy Living Ctre</td>
<td>3</td>
<td>249</td>
<td>1.2%</td>
</tr>
<tr>
<td><strong>S&amp;W Total</strong></td>
<td></td>
<td><strong>879</strong></td>
<td><strong>20888</strong></td>
<td><strong>4.2%</strong></td>
</tr>
<tr>
<td><strong>District Total</strong></td>
<td></td>
<td><strong>2981</strong></td>
<td><strong>68506</strong></td>
<td><strong>4.4%</strong></td>
</tr>
</tbody>
</table>
The acute admissions for these care homes over the last 3 years is broken down below.

<table>
<thead>
<tr>
<th>Acute admissions</th>
<th>06/07</th>
<th>07/08</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>611</td>
<td>681</td>
<td>634</td>
</tr>
<tr>
<td>Cost</td>
<td>£1,522,395.21</td>
<td>£1,667,817.76</td>
<td>£1,540,718.45</td>
</tr>
<tr>
<td>Rate of admission per 1000 population in Care homes</td>
<td>288</td>
<td>355</td>
<td>322</td>
</tr>
<tr>
<td>Numbers of 0 or 1 night stays</td>
<td>174</td>
<td>234</td>
<td>224</td>
</tr>
<tr>
<td>% of 0 or 1 night stays</td>
<td>28%</td>
<td>34%</td>
<td>35%</td>
</tr>
</tbody>
</table>

* Numbers of patients in a care home only available for August 2008. Rates of admissions for all 3 years have been estimated based on this data.

The above data illustrates that patients in care homes have a higher rate of acute admissions with a slightly higher percentage of 0 or 1 night stays.

The group discussed that the current support provided by practices to patients in care homes generally focussed on managing acute illnesses and felt that this group of patients should be supported proactively to prevent or manage illness better in the home. The group also highlighted the need to improve medication compliance including feeds and dressings. The PCT quality standards for care homes were discussed and seen as an opportunity for practices to work with care homes to improve the care of patients.

**3.2 Dementia**

As at 07/08 national QOF data, the alliance had 760 patients with a diagnosis of dementia this compares to an expected prevalence of 1,578 for the population of S&W Alliance.

<table>
<thead>
<tr>
<th>Admissions</th>
<th>2005/06</th>
<th>2006/07*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bradford Teaching Hospital</td>
<td>56</td>
<td>41</td>
</tr>
<tr>
<td>Airedale General Hospital</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Bradford District Care Trust</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Total admissions</td>
<td>62</td>
<td>46</td>
</tr>
</tbody>
</table>
Of the 62 admissions with a primary diagnosis of dementia in 2005/06, 15 (24%) patients were from a care homes. Of the 46 admissions with a primary diagnosis of dementia in 2006/07, 15 (33%) patients were from a care homes.

The group agreed that earlier detection of dementia was needed, along with a more comprehensive annual assessment to prevent or manage illness better. The availability of IAPT for older people, a 24 hour crisis team was also discussed and the group felt that these would be developed as a result of the Darzi Mental Health plans. The group did identify the need for better prescribing of antipsychotics and better links with the voluntary and community support groups available locally.

3.3 Falls and fractures
The group identified the need for a more comprehensive secondary prevention falls assessment to be undertaken for the over 65s at risk. Earlier identification of patients at risk of Osteoporosis was also discussed.

3.4 Carers
Building on the QOF requirement to have a carer’s policy in the practice, the group felt there was a need to have a register of carers with an annual assessment of their needs.

3.5 Agreed area of focus
The group ranked the above 4 areas and agreed that patients in care homes and those with dementia living in their own home were the most vulnerable in terms of their health and therefore the highest priorities. In particular the group agreed there was a need for an annual comprehensive assessment for these patients.

Currently most practices see their patients that reside in a care home during a review visit (medication, chronic disease review) or during an acute illness. Patients with Dementia living at home receive an annual review for their condition, medication reviews and support during an acute episode.

These cohorts of patients are deemed to be more vulnerable in terms of their health than the general population of over 65s, however, are often only seen for a particular element of their health at any one time. The acute illnesses are often preventable, and when they do occur could be managed within the patient’s home (whether that be their own home or the care home they live in) with the appropriate care plan and support to enact that care plan.

4. The services currently provided
Patients in the cohort receive health care during illness either from the GP practice, district nursing service, out of hours service or by attending the hospital.

There are various community based services that patients can be referred into or access through the care home. Additionally the Alzheimer’s society support
patients and carers. There are a number of Wellbeing cafes in the locality that provide support and activities for older patients with a mental health problem and their carers.

5. Service development options

The group discussed what a comprehensive annual assessment would entail and identified the following that could be developed into a standard template:

**Annual assessment for the over 65s**

**Mental Health** - Cognitive impairment and depression  
Geriatric Depression Screen (GDS)  
6 CIT (tool)  
Mental health advocacy  
Advanced directive/EOL plans

**Physical Health** - Standing and sitting BP, pulse, routine bloods  
Nutrition – MUST (tool)  
Tissue viability  
Mobility – Falls, aids, therapy  
Osteoporosis risk  
Oral health  
Continence – urinary and faecal  
Pain management  
Medication  
Podiatry

**Lifestyle** - Smoking  
Alcohol  
Drugs

**Social** – Isolation, economic, housing  
Carer identified

**Actions** – care management plan

The annual assessment would enable each practice to hold and maintain a register of patients residing in a care home and improve the identification of patients with dementia (many of whom will be living in a care home).

The assessment would enable a care plan to be developed with the patient and their carer where appropriate. This would then be discussed with the care home/carer to enable them to enact the care plan with support from the practice. A 6 month follow up would be done at the same time as medication or other review. Access to clinical records in the care home would support the assessment process. Help the aged have installed computers in some care homes which could be configured to enable practices to access SystmOne. The organisation could be approached to consider installing computers in other care homes.
Care Homes
Practices would support the care homes staff and the PCT care homes lead in identifying any training and development areas that may be appropriate. Through the assessment process practices would be supporting care homes in the achievement of their quality standards and could highlight any performance issues to the PCT care homes lead where necessary.

Anticipated benefits
- Improved relations/communications with care homes
- Early identification of health problems/risks
- Standardised processes (quality care)
- Falls prevention
- Reduction poly pharmacy
- Reduced emergency admissions
- Reduced A+E attendances
- Improved patient safety
- Improved patient care/quality of care
- Multidisciplinary working
- Increased support care homes
- Identified unmet need
- Improved evidence based practice (inc. NICE)

6. Commissioning intentions

The commissioning intentions are to be agreed at the July meeting of the Alliance. Development of a comprehensive holistic annual assessment process for older people (over 65) in care homes or with dementia living in their own home will be discussed. Attached as appendix 4 is an overview of the Care Homes Project run by Carlton Medical Practice which illustrates the quantifiable and qualitative outcomes that can be achieved through this suggested approach.
### Appendix 1

#### Practice Populations as at 31 December 2008

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* S&W: Bradford South & West Commissioning Alliance
Appendix 2

A&E Attendance Rates in 2008, Aged 65+

- Individual Nursing Homes
- Bradford
- All Listed Nursing Homes
Appendix 3

Non-Elective Admission Rates in 2008, Aged 65+

- **Individual Nursing Homes**
- **Bradford**
- **All Listed Nursing Homes**
Appendix 4: Carlton Medical Centre – Care Homes Project

The Care Homes project is an approach to working collaboratively with homes in a particular locality in an effort to improve communication and the quality of care delivered to patients in that setting.

There was a general consensus amongst GP practice staff that the service provided to care home patients was generally disorganised and reactive. Through clinical meetings and informal discussions, staff expressed a commitment and motivation to improve the quality of care for patients living within a care home setting but required leadership about how to influence this process. To formalise these discussions, a briefing paper was produced and presented to all practice staff at a clinical meeting. It contained a clear description about how an improved method of case management of these residents could result in several positive outcomes that could be measured in both positive qualitative and quantitative effects for the GP practice, care home staff and ultimately the patient. The Care Homes project was also added as a standing agenda item in the monthly ‘time out’ sessions attended by all staff members of the GP practice team. This was an important opportunity to share information and discuss any problems experienced by staff in relation to this venture.

Each Home Manager involved within the Care Homes project was visited in turn to provide an overview and raise the profile of this development. This also provided an opportunity to learn first hand how care staff felt about the service that they received from the GP practice and any ideas staff had about opportunities to improve this relationship, which could potentially result in benefits for all parties (care home, GP practice and patient).

During the first visit to each care home, the lead clinician discussed with staff a mutually convenient time to interview each patient. This was decided with the staffs’ knowledge and preference about the quieter times of the working week for a NP visit. Care staff were asked about opportunities to improve the relationship between each home and GP practice and various ideas were suggested and implemented that resulted in benefits for both the care staff and GP practice. Care staff described the difficulty in obtaining the correct repeat medications from the GP practice. This issue was also reported to be a problem by the practice administrative staff, as care staff often requested items that were not included within the repeat script but were required in the event of an acute problem, for example, laxatives for constipation. Care staff reported dissatisfaction at not being able to obtain this additional item at the time of request and administrative staffs were frustrated at having to remind care staff about the practice policy for requesting repeat medications. This led to various changes that included a revised approach to the way repeat prescription requests were handled, in future the NP lead for each home would process all repeat medication requests and troubleshoot any problems that arose.

**Aims and Objectives**

- Implementation of a proactive approach to improve the quality of care for older adults registered with the practice and living within a care homes setting.
- An improved case management of these patients to focus attention away from reactive care and towards a holistic approach to each care home resident.
- The Nurse Practitioner acts as case manager for the care home population for those patients that fall outside the Community Matron criteria. The NP carries
out a holistic health interview and assessment for reversible undetected health problems (e.g. falls prevention, malnutrition). The NP undertakes all visit requests for care home patients to build rapport and support continuity of care.

A number of issues and opportunities were identified:

- GP’s were visiting a care home to address acute health problems but due to time constraints these visits were often reactive and offered little opportunity or emphasis upon health promotion in later life.
- For example, this includes attempts to reduce the incidence of accidental falls, fragility fractures, malnutrition, pressure ulcers, immobility and depression experienced by older people. All of these issues are potentially avoidable and result in vast savings, through improvements in financial savings and a reduction in morbidity and mortality.
- Due to the demographics of the practice and visiting rota of the GPs, guaranteeing continuity of care with the same GP was difficult, this was felt to be detrimental when trying to promote a relationship and rapport with patients and care home staff.
- Despite various national and local policies to improve the quality and standards of medicines management for older people the majority of care home residents continue to receive a high quantity of prescribed medications. Prior to implementation of the project, prescribing was less rigorously managed compared to the care home project’s regime, however was in line with the current repeat medicines management guidelines. This was due to little available resources within the practice to support proactive case management and initiate these changes.
- An increasing pressure to reduce avoidable hospital admissions in patients with complex needs led to a practice audit which identified patients residing in care homes as being a specific ‘revolving door’ group with high prescribing costs and an increasing demand for home visits.

As a result of the project the following improvements have been made:

- Through working with Social Services and the Commission for Social Care Inspectorate (CSCI), evidence of poor standards in 2 care homes was identified. This information contributed towards the closing of 1 x residential home. An audit of medication administration in one nursing home revealed errors which led the Home Manager to reevaluate their in-house policies and procedures to improve patient safety.
- An increase in the quality and quantity of physical activity opportunities available within the care homes has been audited as a result of introducing the Physical Activity Coordinator for Older People to care homes.
- A nursing home has appointed an Activities Coordinator after guidance and support from the NPs.
- An increase in referrals to health promotion activities i.e. smoking cessation, exercise classes and counselling.
- 100% of patients have had a holistic health assessment; this includes an assessment of cognition, depression, tissue viability, falls & fracture risk and prescribed medication. This has led to the diagnosis and planned management of previously undetected health problems.
- Because CMP is a paperless practice, the reversion to paper reporting in the care homes has been time consuming and cumbersome. Therefore, in partnership with the tPCT Clinical Informatics department and SystmOne, a
pilot of the SystmOne has been commenced within a care home. The ultimate aim is that the care home will be able to manage CMP patients better through SystmOne. However initially the system will be used solely by the NPs facilitating an assessment of the wider role of SystmOne as a tool in care homes

- Anecdotal evidence from Care Home Managers has confirmed unanimous support for this project, staff now report an improved relationship with the GP practice and an enhanced knowledge and confidence about the health needs of each resident; this could provide one possible explanation for the reduction in domiciliary visit requests.

- All patients involved within the Care Home project now have a single assessment process (SAP) file. This is a patient held record that documents any communication between health and social care professionals. This document aims to improve should improve communication and reduce repetition of effort between care home and health/social care staff.

Efficiency gains:

Prescribing

£34651 was saved in the first year through a reduction in the number of inappropriate repeat prescriptions requested. The majority of these savings have been made in:

- Laxatives (18 prescriptions stopped)
- Proton pump inhibitors (12 prescriptions stopped)
- Analgesia (14 prescriptions stopped)
- Skin (14 x topical preparations stopped)
- Wound dressings (19 prescriptions stopped)

Some new repeat prescriptions were set up at an annual cost of £3966.

: £30685 overall reduction in annual prescribing costs.

All older people living within a care home setting now receive a regular (monthly) review of their medications. There is around 30% turnover of residents but since the start of this project the number of patients has increased by 12%.

A&E Attendances

There has been a 36% in reduction in attendances to A&E from people who live within a care home setting since this project started.
Requests for a Domiciliary Visit

The number of requests for a domiciliary visit has steadily reduced since the introduction of the Care Homes project. This is probably due to the regular surveillance care that care home residents now receive; this assists to pre-empt and potentially reduce any acute and chronic deterioration in health. Savings in GP time have generated 48 more appointments per week.

Acute admissions

9 potential admissions were avoided during an 8 month period which could translate into 13 or 14 a year. The average cost of an admission per the practice’s 2008-9 budget is £1288, giving a saving of £17390pa.
Appendix 6: Alliance strategy for reducing infant mortality

Bradford South & West Commissioning Alliance
Health inequalities – Infant Mortality

1. Introduction
Bradford South & West Commissioning Alliance identified Infant Mortality as a priority area for specific wards and the local practices. A small workgroup was set up to consider what the needs were and identify options to recommend to the Alliance Steering Group.

Workgroup:
- Clare Connelly, GP, Horton Park
- Kathy Carpenter, Nurse Practitioner, Ridge Medical Practice
- Nick Nurden, Business Manager, Ridge Medical Practice
- Fiona Purdie, Business Manager, Parklands Medical Practice
- Ann Hobbiss, Every baby matters Public Health Co-ordinator
- Clare Offer, Senior Public Health Manager
- Jacquie White, General Manager, S&W PBC Alliance

The workgroup met twice, 20th January & 23rd February, following which Kathy and Jacquie met with a few individuals to scope out a number of potential options.

2. Vision for S&W

The Alliance will improve antenatal health, child health & development and economic self-sufficiency for mothers and babies in the practice populations of Horton Park, Parklands and the Ridge.

3. Assessment of need

The infant mortality rates for 2004 – 2006 (latest available) indicate Great Horton, Little Horton and the City wards as having some of the highest rates of infant mortality across the district. In attributing this data to practices, the highest rates for S&W fell within the 3 participating practices. The demographics for these patients indicate that there is a mix of south asian women, young white women, and with high levels of deprivation. The causes of mortality are mainly due to genetic disorders and low birth weight.

4. The services currently provided

All 3 practices are supported by the Community Midwifery team, and have Health Visiting teams attached.

There are various health promotion services across the district aimed at reducing smoking, increasing breast feeding etc. In addition there is a genetics screening and counselling service.

5. Service development options

The group considered the following options:
**Doulas**
Doulas generally work independently, offering support during labour and postnatally. Continuous and consistent support in labour is the main aim. The doula supports and helps parents make decisions but does not give advice e.g. on home versus hospital birth, breast-feeding, medical intervention.

Recognised outcomes are: reduced C-section rate; reduced length of first time labour; increased likelihood of breast feeding; decreased need for pain relief during labour.

Doulas can be approved through the organisation Doula UK, in which case they will have completed a Doula-UK approved training course. They are not necessarily midwives or health professionals – some come from such careers or do it in preparation for midwifery training. The code of practice states that even if trained as health professionals, doulas do not give any form of medical care – they are there to support the parents and aid communication with clinicians.

The Doula model was felt by the group to be expensive and had too much of a focus on the later stages of birth

**Family Nurse partnership**
The PCT has been accepted as a pilot site for this model that provides very intensive support to young 1st time mums (under 20) from very deprived backgrounds. The programme will work with a few mums in the Tong and Little Horton areas (and a few others across the district) so will pick some of the neediest patients in these wards. However, it will only work with 25 families in each ward over 3 years so whilst the evidence demonstrates the huge impact the programme can have, it will only support a very small number of patients in our alliance. Therefore the group felt that we still need to invest in some additional specific support and ensure our model links in with this pilot.

**Community Development worker**
The group discussed the usefulness of an additional post to specifically identify and support relevant mothers to be. The group weren't sure of the extra value of this and felt the family support assistant would be the better option to explore.

**Maternity assistant**
Citycare Alliance is working with the community midwifery team to explore the possibility of reconfiguring some antenatal clinics and employing maternity assistants

These are women recruited into a Band 2 role from the local community – as non clinical assistants to midwives with the aim of both doing basic tasks to assist, and undertaking a general health promotion role.

The group thought that this model was too hospital focussed with the risk that staff would be pulled out to cover absence within the midwifery team. The group strongly felt that the role should be part of the health visiting team acting as more of a family assistant with strong links to the childrens centres and the midwifery team rather than attached to the midwifery team. The group felt this would provide a more holistic support to women.
Family support assistant
The group discussed an alternative model to the maternity assistant role. It was agreed that a higher skilled family support assistant sitting with the Health Visitor team was a more appropriate post for the practices and patients concerned. The family support assistant would be a band 4, nursery nurse equivalent, working part-time in each of the 3 localities as part of the health visiting teams (i.e. 3 roles). The roles would provide early proactive support and advocacy to women identified/referred to improve their health and that of their child during and after pregnancy. The roles would also raise awareness of other appropriate services e.g. welfare support, children centres etc. and support women to access them.

Genetics training sessions
There are currently a small number of training programmes on genetics risk that are organised by the PCT for specific provider staff. The group felt that commissioning a few days of the social/cultural training programme with a small element of clinical training would be useful for the wider practice teams.

6. Commissioning intentions
The Alliance will commission a Family Support Assistant service for the 3 practices with an evaluation after 12 months to review the impact.