

Public Document Pack

Agenda for a meeting of the Bradford and Airedale Health and Wellbeing Board to be held on Wednesday 6 April 2016 at 10.00, in the Ernest Saville Room, City Hall, Bradford

Dear Member

You are requested to attend this meeting of the Bradford and Airedale Health and Wellbeing Board.

The membership of the Board and the agenda for the meeting is set out overleaf.

Yours sincerely



Interim City Solicitor

Notes:

- This agenda can be made available in Braille, large print or audio format on request by contacting the Agenda contact shown below.
- The taking of photographs, filming and sound recording of the meeting is allowed except if Councillors vote to exclude the public to discuss confidential matters covered by Schedule 12A of the Local Government Act 1972. Recording activity should be respectful to the conduct of the meeting and behaviour that disrupts the meeting (such as oral commentary) will not be permitted. Anyone attending the meeting who wishes to record or film the meeting's proceedings is advised to liaise with the Agenda Contact who will provide guidance and ensure that any necessary arrangements are in place. Those present who are invited to make spoken contributions to the meeting should be aware that they may be filmed or sound recorded.
- If any further information is required about any item on this agenda, please contact the officer named at the foot of that agenda item.

From:

Meic Sullivan-Gould

Interim City Solicitor

Agenda Contact: Fatima Butt

Phone: 01274 432227

E-Mail: fatima.butt@bradford.gov.uk

To:

City of Bradford
Metropolitan District Council



Members of the Board -

MEMBER	REPRESENTING
Councillor David Green (Chair)	Leader of Bradford Metropolitan District Council
Councillor Ralph Berry	Portfolio Holder for Health and Social Care
Councillor Simon Cooke	Bradford Metropolitan District Council
Kersten England	Chief Executive of Bradford Metropolitan District Council
Dr Andy Withers	Bradford District Clinical Commissioning Group
Helen Hirst	Bradford City/ Bradford District Clinical Commissioning Group
Dr Philip Pue	Airedale, Wharfedale and Craven Clinical Commissioning Group
Dr Akram Khan	Bradford City Clinical Commissioning Group
Brian Hughes	Locality Director, West Yorkshire
Anita Parkin	Director of Public Health
Bernard Lanigan	Interim Strategic Director of Adult and Community Services
Michael Jameson	Strategic Director of Children's Services
Javed Khan	HealthWatch Bradford and District
Sam Keighley	Bradford Assembly representing the Voluntary and Community sector
Simon.Large/Bridget Fletcher or Clive Kay	One Representative of the main NHS Providers

A. PROCEDURAL ITEMS

1. ALTERNATE MEMBERS (Standing Order 34)

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

2. DISCLOSURES OF INTEREST

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

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

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

Notes:

- (1) Members may remain in the meeting and take part fully in discussion and voting unless the interest is a disclosable pecuniary interest or an interest which the Member feels would call into question their compliance with the wider principles set out in the Code of Conduct. Disclosable pecuniary interests relate to the Member concerned or their spouse/partner.
- (2) Members in arrears of Council Tax by more than two months must not vote in decisions on, or which might affect, budget calculations, and must disclose at the meeting that this restriction applies to them. A failure to comply with these requirements is a criminal offence under section 106 of the Local Government Finance Act 1992.
- (3) Members are also welcome to disclose interests which are not disclosable pecuniary interests but which they consider should be made in the interest of clarity.
- (4) Officers must disclose interests in accordance with Council Standing Order 44.

3. MINUTES

Recommended-

That the minutes of the meeting held on 8 February 2016 be signed as a correct record (previously circulated).

4. INSPECTION OF REPORTS AND BACKGROUND PAPERS

(Access to Information Procedure Rules – Part 3B of the Constitution)

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

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

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

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

(Fatima Butt - 01274 432227)

B. BUSINESS ITEMS

5. WORKING BETTER TOGETHER - A WHOLE SYSTEM FOR HEALTH AND SOCIAL CARE

Previous Reference: Minute 27 (2015/16)

The Interim Director of Adult and Community Services and the Chief Clinical Officer of the Airedale, Wharfedale and Craven, and Chief Officer Bradford City and Bradford Districts Clinical Commissioning Groups will submit **Document “O”** which provides progress on work across the health and care system to “create a sustainable health and care economy that supports people to be healthy, well and independent” (Bradford District and Craven Five Year Forward View). It also includes an update on progress to develop the Learning Disability Transforming Care Plan for the District and details of the Better Care Fund for 2016/17 which continues to be part of the alignment of resources across the health and care system to support integration.

Recommended-

- (1) That the Board receives the Bradford and Craven Sustainability and Transformation Plan after its July 2016 submission.**
- (2) That the Board notes the revised governance arrangements to support development and implementation of the Sustainability and Transformation Plan.**
- (3) That the Board receives the Better Care Fund 2016/17 following submission to NHS England 25th April 2016.**

- (4) **That the Board receives the Better Care Fund 2016/76 quarterly assurance submissions to NHS England.**

(Rebecca Malin – 01274 237689)

6. **UPDATE ON PROGRESS/BUSINESS ARISING BETWEEN BOARD MEETINGS OR AT THE BOARDS SUB GROUPS – BETTER CARE FUND**

The Chair's progress report (**Document "P"**) provides updates on business arising between Board meetings or at the Board's sub-groups.

Members are informed that the Chair has received and signed off two items in relation to the Better Care Fund on behalf of the Health and Wellbeing Board.

The first is the 2015-16 Quarter 3 performance report from the Better Care Fund which was submitted to NHS England on 26th February.

The second was the proposed scheme for the 2016-17 Better Care Fund intentions which was submitted to NHS England on 21st March 2016.

Provisional Board meeting dates for 2016-17 will be reviewed to enable the full Board to receive and review the Better Care Fund updates before submission to NHS England.

The Board is asked to note the progress being made since the last update.

(Angela Hutton – 01274 437345)

7. **MENTAL HEALTH IN BRADFORD AND AIREDALE**

Previous Reference: Minute 29 (2014/15)

In February 2015 the Health and Wellbeing Board received a report on Mental Health and Public Mental Wellbeing and resolved:

- (1) That adopting a strategic approach whereby Public Mental Wellbeing is considered as a strategic theme in light of both tangible and indirect benefits be endorsed.
- (2) That ongoing work to develop this across Council workforce, working with Morrisons and other local providers be supported.
- (3) That a further detailed report on Public Mental Wellbeing and the work being undertaken in this area be submitted to a future meeting of the Board.

In accordance with the above the Director of Public Health will submit **Document "Q"** which continues the strategic focus and addresses the request made at that meeting.

Recommended-

- (1) That the Health and Wellbeing Board notes the contents of the report.**
- (2) That the Health and Wellbeing Board continues to prioritise this issue and ensures that the District has adequate resource for prevention and early intervention in respect of mental health and mental illness.**
- (3) That the Health and Wellbeing Board supports the development of an integrated Mental Health strategy and receives further updates through the standing item on development of a whole system for health, care and wellbeing.**

(Dr Andrew O'Shaughnessy - 01274 432612)

8. HEALTH AND WELLBEING BOARD FORWARD PLAN 2016-17

A presentation will be provided on the Health and Wellbeing Board's Forward Plan for 2016-17.

(Angela Hutton – 01274 437345)

Report of the Interim Director of Adult and Community Services and the Chief Clinical Officer of the Airedale, Wharfedale and Craven, and Chief Officer Bradford City and Bradford Districts Clinical Commissioning Groups to the meeting of Health and Wellbeing Board to be held on 6th April 2016.

Subject:

O

Working Better Together – A Whole System for Health and Social Care

Summary statement:

A progress update on work across the health and care system to “create a sustainable health and care economy that supports people to be healthy, well and independent” (Bradford District and Craven Five Year Forward View).

Bernard Lanigan, Interim Strategic Director, Adult and Community Services

Helen Hirst, Chief Officer Bradford City and Bradford Districts Clinical Commissioning Groups

Phil Pue, Chief Clinical Officer, Airedale, Wharfedale and Craven Clinical Commissioning Group

Portfolio:

Health and Social Care

Report Contact: Rebecca Malin, Associate Director of Transformation Programmes

Phone: (01274) 237689

E-mail: Rebecca.malin@bradford.nhs.uk

Overview & Scrutiny Area:

Health and Social Care



1. SUMMARY

The report provides a progress update on work across the health and care system to “create a sustainable health and care economy that supports people to be healthy, well and independent” (Bradford District and Craven Five Year Forward View). It also includes an update on progress to develop the Learning Disability Transforming Care Plan for the District and details of the Better Care Fund for 2016/17 which continues to be part of the alignment of resources across the health and care system to support integration.

2. BACKGROUND

The Health and Wellbeing Board signed off the Bradford District and Craven Five Year Forward View in July 2014 and has received a number of reports during 2015 on working together to develop a whole system approach to health and social care.

The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It allows for the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund. The Better Care Fund is a financial incentive for the integration of health and social care. It requires Clinical Commissioning Groups and local authorities to look to pool budgets and to agree an integrated spending plan for how they will use their Better Care Fund allocation. Current health and care approaches have evolved to respond reactively to changes in an individual's health or ability to look after themselves, and they often do not meet people's expectations for person-centred co-ordinated care.

Greater integration is seen as a potential way to use resources more efficiently, in particular by reducing avoidable hospital admissions and facilitating early discharge. The Health and Wellbeing Board signed off the Better Care Fund for 2015/16 in February 2015 and has received quarterly submissions to NHS England accordingly during the course of 2015/16 (following sign off out of committee).

The Health and Wellbeing Board resolved in February 2016 to receive further updates on work being progressed across the health and care system.

3. DELIVERY OF THE FIVE YEAR FORWARD VIEW

3.1 Sustainability and Transformation Plan

Bradford health and care partners continue to work together to “create a sustainable health and care economy that supports people to be healthy, well and independent” (Bradford District and Craven Five Year Forward View).

Our working together continues under the umbrella of the Sustainability and Transformation Plan (STP) – a place-based*, multi-year plan built around the needs of



local populations. NHS planning guidance requires a plan for the years 2016/17 – 2020/21 which will clearly articulate our gaps; health and wellbeing, care and quality, finance and efficiency (referred to as the triple aim) along with our priorities to address these.

The planning guidance is backed up by £560 billion nationally of NHS funding, including a new Sustainability and Transformation Fund which will support financial balance, the delivery of the national Five Year Forward View, and enable new investment in key priorities.

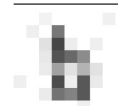
At a minimum the STP will describe:

- a local cross-partner prevention plan;
- increased investment in the out-of-hospital sector, including how to deliver primary care at scale;
- local ambitions to deliver seven day services;
- plans for implementing new models of care with partners;
- collective action on quality improvement;
- collective action on key national clinical priorities e.g. improving cancer outcomes increasing investment in mental health services and parity of esteem;
- these and other changes must ensure the local system returns to financial balance;
- strategic commitment to engagement at all levels, informed by the 'six principles'.

Health and care partners made an initial submission of the Bradford District and Craven STP in March 2016 detailing governance arrangements, preliminary analysis of the health and wellbeing, care and quality, finance and efficiency (triple aim) gaps and emerging priorities. This is being further enhanced ahead of a 'checkpoint' submission in April 2016 followed by the final submission in July 2016. Throughout July NHS England along with NHS Improvement and Public Health England will assess each STP. Plans of the highest standard will gain access to transformation funding from April 2017.

NHS England has determined that the footprint for planning will be West Yorkshire and that Rob Webster, recently appointed as Chief Executive of South West Yorkshire Partnership NHS Foundation Trust, will be the STP lead for West Yorkshire. Prior to this announcement the West Yorkshire health and care community had been developing an approach that saw six STPs reflecting each local HWB footprint together with an umbrella STP for those areas that should be planned for at a West Yorkshire population level. These are currently specialised services, cancer, stroke and urgent and emergency care (including some aspects of mental health). Rob Webster has confirmed that this approach continues and he subscribes to the view that it is local transformation that will be key to future sustainability. So we continue to develop our local STP and as far as we are aware will continue to submit this plan in line with NHS England's planning process.

*place-based 'systems of care' are those where collaboration between NHS organisations and other services takes place to address the challenges and improve the health of the populations they serve.



3.2 Governance

In order to achieve an agreed STP and to subsequently oversee its delivery the Integration and Change Board (ICB) discussed, and are working towards, a revised governance structure. As part of our STP we will be describing how our joint transformational programmes will aid closing of the triple aim gaps. As such these programmes will report directly to the Sustainability and Transformation Board, which in turn reports to ICB. A visual representation of the governance structure is attached at Appendix A.

To facilitate the coordinated delivery of both our transformational programmes and enabling programmes ICB agreed to invest in a shared portfolio management office (PMO). The PMO will work with and be accountable to ICB for the delivery of our interdependent portfolio.

3.3 Transforming Care for people with Learning Disabilities

‘Transforming Care for people with learning disabilities – next steps’ is a national programme of work developed following the Winterbourne View Concordat. Stephen Bubb author of this report states that ‘Over the past few years people with learning disabilities and/or autism have heard much talk but seen too little action’. The programme therefore focuses on improving services for people with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition. This will drive system-wide change and enable more people to live in the community, with the right support, and close to home.

The programme endorses the view that children, young people and adults with a learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives, and to be treated with dignity and respect. They should have a home within their community, be able to develop and maintain relationships, and get the support they need to live healthy, safe and rewarding lives.

3.3.1 Lead responsibilities and areas of focus

Delivery of the programme within Bradford District is a collaborative working across health and social care. Helen Hirst, Chief Officer Bradford City and Districts Clinical Commissioning Groups (CCGs) is the lead Senior Responsible Officer (SRO) with the Local Authority responsible for the deputy SRO role through Bernard Lanigan, Acting Strategic Director – Adult and Community Services. As the lead provider for Learning Disabilities clinical support services Bradford District NHS Foundation Trust plays a key role in the delivery of the agenda. The work undertaken as part of the Transforming Care programme will align with the Children and Young People (CYP) Programme to ensure that a whole system approach is adopted across all age service provision.

As part of developing the Bradford Learning Disability Transforming Care plan, we will develop a communication strategy to engage and involve families and people with learning disabilities and/or autism in this process.

The Local Authority with involvement from the CCG is establishing a commissioning



framework for residential and nursing provision that will support the delivery of this work and to give people choice of provider to meet their needs. The aim is to develop the market place for specialist providers who can provide support to people within a 'Step up/Step down model. The Local Authority is also working closely with housing developers and providers to increase the choice of housing options for people with complex needs.

The local programme is a 3 year delivery programme (2016 – 2019) focused on three key areas.

1. Reshaping current provision of services to reduce dependency on in patient provision to support people with complex behaviour presentations.
2. Developing the provider market with specialist providers to support people with complex presentations in the community
3. Promoting mainstream health provision for people with Learning Disabilities

To date the following work has started:

- Programme Management Board established.
- Delivery plan, risk log, communication plan (to ensure all stakeholders engaged) being developed
- Financial analysis of out of area costs – to be produced by NHS England - Specialist Commissioning.
- Awaiting advice from NHS England as to the number of in-patient beds required per million of population for our area.
- Review of provider contracts from both CCG and LA commissioning to ensure delivery of the transformation agenda
- Work on use of personal Health Budgets.

3.4 Better Care Fund

In 2016-17, NHS England set the following conditions, which local areas will need to meet to access the BCF Funding:

- A requirement that the Better Care Fund is transferred into one or more pooled funds established under section 75 of the NHS Act 2006
- A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s)
- A requirement that plans are approved by NHS England in consultation with DH and DCLG (as set out in section 3 below)
- A requirement that a proportion of the areas allocation will be subject to a new condition around NHS commissioned out of hospital services, which may include a wide range of services including social care.

NHS England also require that Better Care Fund plans demonstrate how the area will meet the following national conditions:

- Plans to be jointly agreed;
- Maintain provision of social care services;
- Agreement for the delivery of 7-day services across health and social care to



prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate;

- Better data sharing between health and social care, based on the NHS number;
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;
- Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;
- Agreement on local action plan to reduce delayed transfers of care

Locally, Health and Care partners have agreed to a larger Better Care Fund (BCF) for 2016/17 by aligning the budgets of Mental Health and Learning Disabilities as previously agreed at Health and Wellbeing Board (8th February 2016), in addition the Council has included the Disabled Facilities Grant in the Fund for 2016-17.

In previous years, the three CCGs have been able to invest more than the minimum requirement in the BCF to protect Social Care. Following the announcement of the NHS financial allocations, NHS Airedale, Wharfedale & Craven CCG currently have a draft financial plan which predicts a deficit in 2016/17. As a result, the CCG is reviewing all of its current expenditure and is developing proposals to ensure best value for money to deliver services to their population. As a result they are reducing the additional investment in the BCF by £400k in 2016/17 and are working together with the Local Authority to understand the risk this may pose and any mitigating actions that need to be put in place. Additionally, they remain confident they can continue to work with partners in developing new and more innovative ways of joining up services to address the respective financial challenges ahead.

Draft narrative for each BCF scheme along with a detailed financial plan will be submitted to NHS England on 21st March 2016. Initial signoff has been undertaken outside of committee, through the Chair of HWB. A final submission will be made to NHS England on 25th April 2016 and subsequently brought to a future Health and Wellbeing Board. Quarterly BCF submissions which are required to be submitted to NHS England to provide assurance on delivery against the plan will be attempted to align with HWB dates in 2016/17 as they were signed off out of committee during 2015/16 and received retrospectively. Alongside this a detailed BCF dashboard is being developed by health and care partners and both of these will ensure a more detailed dialogue on the effectiveness of the BCF plan in contributing to the delivery of our Sustainability and Transformation Plan.

The total BCF pooled budget for 2016/17 is **£176,568,963** which is made up of:

Local Authority	£67,391,468
CCG Minimum Required Contributions	£34,571,495
CCG Additional Contributions	£74,606,000



4. FINANCIAL & RESOURCE APPRAISAL

The financial implications of the BCF are an intrinsic part of the BCF plan development process and are being worked through and fully understood respective Financial Officers accordingly. The submission of the BCF plan for 2016/17 includes detailed finance and activity.

The STP will be subject to economic modelling to assess the financial and efficiency gap is being met by the planned key elements of transformation. This work is underway across our partner Directors of Finance group. Additionally access to the national NHS transformation fund from April 2017 is predicated on the development of a robust plan of the highest standard.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

Risk management and governance issues are fundamental elements of both the BCF and STP are being dealt with as part of the overall development and implementation process.

Health and Wellbeing Boards jointly agree BCF plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s). Ultimately BCF plans are approved by NHS England in consultation with DH and DCLG.

6. LEGAL APPRAISAL

No direct implications arising from the contents of this report.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

None

7.2 SUSTAINABILITY IMPLICATIONS

None

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

None

7.4 COMMUNITY SAFETY IMPLICATIONS

None

7.5 HUMAN RIGHTS ACT

None



7.6 TRADE UNION

None

7.7 WARD IMPLICATIONS

None

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

None

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

No options are provided.

10. RECOMMENDATIONS

10.1 That the Board receives the Bradford and Craven Sustainability and Transformation Plan after its July 2016 submission

10.2 That the Board notes the revised governance arrangements to support development and implementation of the Sustainability and Transformation Plan

10.3 That the Board receives the BCF 2016/17 following submission to NHS England 25th April 2016

10.4 That the Board receives BCF 2016/76 quarterly assurance submissions to NHS England

11. APPENDICES

Appendix 1 – Representation of revised governance arrangements to support delivery of Bradford District and Craven Five Year Forward View

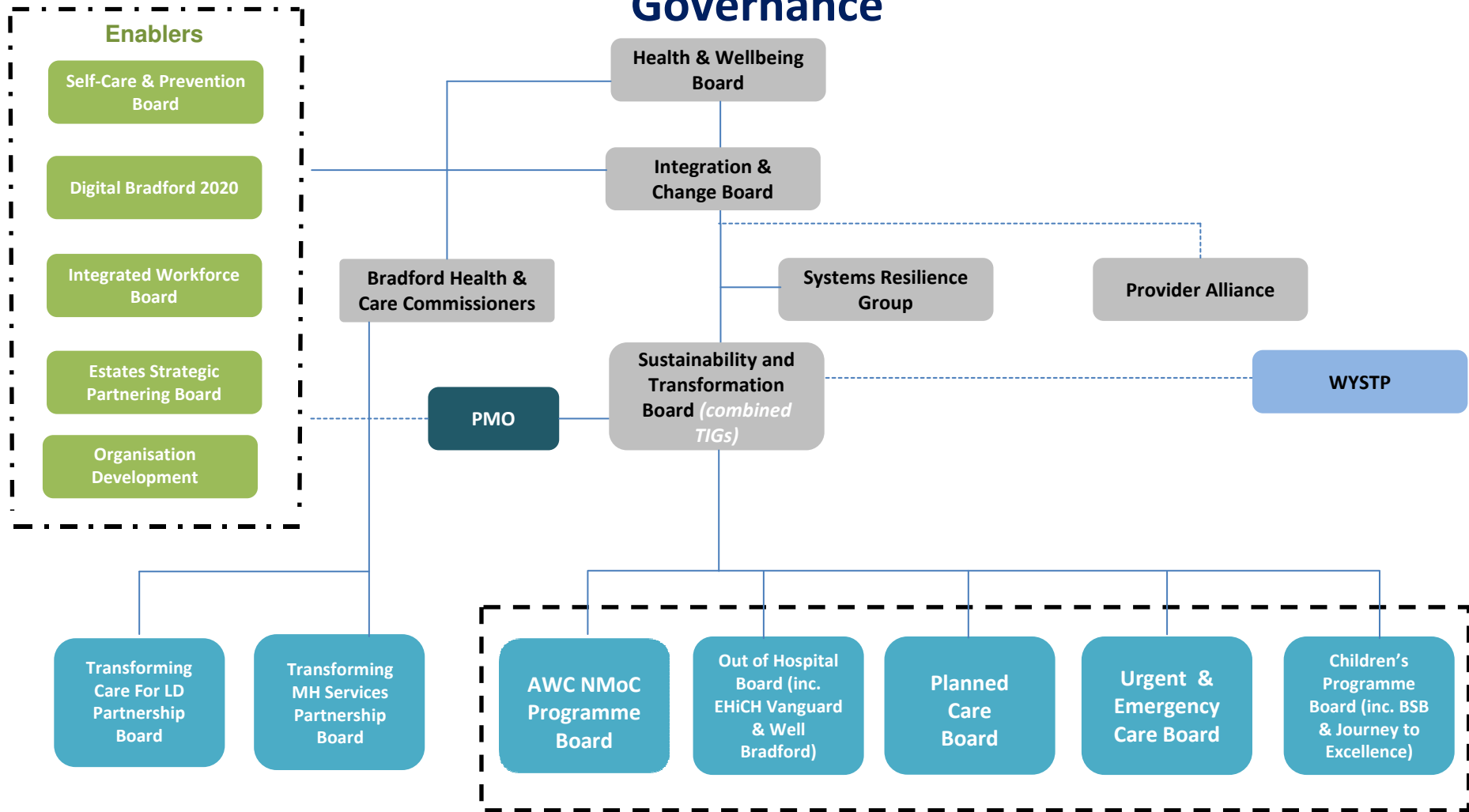
12. BACKGROUND DOCUMENTS

None



Bradford District & Craven – Sustainability & Transformation

Governance



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Report of the Chair to the meeting of the Health and Wellbeing Board to be held on 6th April 2016.

P

Subject:

Short updates on progress or business arising between Board meetings or at the Board sub-groups.

1. Better Care Fund: 2015-16 Quarter 3 reporting and 2016-17 intentions

Summary statement: The report provides short updates on progress or business arising between Board meetings or at the Board sub-groups.

Cllr David Green, Chair - Health and Wellbeing Board

Portfolio:
Health and Social Care

Report Contact: Angela Hutton
Phone: (01274) 437345
E-mail: angela.hutton@bradford.gov.uk

Overview & Scrutiny Area:
Health and Social Care



1. SUMMARY

This Chair's Highlight report provides short updates on business conducted under Chair's action between Board meetings, updates on progress reported to the Chair between Board meetings and business conducted at the sub-groups to the Health and Wellbeing Board as follows:

2. BACKGROUND

The background to each item is described in the relevant part of section 3.

3. OTHER CONSIDERATIONS

3.1 Business conducted between meetings under Chair's action

The Chair has received and signed off two items in relation to the Better Care Fund on behalf of the Health and Wellbeing Board.

The first is the 2015-16 Quarter 3 performance report from the Better Care Fund which were submitted to NHS England on 26th February. See Appendix 1 for narrative and data.

The second was the proposed scheme for the 2016-17 Better Care Fund intentions which were submitted to NHS England on 21st March 2016. This item is described in the paper for the separate agenda item on Working Better Together - Whole System Change.

Provisional Board meeting dates for 2016-17 will be reviewed to enable the full Board to receive and review the Better Care Fund updates before submission to NHS England.

4. FINANCIAL & RESOURCE APPRAISAL

Financial and resource appraisal in relation to the Better Care Fund is reported to the Board in exception through Bradford Health and Care Commissioners. See the paper for the separate agenda item on Working Better Together - Whole System Change.



5. RISK MANAGEMENT AND GOVERNANCE ISSUES

Risk management and governance issues in relation to the Better Care Fund are reported to the Board in exception through Bradford Health and Care Commissioners. See the paper for the separate agenda item on Working Better Together - Whole System Change.

6. LEGAL APPRAISAL

No direct implications arising from the contents of this report.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

No implications

7.2 SUSTAINABILITY IMPLICATIONS

No direct implications arising from the contents of this report.

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

No direct implications arising from the contents of this report.

7.4 COMMUNITY SAFETY IMPLICATIONS

No direct implications arising from the contents of this report.

7.5 HUMAN RIGHTS ACT.

No direct implications arising from the contents of this report.

7.6 TRADE UNION

No direct implications arising from the contents of this report.

7.7 WARD IMPLICATIONS

No direct implications arising from the contents of this report.

8. NOT FOR PUBLICATION DOCUMENTS

None



9. OPTIONS

No options are provided.

10. RECOMMENDATIONS

No Recommendations are provided.

11. APPENDICES

Better Care Fund Quarter 3 Narrative

12. BACKGROUND DOCUMENTS



Bradford Quarter 3
2015-16 BCF Report.



	FOR INFORMATION
Health and Wellbeing Board: 6 th April 2016	Agenda Item: Chair's Highlight report Appendix 1
Paper Title: Better Care Fund (BCF) Q3 report	
Paper Author: Rebecca Malin Associate Director of Transformation Programmes Bradford Districts and Bradford City Clinical Commissioning Groups	

Context:

The 2015-16 Better Care Fund (BCF) quarter 3 report is due for submission to NHS England on the 26th February 2016. The report and supporting narrative below is presented to the Health and Wellbeing Board (via the Chair) for approval ahead of submission.

The submission will subsequently be presented for information to Bradford Health and Care Commissioners (BHCC).

Summary:

The report demonstrates progress is continuing against the implementation plan. To support this, BCF metrics and performance indicators demonstrate consistency with the plan.

Performance for our local metric (increase the diagnosis rate for people with dementia) has continued to be strong and consistently above the 71% target this year, with performance at the end of Q3 standing at 81.2%. N.B. this metric is based on the footprint of the three CCGs – we are currently unable to split out Craven GP practices population.

Throughout this year partners have reported an ongoing risk regarding Non Elective activity. A reduction in admissions is linked to the expanded virtual ward. The delayed opening of which has



resulted in an overtrade position forecast to be £3m above plan. As such the Performance Fund will be required to fund this increase in activity.

As per previous quarters NHS England has asked what additional planning support we would like. We have again identified and expressed a need for additional support around data interpretation and analytics. In particular to help align local business intelligence and analytics across all health and care partners who are party to the BCF plan. In the absence of this however partners have developed a dashboard detailing the planned versus actual for each BCF scheme. This is being presented to Bradford Health and Care Commissioners (BHCC) for review and discussion each quarter.

In February 2016 BHCC agreed to discharge its responsibilities as a Partnership Board for the Section 75 agreement which is due to be signed off imminently by our respective CCGs and the LA.

Whilst detailed planning guidance for the BCF 2016/17 is awaited from NHS England BHCC progressed and agreed the following:

- The BCF is transferred into one or more pooled funds established under a Section 75 agreement;
- The HWB agree plans for how the money will be spent with plans approved by the LA and CCGs
- Plans are approved by NHSE

The 2016/17 BCF Policy Framework was published in January 2016 detailing:

- the BCF will be increased to a mandated minimum of £3.9 billion;
- local flexibility to pool more than the mandatory amount will remain;
- for 2016/17 the £1 billion payment for performance framework will be removed. In place of the performance fund are two new national conditions, requiring local areas to fund NHS commissioned out-of hospital services and to develop a clear, focused action plan for managing delayed transfers of care (DTCOC), including locally agreed targets.

Partners will be required to develop, agree and submit the following:

- A short, jointly agreed narrative plan including how they are addressing the national conditions;
- Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes
- A scheme level spending plan demonstrating how the fund will be spent
- Quarterly plan figures for the national metrics (Non-Elective admissions (NEL), DTCOC, Reablement; Care home admissions)

At the Health and Wellbeing Board meeting 24 November 2015 the appetite to accelerate progress on the scale and pace of our joint commissioning was noted. Included in this was the proposal to further develop the scope and scale of the BCF from 2016/17. Discussions have since taken place between Directors of Finance from the CCGs and CBMDC regarding an initial expansion of the BCF. An initial assessment of the BCF Plus scoped an opportunity to create a BCF in excess of



£200m which is broken down into the following five categories:

- Keeping people well in the community;
- Active support and recovery;
- Independent living solutions;
- Long-term high support
- Adult inpatient medical emergency admissions

Each partner will continue to work through their respective budgets ahead of a formal submission (TBC) to NHSE.

Focus for Bradford Health and Wellbeing Board.

To note and approve the Q3 submission.

Background Document

1. For information: Quarter 3 2015/16 BCF report.



Bradford Quarter 3
2015-16 BCF Report.



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Better Care Fund Q3 2015/16	
Health and Well Being Board	Bradford
completed by:	Rebecca Malin
E-Mail:	Rebecca.Malin@bradford.nhs.uk
Contact Number:	01274 237689
Who has signed off the report on behalf of the Health and Well Being Board:	Councillor David Green, Leader Of Council CBMDC

Budget Arrangements

Page 9	Have the funds been pooled via a s.75 pooled budget?	Yes
	If it has not been previously stated that the funds had been pooled can you now confirm that they have?	<Please Select>
	If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes: Source: For the S.75 pooled budget question which is pre-populated, the data is from the Q1/Q2 data collection previously filled in by the HWB

Narrative

Please provide a brief narrative on overall progress in delivering your Better Care Fund plan at the current point in time, please also make reference to performance on any metrics not directly reported on within this template (i.e. DTOCs).

Section 75 agreement in place as of Q2. Formal sign off by each CCG and Local Authority is imminent.

Following confirmation of the non-elective overtrade on CCGs' healthcare contracts, the performance fund will be used to fund this activity. Forecast - £3m above plan.

Partners have a robust performance management framework in place, centred around the ASCOF but also encapsulating local activity and productivity measures across access, assessment and support services. In 2014-15 we were the top performing local authority in Yorkshire and Humber on 4 ASCOF measures (Self Directed Support and Direct Payments for Carers, Carers Quality of Life and Carers Social Contact) and in the Top 3 for 9 of the measures.

Performance across our metrics remained strong in Q3 with partners expecting to either achieve all targets or demonstrate improvement (but not meet the target).

Our excellent performance on Delayed Transfers of Care, both overall health and social care, was highlighted in Regional Sector Led Improvement as best practice and in December 2015 we delivered a 'Masterclass' session at a joint Local Authority and NHS Regional event chaired by Sandy Keene from National ADASS.

Our implementation plans for Integrated Digital Care Records are on track to 'Go-live' in July 2016 where the NHS Number will be the unique ID used across Adult Social Care. We are also exploring opportunities for integrated data to inform commissioning and further service improvement.

A new ASCOF measure, reflecting the Department of Health's commitment to integrated care, was added to the framework in 2014-15. The development work undertaken has underlined the challenging nature of such an indicator and, on conclusion of the unsuccessful cognitive testing, the recommendation was that no underpinning questions would be added to the Adult Social Care survey. However, in order to highlight the importance placed on integrated care, the DoH have retained a placeholder on the "effectiveness of integrated care" and work is continuing on how best to include such a measure.

In Bradford we have included an additional question in our last 3 annual Adult Social Care Surveys asking people who receive long term Adult Social Care support their experience of effective co-ordinated Integrated Care Services and will be looking to extend this into an already established personal outcome evaluation of Short Term Support. The local authority will feed this into discussions on the local metrics underpinning BCF Planning for 2016-17.

Report of the Director of Public Health to the meeting of Health and Wellbeing Board to be held on 6th April 2016.

Q

Subject:

Mental Health in Bradford and Airedale

Summary statement:

The report defines mental health, mental illness and stigma, provides local data on the incidence and prevalence of mental illness, information on partnership working and services and explores how wider social and economic factors affect our mental health and how mental illness affects our physical health.

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Health and Social Care

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Overview & Scrutiny Area:

Health and Social Care



1. SUMMARY

Mental Health

Mental health is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

Being mentally healthy doesn't just mean absence of a mental health problem.

Some people call mental health 'emotional health' or 'well-being' - **it is just as important as good physical health.**

Mental Illness

A mental illness, psychiatric disorder or psychological disorder, is a medical diagnosis of a behavioural or mental pattern that causes either suffering or a poor ability to function in ordinary life. Such features may be persistent, relapsing and remitting, or occur as a single episode. Many disorders have been described, with signs and symptoms that vary widely between specific disorders (WHO factsheet).

Stigma

Stigma is a mark of **disgrace** that sets a person apart. When a person is labelled by their illness they are seen as part of a stereotyped group. Negative attitudes create prejudice, which leads to negative actions and discrimination.

75% of people with a mental illness report that they have experienced stigma ^(x)

Families are also affected by stigma, leading to a lack of support.

For mental health professionals, stigma can mean that they themselves are seen as abnormal, and psychiatric treatments are often viewed with suspicion and horror.



2. Introduction – The Experience of Mental Illness in Bradford

In February 2015 the Health and Wellbeing Board received a report on Mental Health and Public Mental Wellbeing and resolved:

- (1) That adopting a strategic approach whereby Public Mental Wellbeing is considered as a strategic theme in light of both tangible and indirect benefits be endorsed.**
- (2) That ongoing work to develop this across Council workforce, working with Morrisons and other local providers be supported.**
- (3) That a further detailed report on Public Mental Wellbeing and the work being undertaken in this area be submitted to a future meeting of the Board.**

This paper continues the strategic focus and addresses the request at that meeting to look across the life course and from prevention through to treatment.

2.1 Individual experience of mental illness

The paper begins by following a notional individual journey through the experience of mental illness in Bradford. This is summarised below for a fictional individual - “Paul”.

1. Community and Life

We can consider this a period of good mental health with no history of mental illness. Paul lives a reasonably fulfilling life, he has a wife and two young children and a close group of friends who he sees every week when they sing together in a church choir. He works as a postman and is fit and well. He travels regularly either to see his parents who live some distance away, or on holidays abroad, which he tries to do twice per year.

2. Symptoms of Mental Illness

Quite suddenly and without warning or reason, Paul begins to feel tired and listless. He has started giving his apologies for weekly singing and is lying in bed in the evenings. His friends have tried to help him but he is defensive and resents any implication that he is ill or cannot cope. He begins taking time off work citing a variety of fabricated illnesses, he dreads the thought of walking through the community on his own, or talking to strangers on the doorstep. Eventually he is told in a formal letter that he will lose his job if he does not improve his sickness record. This is the incident which makes him admit to himself that he must have a psychiatric problem but he is terrified of this and believes he will have his family taken away from him. He starts to drink heavily and exploring thoughts of killing himself.

3. Presentation to Services

a. Voluntary

Eventually Paul reveals everything to his wife who asks his closest friend Brian to come



over and talk it through together. Brian has been searching the internet to try to understand what is wrong with Paul, and brings with him a number of printed articles from government and voluntary sector websites. Paul is initially very defensive at the thought of being mentally ill but is overwhelmed when Brian shows him what he has found and he realises that he is clinically depressed. He agrees to go with Brian and his wife to see his GP as an urgent appointment the next day.

b. Involuntary

Paul remains in denial and his drinking becomes more severe. He begins to believe that his wife and friends are ganging up on him behind his back. This leads to arguments and his wife moves out, taking the children with her. Paul gets into a fight in a pub and is arrested. The arresting officer recognises that Paul is expressing vivid paranoid thoughts and decides to contact mental health services having used a short assessment tool available to him at the police station. Under the processes of the local Crisis Care Concordat (CCC) for mental health, a duty doctor arrives and diagnoses Paul as having an acute psychotic episode. There is no option but to detain Paul under The Mental Health Act as he is a danger to both himself and others (i.e. he has been “sectioned”).

4. Diagnosis and Treatment

- In scenario **a.** above, Paul’s GP makes an instant diagnosis of depression and explains to Paul that this is a common condition that can be effectively treated, in Paul’s case by starting him on a course of antidepressants, and by referring him to the Bradford District Care Trust Improving Access to Psychological Treatments (IAPT) pathway where he will be able to receive a “talking therapy” such as Cognitive Behavioural Therapy (CBT).
- In scenario **b.** Paul’s condition is rapidly diagnosed and he is started on a course of antidepressants as an inpatient on the Maplebeck Ward at Lynfield Mount Hospital. He remains detained on section until his condition improves. He will now receive aftercare as an outpatient and his wife and GP are informed.

5. “In The System”

Paul’s condition improves substantially and his paranoia disappears. He regrets not contacting his doctor sooner. He is at home receiving support from a BDCT Community Psychiatric Nurse (CPN) who recommends that he expands his support network by visiting a Voluntary Sector organisation which helps people get back to work after a diagnosis of mental illness.

Paul sees his GP regularly, initially every week, and has one more appointment with a BDCT psychiatrist at Lynfield Mount, where he is discharged. He remains under the care of his GP and CPN. His family move back in and his friends visit him regularly.

6. Recovery and Reintegration

Eventually Paul feels ready to return to work. His employers have been sympathetic but explain that he must inform them far sooner if his condition deteriorates – he is a valued employee who they do not want to lose. They explain that he is one of a number of employees with mental illness and that they consider it no different from any other illness and will provide all the support he needs to stay in work. Paul returns to work and, despite



being initially wary of colleagues who he expects to avoid him, finds that he fits in just as before. Crucially he remains in contact with the Voluntary Organisation and his GP who have given him and his wife clear instructions as to how to recognise early any return of his symptoms and who to contact should this happen. Paul returns to his weekly singing and plans a holiday with his family. Life is good.

2.1 Background and national context

One in six adults experiences a mental health problem at any one time. For some, mental health problems are treated and never return, however, for some people mental health problems last for many years, especially if not appropriately treated.

The World Health Organisation (WHO) defines mental health as '*a state of well-being in which every individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*' (WHO, 2001). As such, mental health is greater than just the absence of mental illness, but includes the notions of positive self esteem, coping mechanisms and the importance of empowerment and control.

The presence of mental illness and behavioural disorders is described by WHO as '*clinically significant conditions characterised by alterations in thinking, mood (emotions) or behaviour associated with personal distress and/or impaired functioning... such abnormalities must be sustained or recurring and they must result in some personal distress or impaired functioning in one or more areas.... They are also characterised by specific symptoms and signs, and usually follow a more or less predictable natural course, unless interventions are made*' (WHO, 2001).'

The spectrum and severity of conditions that encompass mental health disorders is both broad and complex, and includes:

- Common mental health problems such as anxiety, depressive disorders, depressive episodes, phobias and panic disorders;
- Severe and enduring mental health problems such as schizophrenia, schizotypal and other delusional disorders, manic episodes, bipolar affective disorder and other affective disorders with psychotic symptoms.

National Context

The Chief Medical Officer Report provides an overview of the evidence regarding mental health. The report highlights that mental health problems are the single largest cause of morbidity in the United Kingdom with a cost to the economy of up to £100 billion pounds. It is also important to note that up to 75% of people with mental health problems receive no treatment and that real terms spending has been falling across the UK.

The CMO report covers the epidemiology of mental illness and draws upon data from the Adult Psychiatric Morbidity Survey (Bebbington et al, 2009). The majority of adults living with mental illness are reported to display the first symptoms of mental illness before the



age of 16. Further, most severe mental illness has a less severe presentation prior to worsening of symptoms. The onset of schizophrenia is highest in young adults. The highest prevalence of mental illness in adults is found in people in their forties and fifties, and the lowest levels in their sixties and seventies. The midlife increase could potentially be due to stress and unpredictable life events at this age.

Common mental disorders and eating disorders are more likely in women than in men. Black and Minority Ethnic groups (BME) are at higher risk of common mental disorders, psychosis and bipolar disorders.

Common mental disorders also appear to be more prevalent in deprived areas; this relationship is more pronounced for severe depression. Debt, housing conditions, adverse working conditions, carer strain, abuse and unemployment have all been identified as risk factors for mental ill health. Social relationships can be a supporting factor or a stressor depending on the nature of the relationship.

There is a complex interplay between physical and mental health. People with chronic physical conditions are more likely to suffer from poor mental health. People with poor mental health are more likely to suffer from poor outcomes including premature mortality and, for a range of reasons, less likely to have equal access to treatment for physical conditions. Particular issues may relate to lifestyle choices and adherence to medical therapy.

Whilst our collective understanding of mental health has certainly come a long way, there remain significant areas of uncertainty. In particular, a recent focus on wellbeing is not supported by clear evidence - but is now incorporated into the Care Act. The Chief Medical Officer therefore recommends focusing on the WHO public mental health framework which places the emphasis on mental illness prevention, mental health promotion, treatment, recovery and rehabilitation.

The 2011 Government Strategy *No health without mental health* set out the Government's ambition in relation to mental health – to improve people's mental health and increase recovery from mental health problems, improve the physical health of people with mental health problems, improve the experience of care and support, and decrease avoidable harm, stigma and discrimination (HMG/DH, 2011).

This strategy also placed an emphasis on parity of esteem for mental and physical health (HMG/DH, 2011). A working group of the Royal College of Psychiatrists has been working to clarify the concept and describes it simply as the idea "*that mental health and physical health should be valued equally*" (RCPsych, 2013). This can further be distilled into a number of objectives, including: equal access to high quality services, resource allocation according to need, equal attention to service improvement and equal focus on outcomes. The Health and Social Care Act has also enshrined in law the Secretary of State's responsibility to improve the mental health of the population (Health and Social Care Act, 2012).

Recent years have seen times of economic challenge, and evidence suggests that such challenges can lead to increased stress, lower levels of wellbeing and increasing prevalence of mental health conditions (Cooper, 2011).



In addition to parity of esteem with physical health, it is now widely acknowledged that Social Care plays a vital role in the recovery of people with mental health problems. Issues such as housing, employment, financial stability, culture and belief, family and friends, education and activities are very important in maintaining good mental health.

Recent guidance and developments include the Mental Health Taskforce, significant reports on in-patient care, patient voice and the Crisis Care Concordat – which has been successfully developed and implemented in the District.

3 Mental Health in Bradford and Airedale

In respect of how we can assess the level of “happiness” across the District, in an attempt to develop a shared understanding, the cross Government Whitehall Well-Being Working Group has defined well-being as:

‘a positive physical, social and mental state; it is not just the absence of pain, discomfort and incapacity. It requires that basic needs are met, that individuals have a sense of purpose, that they feel able to achieve important personal goals and participate in society. It is enhanced by conditions that include supportive personal relationships, strong and inclusive communities, good health, financial and personal security, rewarding employment, and a healthy attractive environment.’

It is increasingly recognised that people with higher well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health. Promoting well-being is a priority for the Government and as a result the Office of National Statistics have developed national measures of well-being, centred around four questions (Table 1 and Figure 1 below).

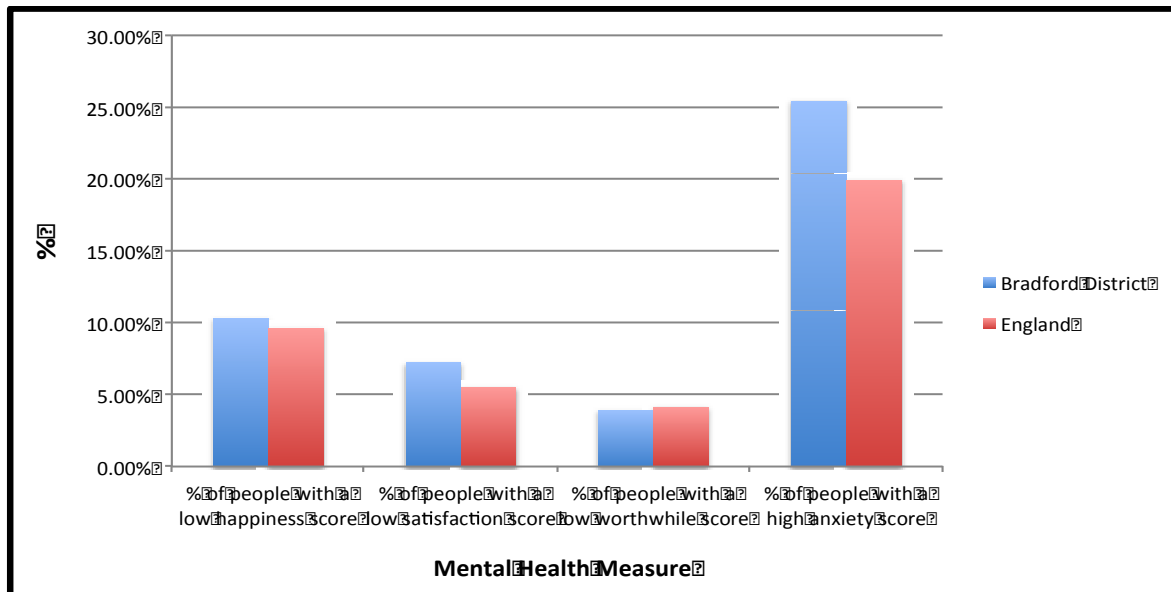
Although it appears from Table 1 that people in Bradford report lower levels of wellbeing than people in England as a whole, the results are not statistically significantly different, with the exception of anxiety score, in which a high proportion of people in Bradford reported feeling anxious the day before the survey.

Table 1 Wellbeing in Bradford as measured by ONS Wellbeing Measure, 2013/14

	Bradford District	England
% of people with a low happiness score	10.40%	9.70%
% of people with a low satisfaction score	7.30%	5.60%
% of people with a low worthwhile score	4.00%	4.20%
% of people with a high anxiety score	25.50%	20.00%



Figure 1 Wellbeing in Bradford as measured by ONS Wellbeing Measure, 2013/14. From left to right - % of people with: low happiness, low satisfaction, low worthwhile, high anxiety



3.2 – An overview of mental illness in Bradford and Airedale

3.2.1 Defining and classifying mental illness - Mental Health Care Clusters

In 2008 a consortium of mental health care providers in the North East of England developed a model of 21 Care Clusters. This model encompasses **descriptions of groupings of people needing mental health support based** on them having similar needs. The model moves away from purely diagnostic descriptions of people to one of broadly described needs

There are three “**super clusters**” of these groupings, namely:

- **Non-psychotic illness** (clusters 1-8) – e.g. anxiety and depression. These clusters also include people suffering with phobia, obsessive compulsive, personality and eating disorders.
- **Psychotic illness** (clusters 10-17) – e.g. schizophrenia
- **Organic illness** (clusters 18-21) – e.g. dementia, including Alzheimer’s Disease and other forms of dementia affecting people’s mental health.

Adopting healthcare clustering is one way of **standardising the provision of resources and levels of care** provided Care clusters also form the classification system of *Payment by Results* (PbR), the way our services are funded. Clustering should also be used to support care planning and recovery for specific clients groups.



Each month an estimated **113** people present to mental health services because of a severe and complex non-psychotic illness, equivalent to around 1,356 people each year.

As of August 2014, there were **1,428 people in clusters 5-7** under the care of mental health services, representing 18% of all of those in mental health services. Consistent with other clusters, the majority of people were from Districts CCG, followed by AWC, most likely reflecting population size.

Of those with a very severe and complex non-psychotic illness, the majority of people were assigned to cluster 7 (**72%**).

Table 2 below shows a number of examples of how different clusters translate into clinical activity and care. The activity ranges from low intensity, GP-focused short term community care for patients in Cluster 1, to longer term treatment accessing specialist (BDCT and CBMDC local Authority provided) care - but still in the community – for Cluster 4. IAPT refers to Psychological Therapies.

Table 2 Example of how Clusters in “Super Cluster” 1 are Represented in Activity

Cluster	Description of condition	Indicative episode of care	Description of needs
1	Common mental health problems (low severity)	8-12 weeks	Likely to have needs met in IAPT step 2 services, GP care only, or other VCS setting
2	Common mental health problems (low severity with greater need)	12-15 weeks	Likely to have needs met in IAPT step 2 or step 3 services, GP care only, or other VCS setting.
3	Non-psychotic (moderate severity)	4-6 months	Likely to have needs met in IAPT step 3 services, or other VCS setting
4	Non-psychotic (severe)	6-12 months	May have needs met in IAPT step 3 services but increasing severity and likely risk issues likely to be treated in non-urgent specialist mental health services e.g. CMHT

3.2.2 Non-Psychotic Mental Disorders

(Note – for the purpose of brevity, only common non-psychotic mental disorders as outlined below are described in detail in this report. Details of rarer and psychotic illness are available from the author and will be available at the Health and Wellbeing Board meeting).

What are common mental disorders?

Common mental disorders are described by the Office of National Statistics Psychiatric Morbidity Survey as, *‘mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise different types of depression and anxiety.’*

Depression and anxiety are often categorised as common mental disorders. Depression can present with a range of symptoms including low mood, lack of appetite, difficulty



sleeping, loss of enjoyment, difficulty moving and thoughts of self harm or suicide (Halverson, 2015). Depression and anxiety can both recur over time.

How many people experience common mental disorders in Bradford District and Craven?

Estimating the number of people experiencing common mental disorders is difficult; this is, in part, because common mental disorders can be episodic in nature. There are two ways in which we can measure or estimate the number of people experiencing common mental disorders; we can consider prevalence and incidence. Prevalence refers to all cases diagnosed over a specified time period. Incidence refers to new diagnoses, again within a specified time period.

The issue is further complicated by the classification of mental health problems and the way in which we define and measure common mental disorders. Some measures of the frequency of common mental disorders refer to specific conditions such as depression or anxiety, whilst others relate to common mental disorders in general.

The only thing that we can be certain about is the number of people who have been diagnosed with depression in primary care and are recorded on a primary care disease register (QoF). The QOF register, however, does not include people with anxiety (unless depression is also diagnosed). All other data pertaining to the prevalence and incidence of common mental disorders are modeled estimates, which include slightly different combinations of mental health problems in their calculations. This makes interpretation difficult.

Incidence of Depression

In respect of the prevalence and incidence of diagnosed depression in Bradford District and Craven, the most robust tool available is the QOF register, where diagnosed cases of depression are recorded. In 2013/14 **5,520** people were diagnosed with depression and recorded on a GP register as such across the three CCGs in Bradford District. The incidence, expressed as a %, is similar across the three CCGs (**AWC: 0.9%, City: 1.0%, Districts: 0.9%**), but is higher than that in England (**0.71%**).

Prevalence of Depression

Whilst incidence describes the number of new cases of depression diagnosed and recorded on GP registers, prevalence describes the number of people who have ever been diagnosed with depression. QOF registers provide an estimate of the number of people who have been diagnosed with depression since April 2006. Some of these individuals may have gone on to recover from their episode of depression, however given the episodic nature of depression, it is likely that a proportion may still be experiencing depression.

Across the three CCGs, almost **33,000** people have been diagnosed with depression at some time **in the last eight years**. The recorded prevalence amongst working age adults varies between CCGs; prevalence is highest in **AWC (8.1%)**, followed by **Districts (7.5%)** and **City (6.3%)**.

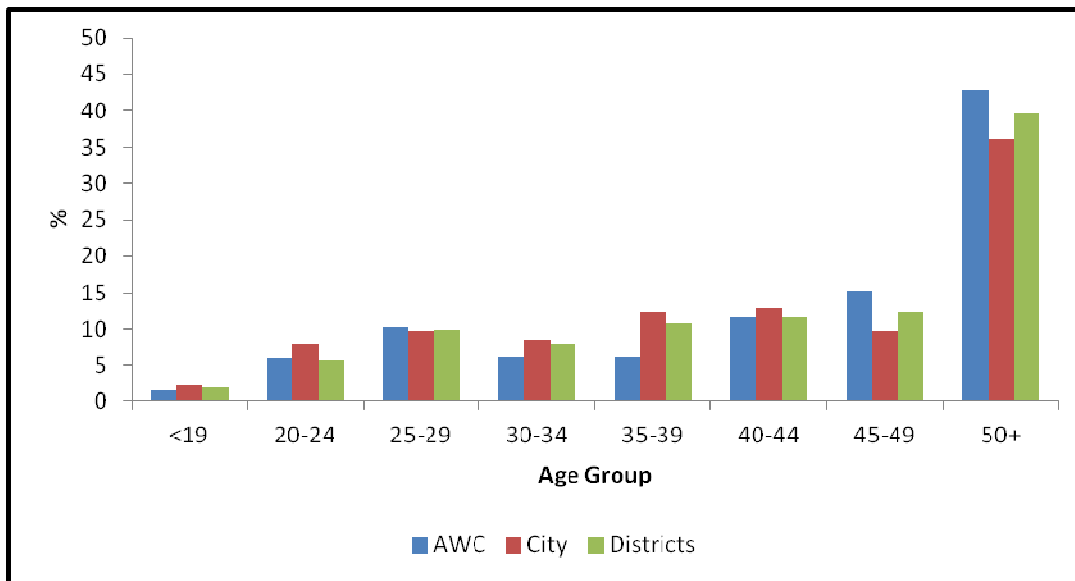
In respect of the broader epidemiology of common mental illness in Bradford and Airedale:



3.2.3 Age, Gender and Ethnicity profiles

Across all three CCGs the majority of people with a severe and complex non-psychotic illness cared for in mental health services were female, although in AWC females accounted for a significantly higher proportion of those under the care of services. The average (mean) age of patients at the time of presentation to services was also similar across the three CCGs (ranging from 44 years old in City to 48 years old in AWC).

Figure 2 - Age profile of presentations to mental health services for non-psychotic severe and complex mental illness



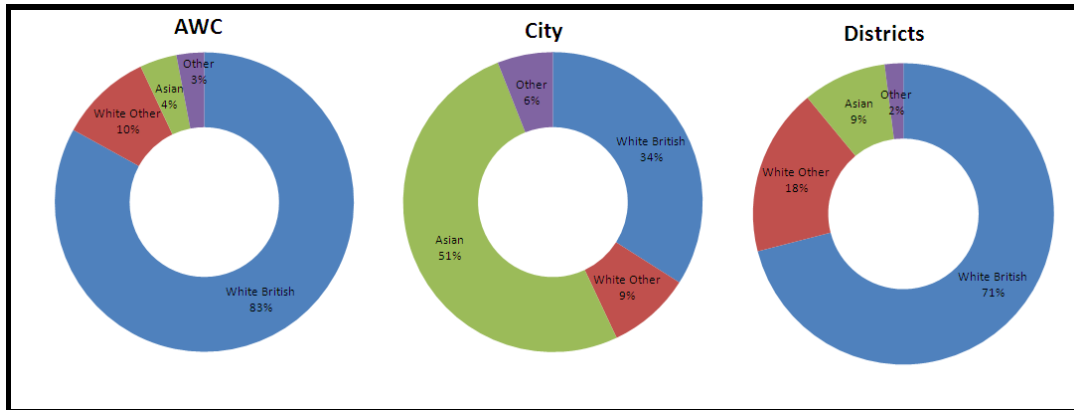
Source: Mental Health Minimum Dataset

The ethnic profile of those presenting to services varies across the three CCGs is a reflection, in part, of the demographics of individual CCG populations. In AWC and Districts, the majority of people were White British, followed by White Other and then Asian. In City, the majority of people were from Asian ethnic groups, followed by White British and White Other.

Data on ethnicity is not particularly well recorded at GP practice level and therefore, ethnicity profiles for specific age groups i.e. the adult population, do not exist. Accordingly, in the absence of robust data it is difficult to say with confidence how much this data on ethnicity is a reflection of the local population demographics and how much may be a reflection of the higher incidence of mental illness amongst some BME groups. It should, however, be noted that the ethnic profile of those presenting to services with non-psychotic mental illness differs from those presenting to services with psychotic mental illness.

Figure 3 - Ethnicity of presentations to mental health services for non-psychotic severe and complex mental illness





Source: Mental Health Minimum Dataset

3.2.4 Wider Determinants of Mental Health in Bradford and Airedale

This section is informed by a Common Mental Health Disorders Profiling Tool, developed by Public Health England to support an intelligence driven approach to understanding and meeting need. It collates and analyses a wide range of publically available data on prevalence, risk, prevention, early intervention, assessment, treatment, outcomes and service costs. It provides commissioners, service providers, clinicians, services users and their families with the means to benchmark their area against similar populations and gain intelligence about what works.

Data are presented to illustrate **Risk** and Related Factors, Prevalence, Services, Quality and Outcomes, and Finance with indicators intended to offer important elements of wider determinants that could not be otherwise gained. Each indicator is assessed and labelled with its quality rank.

(Note - data are drawn from many sources and vary by time period, population and presentation of values – some are should be taken with interpretation).

Table 3 below shows a high level summary for Bradford District using key indicators designed to help commissioners assess and benchmark how they manage mental illness.

Key observations include:

- Social deprivation scores are higher compared to regional scores
- Long-term illness/disability scores are lower than regional scores
- Household overcrowding is higher than regional figures
- Migrant GP registrations are higher than regional figures
- Higher risk drinking is at the lower boundary of regional figures
- The proportion of unpaid carers is lower than regionally



Table 3 Wider Determinants of Mental Health, Bradford 2010-15

Source: Public Health England

Indicator	Period	Compared with benchmark: ● Lower ● Similar ○ Higher							
		Bradford		Region		England		Yorkshire and the Humber region	
		Count	Value	Value	Value	Lowest	Range	Highest	
Socioeconomic deprivation: overall IMD score	2010	-	32.6	-	21.7	-	-	-	
Socioeconomic deprivation: % of people living in 20% most deprived areas	2014	234,587	44.4%	28.1%	20.2%	0.0%		53.0%	
Statutory homelessness: rate per 1000 households	2014/15	304	1.5	1.4	2.4	0.1		3.6	
Supported asylum seekers: Rate per 10,000 population	2013/14 Q2	183	3.5	4.4	3.9	0.0		15.2	
Children in poverty: % living in low income households	2013	29,595	24.0%	20.6%	18.6%	7.4%		31.1%	
Higher risk drinking: % of people drinking at increasing or higher risk levels	2008 - 09	-	19.7%	22.2%	22.3%	19.7%		25.1%	
Physical activity: % of population engaging in recommended levels of physical activity	2014	-	50.6%	-	57.0%	-	-	-	
Quality of indoor living environment: IMD score	2010	-	48.1	-	21.7	-	-	-	
Long-term health problems or disability: % of people whose day-to-day activities are limited by their health or disability	2011	90,527	17.3%	18.8%	17.6%	15.2%		23.9%	
Unpaid carers: % of population who provide substantial unpaid care	2011	12,305	2.36%	2.56%	2.37%	1.76%		3.45%	
Adults with low education: % of adults that have no qualifications or level one qualifications	2011	167,305	41.8%	39.3%	35.8%	28.6%		46.6%	
Lone parents households: % of households that have lone parents with dependent children	2011	15,305	7.7%	7.1%	7.1%	4.5%		9.1%	
Relationship breakup: % of adults whose current marital status is separated or divorced	2011	47,230	11.8%	11.9%	11.6%	10.2%		13.8%	
Household overcrowding: % of households with occupancy rating for bedrooms of -1 or less	2011	12,721	6.4%	3.7%	4.8%	1.5%		6.4%	
Rented accommodation: % of all households living in rented accommodation	2011	65,583	32.9%	34.0%	34.5%	22.8%		48.5%	
English Language skills: % of people who cannot speak English / speak it well	2011	23,965	4.82%	1.61%	1.65%	0.26%		4.82%	
Population turnover (internal migration): Rate per 1,000 resident population	2014	32,162	60.9	76.6	90.7	54.6		130.2	
Migrant GP registrations: Rate per 1,000 resident population	2014	6,185	11.7	9.3	11.7	1.2		19.6	

3.2.5 Community Mental Health – Clinical Commissioning Groups

Public Health England has published community mental health profiles based on CCG prevalence for 2012/13 compared with England, these are shown below (note some figures vary slightly from data shown above due to the year difference in data collection period). Key observations include:

- Bradford Districts CCG reports higher prevalence in all measures except % long term illness
- Airedale, Wharfedale and Craven CCG is the only CCG showing lower % long-term illness
- Bradford City CCG is notably higher for depression incidence and depression/anxiety prevalence

Table 4 Airedale, Wharfedale and Craven CCG Community Mental Profile 2012/13



		Alredale, Wharfedale And Craven		Sub-region	England	England		
Indicator	Period	Count	Value	Value	Value	Lowest	Range	Highest
Depression: QOF prevalence (18+)	2012/13	7,852	6.4%	-	5.8%	2.9%		11.5%
Depression: QOF incidence (18+)	2012/13	1,507	1.2%	1.2%	1.0%	0.5%		1.9%
Depression and anxiety prevalence (GP survey)	2012/13	285	10.8%	12.8%	12.0%	8.1%		19.3%
Mental health problem: QOF prevalence (all ages)	2012/13	1,367	0.87%	0.81%	0.84%	0.48%		1.46%
% reporting a long-term mental health problem	2012/13	85	3.5%	-	4.5%	2.5%		8.2%

Table 5 Bradford City CCG Community Mental Profile 2012/13

		Bradford City		Sub-region	England	England		
Indicator	Period	Count	Value	Value	Value	Lowest	Range	Highest
Depression: QOF prevalence (18+)	2012/13	4,597	5.6%	-	5.8%	2.9%		11.5%
Depression: QOF incidence (18+)	2012/13	1,543	1.9%	1.2%	1.0%	0.5%		1.9%
Depression and anxiety prevalence (GP survey)	2012/13	277	17.1%	12.8%	12.0%	8.1%		19.5%
Mental health problem: QOF prevalence (all ages)	2012/13	1,058	0.89%	0.81%	0.84%	0.48%		1.46%
% reporting a long-term mental health problem	2012/13	85	4.4%	-	4.5%	2.5%		8.2%

Table 6 Bradford Districts CCG Community Mental Profile 2012/13

		Bradford Districts		Sub-region	England	England		
Indicator	Period	Count	Value	Value	Value	Lowest	Range	Highest
Depression: QOF prevalence (18+)	2012/13	15,497	6.1%	-	5.8%	2.9%		11.5%
Depression: QOF incidence (18+)	2012/13	2,899	1.1%	1.2%	1.0%	0.5%		1.9%
Depression and anxiety prevalence (GP survey)	2012/13	744	14.2%	12.8%	12.0%	8.1%		19.5%
Mental health problem: QOF prevalence (all ages)	2012/13	2,982	0.90%	0.81%	0.84%	0.48%		1.46%
% reporting a long-term mental health problem	2012/13	240	4.9%	-	4.5%	2.5%		8.2%

3.2.6 Children and Young People

The Bradford Children's Partnership Strategy - *Our Good Health and Wellbeing Strategy for 2013-2018* includes the following objectives:

- To give every child the best start in life
- To enable all children young people and adults to maximise their capabilities and have control over their lives
- To ensure young people are well prepared for adulthood
- To improve the mental health of young people in the Bradford District.



Over the 5 year period of the strategy there is a commitment to explore, implement and establish a commissioning model which clarifies and makes consistent reporting mechanisms and governance structures to protect the interests of users and providers of children’s mental health and psychological wellbeing services. This will be accompanied by analysis of the total investment in children and young people’s mental health in order to facilitate the remodeling and restructuring of services to deliver high quality mental health interventions wherever children and young people are. This will involve the development and expansion of services to work together more effectively with mental health at the core of service delivery. This will include:

- Development of perinatal/parental mental health services, building on the good work already started through the universal integrated care pathway for 0-5 year-olds to promote attachment and bonding
- Review of the *Early Help* offer. This will involve mapping current provision and producing a gap analysis. The aim is to develop the wider workforce to provide proactive support to children and young people, and so release capacity in the CAMHS service to address the demand for more complex interventions.
- Promotion of access to counselling services, pastoral workers and mental health support in schools through extending coverage of these and providing consistency of governance support and supervision.
- Promotion of specialist mental health links with schools and GP practices to ensure all professionals linked with child services have access to expertise in dealing with mental health issues Development of a school nursing service to deliver mental health interventions at the earliest level with access to specialist mental health workers as necessary
- To extend the development of apps on the back of the success of the Bradford-based ‘Transitions’ app.
- To extend access to WRAP - successfully implemented with children and young people to help manage mental health problems through a solution-based focus.
- Urgent and Emergency Care Vanguard – Children and Mental Health Project
- Development of the Futures in Mind Transformation Plan
- Implementation of the Journey to Excellence Programme

Table 7 Bradford District Mental Health Profile for Children and Young People



Source: Public Health England

Indicator	Period	Compared with benchmark: Lower Similar Higher					Benchmark Value		
		Bradford		Region		England		Yorkshire and the Humber region	
		Count	Value	Value	Value	Lowest	Range	Highest	
Lone parents households: % of households that have lone parents with dependent children	2011	15,305	7.7%	7.1%	7.1%	4.5%		9.1%	
Relationship breakup: % of adults whose current marital status is separated or divorced	2011	47,230	11.8%	11.9%	11.6%	10.2%		13.8%	
Underweight children (Reception year): % of children	2014/15	94	1.39%	0.92%	0.96%	0.40%		1.39%	
Obese children (Reception year): % of children	2014/15	582	8.6%	8.8%	9.1%	6.2%		10.5%	
Underweight children (Year 6): % of children	2014/15	153	2.44%	1.42%	1.42%	0.59%		2.44%	
Obese children (Year 6): % of children	2014/15	1,345	21.5%	19.2%	19.1%	11.9%		22.4%	
Children under 16 in poverty: % of dependent children under 16	2013	29,595	24.0%	20.6%	18.6%	7.4%		31.1%	
Under 18 pregnancy: rate of conceptions per 1,000 females aged 15 - 17	2013	299	27.9	28.5	24.3	9.5		43.3	
Children providing care: % children aged <15 who provide unpaid care	2011	1,276	1.04%	1.02%	1.11%	0.91%		1.15%	
Young people providing care: % people aged 16-24 who provide unpaid care	2011	3,886	6.1%	4.6%	4.8%	2.7%		6.1%	
Children providing considerable care: % children aged <15 who provide 20+ hours of unpaid care per week	2011	263	0.21%	0.20%	0.21%	-	Insufficient number of values for a spine chart	-	
Young people providing considerable care: % people aged 16-24 who provide 20 hours + of unpaid care per week	2011	1,228	1.9%	1.3%	1.3%	0.5%		1.9%	
Families out of work: % of households with dependent children where no adult is in employment	2011	11,843	5.9%	4.4%	4.2%	-	Insufficient number of values for a spine chart	-	
Families with health problems: % of households with dependent children where at least one person has a long term health problem or disability	2011	12,550	6.30%	4.63%	4.62%	-	Insufficient number of values for a spine chart	-	

3.2.7 Service Activity

As at August 2014, 2,133 people with a mild, moderate or severe non-psychotic mental health problem were under the care of mental health services in Bradford and Airedale. The majority of these people were allocated to **Clusters 3 and 4** suggesting that their conditions were at the severe end of the non-psychotic spectrum. This is unsurprising as a significant proportion of people with common mental disorders are likely to be managed in primary care settings. The number of patients in each cluster is broadly as expected given the differences in population size between the CCGs.

Each month an estimated **113 people** present to mental health services because of a severe and complex non-psychotic illness, equivalent to around **1,356 people each year**.

As of August 2014, there were **1,428** people in **clusters 5-7** under the care of mental health services, representing 18% of all of those in mental health services. Consistent with other clusters, the majority of people were from Districts CCG, followed by AWC, most likely reflecting population size.

Of those with a very severe and complex non-psychotic illness, the majority of people were assigned to cluster 7 (72%).

As of August 2014, **344** people were under the care of mental health services because of a chaotic and challenging **non-psychotic disorder**. Aggregated monthly data suggests that on average **25 people each month** are referred into services for treatment – this is



equivalent to between **272 and 312 people each year** across the three CCGs. In terms of absolute numbers, the most presentations each month come from Districts patients, followed by AWC and then City CCG. This is most likely a reflection of the larger population in Districts.

Usually people require long term treatment – the cluster days for this mental health cluster is 365 days, however, of those in treatment as of August 2014, over a quarter had been in treatment for more than one year, most likely reflecting the complex needs of these individuals.

See Appendix 1 for an outline of how primary and secondary mental health services are organised across the District.

3.2.8 Suicide

Each year in England, over 4000 people take their own life (DoH, 2015). This figure has now consistently been rising for the last 5 years (APPG 2015) following a drop in the first decade of the century. Suicide is the second most common cause of death for 5-19 year olds, the leading cause of death for 20-34 year olds, and the second most common cause of death for 35-49 year olds; in addition, there are significant differences in mortality between the genders, with three times as many males taking their own life as females. Only 25% of people who kill themselves have been in contact with mental health services in the last 12 months, although many are in contact with social services, primary care, or have a history of self-harm.

According to the Department of Health, 'Directors of Public Health and Public Health teams in local authorities, working with local Health and Wellbeing Boards have a central role in coordinating local suicide prevention efforts', and Public Health is tasked with bringing together partners from the NHS, Local Authority, third sector and affected members of the public in order to tackle the determinants of self-harm, suicide attempt and suicide in a local area. A multi-agency suicide prevention group for the district has been chaired by a public health consultant for a number of years and has in the past year been put on a more established footing with widened membership, including: Public Health, Adult Social Care and Children's Services, Bradford District Care NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust, Bradford City CCG, Bradford Districts CCG and Airedale, Wharfedale and Craven CCG, The University of Bradford, Bradford Mind, Bradford Samaritans, West Yorkshire Fire and Rescue Service and West Yorkshire Police Service.

One of the group's tasks is to oversee the audit of all suicides in the district, which has been a regular part of the public health team's surveillance work for a number of years. A full audit using a variety of mortality statistics was written in 2013, drawing on coroner reports which give more details of the circumstances in which somebody has taken their own life and constitute the judicial judgement on the cause of death. An update for 2016 is currently being prepared, and has already identified a rising rate of suicide in Bradford, driven in the most part by rising male rates since 2007 (but with female rates now also on the rise). There were 46 deaths from suicide in 2014, with a rolling 3 year average of 12.1 deaths by suicide per 100,000 people, which is significantly above the national rate.



To add to the intelligence provided by the audit, an evidence review has been conducted to identify best practice in national policy and recent academic literature focussing on identifying suicide risk factors and assessing the effectiveness of interventions intended to prevent suicide. In addition, Bradford recently hosted a summit of over 200 professionals from West Yorkshire as part of the Urgent and Emergency Care Vanguard to discuss international evidence on suicide prevention. With this evidence and the audit work in motion, the suicide prevention group is now turning its focus towards action. Ideas and commitments from partners for concrete work are coming forward, and will be discussed by the prevention group in April. The eventual action plan will contain proposals for raising suicide awareness amongst professionals and the general public, better methods of identifying those at risk of taking their own life, and measures aimed at improving the general mental wellbeing of people in Bradford. It is anticipated that this will be finalised this year.

Table 8 Key Suicide Data, Bradford and Airedale 2012-14

Source: Public Health England

Indicator	Period	Bradford		Region	England	England		
		Count	Value	Value	Value	Lowest	Range	Highest
Suicide age-standardised rate: per 100,000 (3 year average) (Persons)	2012 - 14	156	10.9	9.3	8.9	4.5		15.7
Suicide age-standardised rate: per 100,000 (3 year average) (Male)	2012 - 14	119	16.8	15.0	14.1	7.2		25.3
Suicide age-standardised rate: per 100,000 (3 year average) (Female)	2012 - 14	37	5.1	3.7	4.0	-	Insufficient number of values for a spine chart	
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Persons)	2012 - 14	144	36.5	33.9	31.9	10.7		62.6
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Male)	2012 - 14	112	57.7	55.2	50.2	16.4		101.6
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Female)	2012 - 14	32	15.2	12.7	13.7	0.0		26.2
Suicide crude rate 15-34 years: per 100,000 (5 year average) (Male)	2010 - 14	42	11.6	12.5	12.3	4.1		33.5
Suicide crude rate 15-34 years: per 100,000 (5 year average) (Female)	2010 - 14	-	3.0*	3.0	3.4	2.9		4.7
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Male)	2010 - 14	112	23.5	21.9	20.5	7.9		33.8
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Female)	2010 - 14	-	5.7*	5.7	5.9	4.9		7.1
Suicide crude rate 65+ years: per 100,000 (5 year average) (Male)	2010 - 14	23	14.7	10.9	12.4	2.1		24.5
Suicide crude rate 65+ years: per 100,000 (5 year average) (Female)	2010 - 14	-	3.5*	3.5	4.3	3.5		5.2

3.2.9 Mental Health and Physical Health

People with mental health problems are at greater risk of worse physical health than those persons who experience no mental health problems. Evidence suggests that the life expectancy of persons with severe and enduring mental illness is ten years less than that in the general population. Furthermore, the rates of diabetes, cardiovascular disease and respiratory disease are also higher than in the general population. There are a number of reasons for this; firstly persons with a severe mental illness tend to have less healthy lifestyles than the general population, including poorer diets, lower levels of participation in physical activity and higher levels of smoking; secondly, persons with severe mental



illness are likely to experience long term effects from taking antipsychotic medication; and thirdly, persons with severe mental illness have higher rates of alcohol and substance misuse. In addition to these factors, the presence of a mental health disorder may also prevent persons from engaging with health services or they may lack the necessary skills to adequately communicate their symptoms to healthcare professionals. When persons with mental health disorders access healthcare, physical symptoms may be overlooked as mental health is seen as a priority.

Mental health and mental health disorders are associated with a number of complex interacting factors, including social, psychological, behavioural and biological factors. As well as a person's mental health affecting their physical health, a person's physical health can also contribute to the deterioration of a person's mental health. Accordingly, in the development of health services, the interrelationship between mental and physical health needs to be considered to both prevent physical illness in those with mental illness and to prevent mental illness in those with physical illness.

40% of those recorded on SystmOne as having ever experienced anxiety or depression have at least one long term condition; one in five people have one long term condition, whilst one in ten have two long term conditions. This is similar across all three CCGs (figure 11). The most common physical health problems amongst those with depression and anxiety are hypertension, asthma and diabetes. The prevalence of diabetes amongst people experiencing anxiety/depression is markedly higher in City CCG than AWC or Districts – this is unsurprising and reflects the overall prevalence of diabetes in the CCG.

47% of those recorded on SystmOne as having a psychotic or bipolar disorder have a least one long term condition; one in four people have one long term condition, whilst 13% have two long term conditions. This is similar across all three CCGs. The most common physical health problems amongst those with serious mental illness are hypertension, diabetes and asthma with the prevalence of diabetes being significantly higher in City CCG than AWC or Districts CCGs.

Overall the three CCGs compare favourably to England in terms of the achievement of quality (QOF) indicators regarding the management of physical health conditions among people with severe mental illness. There is, however, variation between CCGs and also between GP practices. For example, in City only 81% of patients on the mental health register have a comprehensive care plan documented in their record – this compares to 93.2% in AWC and 91.1% in Districts. Although not presented here, there is also variation at GP practice level.

3.2.10 Public Mental Wellbeing

The concept of Mental Wellbeing, particularly in a population health context, has been a growing influence on thinking and policy in a number of sectors over recent years. It has grown out of an increasing understanding of the importance of personal and community resilience, equity and fairness and asset approaches to local infrastructure, social protection and an active labour market.

In particular, the importance of understanding the distinction between **Mental Wellbeing** and **Mental Health/Illness**. It is possible to have high levels of subjective wellbeing



despite having a mental illness, and vice versa. For example, a person with well controlled schizophrenia, functioning well in society with a happy home life can have a high level of Mental wellbeing, whereas a person with no mental illness who has chronic rheumatoid arthritis, is in constant pain and cannot work, can have very low Mental Wellbeing

There is a growing and increasingly robust evidence base for the effectiveness of interventions in Public Mental Wellbeing - a number of National Institute of Clinical Excellence (NICE) Guidance documents cover this area. In particular, it has been demonstrated, using robust published evidence, the effect that improved Mental Wellbeing can have in the workplace, primarily through:

- a. Reduced absenteeism and presenteeism
- b. Increased productivity

Locally, meetings have taken place with Occupational Health specialists at Morrisons supermarkets. Morrisons have undertaken the journey from evidence to implementation of Mental wellbeing based workplace interventions with some success and are happy to share learning with the Council who are developing an employee wellbeing project.

3.2.11 Economic Costs of Poor Mental Health

Overall costs

It has been estimated that the economic and social costs of mental health problems in England was £105 billion in 2009-10 – taking into account costs for health and social care, loss of output and human costs. Those who developed this estimate think it is likely to be an underestimate.

Additional estimates put the cost of mental illness for Northern Ireland at around £3 billion, Wales £7 billion and Scotland £9 billion. NHS spend on mental health services alone came to around £10 billion in 2008-09. It has been estimated that optimal treatment for mental disorders will only avert 28% of the burden of mental illness, highlighting the need for prevention.

Mental illness and lack of mental wellbeing impact on communities and individuals' lives in many ways, and economic studies assign costs to these different impacts. Most studies include costs due to mental health service usage, but not the additional costs to other health services due, for example, to chronic illness.

Costs to social services are usually included, but only some studies include costs to criminal justice and probation services. Studies may cover sickness absence due to mental illness but not the costs of presenteeism which may be greater. The costs presented therefore provide a very useful baseline but are usually regarded as underestimates for these reasons.

Workplace

In the world of work, one study estimates that sickness absence due to mental ill health



costs around £8 billion per year (70 million working days missed each year, or an average of 2.8 days per year per UK employee). Lost productivity (including presenteeism, where mental health issues lessen work performance) costs £15 billion, and replacing staff who leave their posts because of mental illness costs employers £2 billion. (6)

Unemployment

Government figures show that 43% of those on long-term benefits due to health issues have a primary mental health problem. (7)

Costs of related physical health problems

Poor mental health is associated with physical health problems. Of those with a long-term physical health condition around 30% will also have a mental health problem, and of those with a mental health problem, around 45% will also have a long-term physical health condition. (8) This has an impact on the cost of providing care – treating the physical health issues of patients with a mental health problem is more expensive (even after removing the cost of treating the mental health issue, such as for antidepressants or mental health services). (9)

This can increase costs of healthcare for physical problems by more than 45%, according to some international studies. If applied to NHS expenditure in England, this could mean that £8-13 billion of long-term physical health care costs are due to poor mental health. (10)

Costs to the individual and their families

Poor mental health impacts on individuals and their families, in terms of lost income, lower educational attainment, quality of life and considerably shorter life span.(11) (12)

The economic benefits of mental wellbeing

The economic benefits of mental wellbeing are not as well established as the costs of mental illness. However, mental health promotion has an important contribution to make to overall public health through increasing psychosocial functioning, lowering use of healthcare (13) and reducing morbidity and premature mortality. (14)

As an example, one study estimates that promoting mental wellbeing in a single year cohort of children in Wales could lead to benefits worth over £1billion, (15) while this figure could be nearly £24billion for the whole of the UK. (16) Since benefits accrue across the lifecourse, promoting mental wellbeing in children provides more economic benefits than promoting mental wellbeing at other ages. What does economic evidence tell us about public mental health?

3.2.12 Current Structures and Partnerships

Joint Mental Health and Social Care Commissioning Board

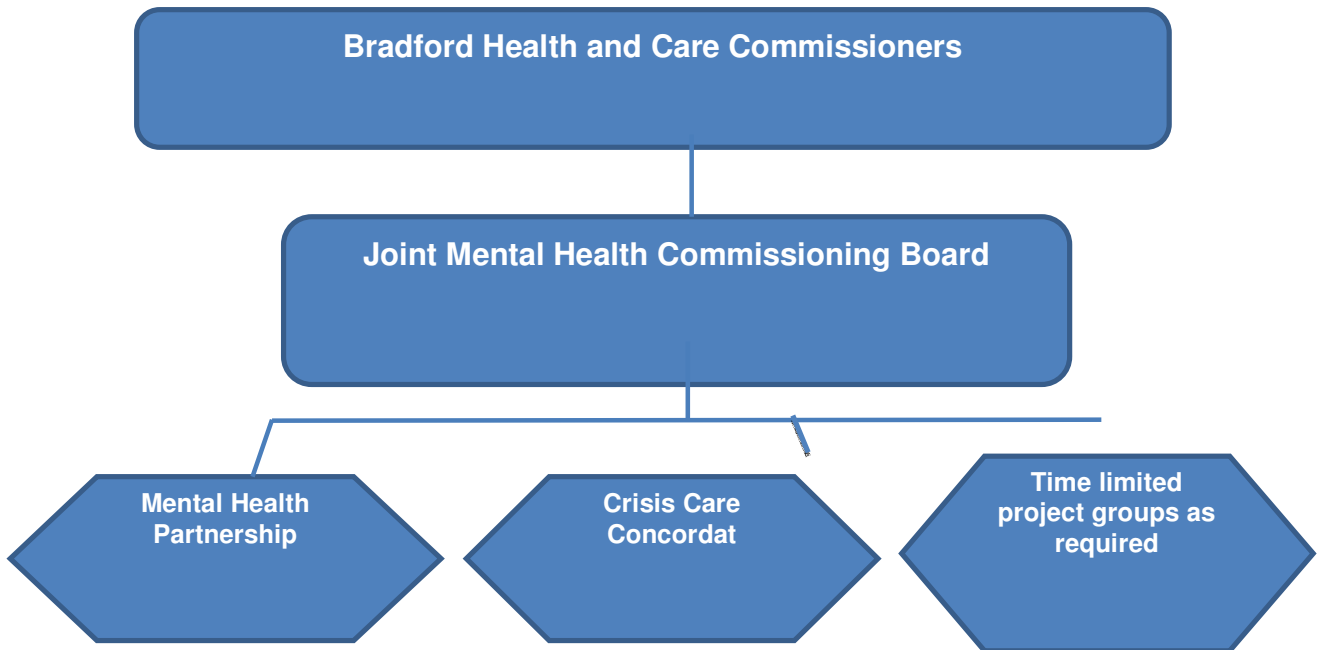
The Joint Mental Health and Social Care Commissioning Board is a partnership commissioning group whose key aims are:



- To oversee the production of a Joint Mental Health Strategy for the district
- To provide strategic direction for the transformation and development of mental health improvement across Bradford and Craven through the implementation of the Bradford and Airedale Vision for Mental Health
- To develop and agree a work plan that delivers the above and that agrees relative priorities:
 - Promote the well-being and recovery agenda
 - Monitor progress against agreed plans
 - Identify gaps in provision and priorities for change
 - Ensure that emergent policy and local needs are reflected in agreed plans and priorities
 - Promote the mental health agenda across all programmes of work within the NHS and LA to ensure that mental health is 'everybody's business'.
 - Promote equality of opportunity for people with mental health problems in Bradford and Airedale
 - Develop a recovery based philosophy to underpin all mental health service provision in the area
 - Facilitate appropriate consultation and participation in areas of service change and development
 - Promote the personalisation agenda in MH services across Bradford and Airedale
 - Improve the quality of life and wellbeing of mental health service users in Bradford and Airedale
 - Ensure a partnership approach to transformation across all programmes of commissioning, with particular emphasis on children, older people and dementia, learning disabilities and long term conditions.
 - Perform a "scrutiny role" for the oversight of quality in mental health services in Bradford and Airedale



The Corporate Governance structure in relation to this partnership is shown below



Bradford District Suicide Prevention Group

The Bradford District Suicide Prevention Group (BDSPG) is a multi-agency stakeholder which exists to reduce the number of suicides occurring in the District, through partnership work, coordination of organisational efforts around suicide prevention, and through making decisions about actions and resources which can be dedicated to this cause.

The BDSPG covers the Local Authority area of Bradford District, encompassing the two Bradford CCG areas and the coterminous part of the CCG area of AWCCCG. The group's core activities are:

- To provide leadership within Bradford to tackle the high rates of suicide in the District
- To monitor on an ongoing basis trends in suicide, attempted suicide and self harm in the District
- To share information, learning, data and intelligence on suicide in the District, including trends and incidents of note within individual organisations
- To support Public Health work to develop, write and implement an action plan to tackle the suicide rate in the District, including individual members committing resources and officer time to closer joint working and initiatives which will have impact in this regard
- To support individual members to help their organisations in raising awareness of suicide prevention and embedding good practice.



Crisis Care Concordat

The Bradford Crisis Care Concordat is a partnership with a joint commitment to improve Mental Health Crisis Response Services in Bradford, Airedale and Craven. It works together across Bradford and Airedale and Craven (and, where boundaries or services overlap, with partners in North Yorkshire, Lancashire, Kirklees and Leeds) to:

- Improve the access to services, response from services, care and support of people experiencing a mental health crisis
- Prevent crisis through effective crisis planning and early intervention.
- Explore how we can commission mental health services to be based on recovery, wellbeing and resilience
- Jointly commission and design services so that they are well planned and appropriate to the needs of the population, with appropriate alternatives to acute or emergency care available when needed
- Provide consistent, timely and appropriate support regardless of the agency that comes into contact with the person in crisis and whatever time of the day or night they require our support
- Work, plan and reflect together so that people in crisis receive an integrated, seamless service without organisational boundaries and difficulties getting in the way
- Develop a multi agency crisis care pathway that links all of the agencies that are signatories to this document

3.2.13 Key Initial Discussion Points

1. Effect on Resilience at community level – underpinning theme across sectors
2. Balance with strategies to manage mental illness – must not confuse to detriment of effectiveness and strategic approach
3. Balance between emerging evidence base and local innovation
4. Inclusion across the life course – older people, younger people, parents
5. Benefits across sectors – financial/productivity, resilience, demand for services

4. FINANCIAL & RESOURCE APPRAISAL

Locally, Health and Care partners have agreed to a larger Better Care Fund (BCF) for 2016/17 by aligning the budgets of Mental Health and Learning Disabilities and to seek to maintain funding for mental health at the current level as previously agreed at Health and Wellbeing Board (8th February 2016).

The financial implications of the BCF are an intrinsic part of the BCF plan development process



and are being worked through and fully understood by respective Financial Officers accordingly. The submission of the BCF plan for 2016/17 to NHS England includes detailed finance and activity.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

Governance is through the Mental Health Partnership Board reporting to the Integration and Change Board and the Bradford Health and Care Commissioners through to the Health and Wellbeing Board.

6. LEGAL APPRAISAL

6.1. Part 1 of the Act places legal responsibility for Public Health within Bradford Council. Specifically Section 12 of the Act created a new duty requiring Local Authorities to take such steps as they consider appropriate to improve the health of the people in its area. The Public Health department within the Local Authority supports the performance of this duty.

6.2. Section 31 of the Act requires local authorities to pay regard to guidance issued by the Secretary of State for Health when exercising their public health functions and in particular local authorities are required to have regard to the Department of Health's Public Health Outcomes Framework.

6.3. S117 is part of the Mental Health Act 1983 that provides for After Care on discharge from hospital following detention on section 3 or 37 of the Act or transfer under hospital direction under section 45A or transfer under section 47 or section 48 of the Act. Aftercare is not defined but can include health or social care type services, specialist accommodation, support to access employment or daycare. Aftercare should be agreed as part of the discharge care plan and continues for as long as it is needed to provide appropriate post discharge care and to prevent readmission to hospital.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

The Public Sector Equality Duty under the Equality Act 2010 requires the council when exercising its functions to have due regard to the need to

- a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010
- b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- c) foster good relations between person who share a relevant protected characteristic and person who do not share it
- d) relevant protected characteristics include age disability, gender, sexual orientation, race, religion or belief

7.2 SUSTAINABILITY IMPLICATIONS

In terms of sustainability of the local health economy the issues discussed in relation to mental health and mental wellbeing will be an important contributory factor in establishing a sustainable health and wellbeing sector. Improving mental health and mental wellbeing is likely to impact positively on physical health as well as reducing the demand for care in relation to mental health



needs.

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

Actions to improve health outcomes will largely reduce greenhouse gas emissions. Active travel is a good example, achieving multiple outcomes for the environment and the health of the population. However it is important to recognise that energy and emissions can be linked with better standards of living - such as car ownership, domestic energy, good diet and flights abroad. Work needs to take place to ensure that improvements in wellbeing do not therefore automatically lead to increased carbon emissions.

7.4 COMMUNITY SAFETY IMPLICATIONS

7.4.1. The scope of Public Mental Wellbeing means that some of its priorities may impact on community safety considerations, including specific issues such as the impact of drug and alcohol use on health; working in communities to develop employment activities; and developing community capacity and participation.

7.5 HUMAN RIGHTS ACT

7.5.1. By virtue of the Human Rights Act 1998 all public bodies (including local government) carrying out their public functions have to comply with the rights set out in the European Convention on Human Rights. Developing priorities of the type set out above and promoting their effective delivery means that the Council will be supporting the principles behind the Convention in particular respect for private and family life, the right to an education, the right to life and the right to be protected from the effects of discrimination.

7.5.2. Action taken to reduce health inequalities is likely to have a positive impact on human rights issues across all aspects of Wellbeing.

7.6 TRADE UNION

None

7.7 WARD IMPLICATIONS

A number of issues governing Public Mental Wellbeing are more prevalent in wards which are identified as experiencing multiple deprivation. Longer term plans will therefore need to engage with a wide range of active organisations on a ward, or sub-ward, basis.

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

None

8. NOT FOR PUBLICATION DOCUMENTS

None



9. OPTIONS

No options are provided.

10. RECOMMENDATIONS

10.1 That the Health and Wellbeing Board notes the contents of this report.

10.2 That the Health and Wellbeing Board continues to prioritise this issue and ensures that the District has adequate resource for prevention and early intervention in respect of mental health and mental illness.

10.3 That the Health and Wellbeing Board supports the development of an integrated Mental Health strategy and receives further updates through the standing item on development of a whole system for health, care and wellbeing.

11. APPENDICES

Appendix 1 – Mental Health Service Overview

12. BACKGROUND DOCUMENTS

None



Primary Care

Much of the management of common mental health problems takes place in primary care. Care Quality (QOF) data can be used to provide an indication of the quality of care for people with depression in primary care.

3.5.1 Assessment of the severity of depression

NICE guidelines state that an assessment of severity in patients with depression is essential to decide on appropriate interventions and improve the quality of care. An assessment of severity as close as possible to the time of diagnosis enables a discussion with the patient about relevant treatment and options, guided by the stepped care model of depression described in the NICE clinical guideline 90.

There is significant variation at both CCG and practice level regarding the proportion of patients who have been assessed as per the NICE guidance (and recorded as such on the QOF register). Almost all patients in AWC and Districts have been assessed – both proportions are higher than the England average. However, in City an estimated 13% of patients have not had an assessment of the severity of their depression recorded on the QOF register.

Table 9: Proportion of patients with a new diagnosis of depression (by CCG, 2013/14), recorded between the preceding 1 April to 31 March, who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care

	Number assessed	% assessed
AWC	1,412	95.50%
City	1,022	86.50%
Districts	2,677	93.60%
England	357,147	90.40%

Source: Bradford QOF

Figures show the variation at a practice level within each of the CCGs. Across all three CCGs the proportion of patients who have had an assessment of the severity of their depression ranges from just 4.5% to 100%. Whilst data quality may, in part, explain some of the variation, it is unlikely to explain it all.

It is recognised that depression is often a chronic disease, yet treatment can be episodic and short-lived. Accordingly, consistent with NICE guidance there is an expectation that people with a new diagnosis of depression should be reviewed not earlier than 10 days, but not later than 35 days after the initial diagnosis.

There is significant variation at both CCG and practice level regarding the proportion of



patients who have been reviewed no later than 35 days after an initial diagnosis (and recorded as such on the QOF register). Overall 85.5% of patients in AWC and 82.1% of patients in Districts were reviewed – higher than the England average. The proportion reviewed in City, however, was significantly lower – 72.2%.

Again there is variation at a GP practice level, ranging from 0% to 87.5%.

Secondary Care - Bradford District Care NHS Foundation Trust

Bradford District Care NHS Foundation Trust (BDCNFT) is a provider of mental health, learning disabilities and community health services across Bradford, Airedale and Craven. Services cover all ages, and include community based care, hospital based mental health care and some specialist learning disabilities support for people too unwell to be treated at home.

Drug and Alcohol Services

- **Airedale Community Drug and Alcohol Service (ACDAS)**, Ingrow Centre, Keighley. For adults over 18 living in Airedale with dual diagnosis and complex alcohol issues.
- **Alcohol Care Team**. A hospital based service aiming to reduce alcohol related presentations, subsequent hospital admissions and engage patients and carers with appropriate services. Key aim to reduce attendances at Accident & Emergency and hospital stays due to alcohol related problems.
- **Bradford Community Drug & Alcohol Service (BCDAS)** Listerhills, Bradford. For adults over 18 living in Airedale with dual diagnosis and complex alcohol issues.
- **City Substance Misuse Service**, Fountains Hall, Bradford. For adults over 18 with substance misuse issues living in Bradford
- **North Bradford Drug Service (NBDS)**. A service for adults over 18 with substance misuse issues living in Bradford.
- **Substance Misuse - Community Services**. Community teams for those who need support to overcome mental health and substance misuse problems but do not require a hospital stay,

Inpatient and Acute Care Services

Bradford

- **In-patient Ashbrook Ward**, Lynfield Mount Hospital. For females aged 18-65 who are experiencing an acute mental illness.
- **In-patient Daisy Hill Intensive Therapy Centre**, Lynfield Mount Hospital. Supports people with severe and complex mental health issues to improve their health and wellbeing through an intensive six month therapy programme.



- **In-patient Maplebeck Ward**, Lynfield Mount Hospital. For males aged 18-65 who are experiencing an acute mental illness.
- **In-patient Oakburn Ward**, Lynfield Mount Hospital. For males aged 18-65 who are experiencing an acute mental illness.
- **Clover Ward**, Lynfield Mount Hospital. A psychiatric intensive care unit for adults over 18 detained under the Mental Health Act. Clover offers a safe environment to receive the necessary care with access to members of a multidisciplinary team which includes Consultant Psychiatrists, Registered Mental Health Nurses, Healthcare Support Workers and Psychologists.

Airedale

- **In-patient Bracken Ward**, Airedale Centre for Mental Health. For anyone over the age of 65 who is experiencing acute mental health issues.
- **In-patient Fern Ward**, Airedale Centre for Mental Health. For males aged 18-65 experiencing acute mental health difficulties.
- **In-patient Heather Ward**, Airedale Centre for Mental Health. For females aged 18 - 65 experiencing acute mental health difficulties.
- **Deployment of Nursing and Social Care staff** through the Intensive Home Treatment team, A and E liaison service and Police Hub Service.

First Response

The BDCNFT First Response service offers support 24 hours a day, seven days a week to people of all ages living in Bradford, Airedale, Wharfedale or Craven experiencing a **mental health crisis**. A Telecoach experienced to talk to people in distress will provide guidance to help you manage the situation. If urgent support is required, a First Responder (Mental Health Nurses and Social Workers) will visit the patient as soon as possible.

Assessment and Treatment Unit, Lynfield Mount Hospital

A specialist assessment and treatment ward for adults over 18 with moderate to severe learning disabilities and mental health problems whose needs cannot be supported at home, in the community or in other adult mental health wards.

Child and Adolescent Mental Health Services

BDCNFT Child and Adolescent Mental Health Services (CAMHS) help children and young people in the local area who may be having problems. They may be very upset or very angry, they may be behaving in unusual ways, or their family or carers, friends or teachers may be very worried about them.

- Child and Adolescent Mental Health Service – Fieldhead Business Centre, BD7
- Child and Adolescent Mental Health Service – Hillbrook, BD20



Community Mental Health Teams (CMHTs)

Community Mental Health Teams (CMHTs) are an important part of the non-urgent care pathway for specialist mental health care. There are 5 CMHTs located across the District. The aim is to enable patients to keep, or regain their place in their local community through prevention and early intervention and achieve their full potential and optimal recovery. A CMHT is made up of a range of mental health experts including doctors, community mental health nurses, social workers, occupational therapists and psychological therapists. GPs can refer into the service.

Early Intervention Team

Based at Culture Fusion, Bradford, this is a team of health and social care experts working alongside young people and families affected by psychosis. It offers quick, intensive and ongoing support and provides evidence-based treatment and therapies

Improving Access to Psychological Therapies (IAPT)

This service provides psychological therapies for people with mild to moderate mental health problems. The service is provided across Bradford, Airedale and from various bases and in GP practices. This service is for people aged 16 years or over who have mild to moderate mental health problems and GPs and other health professionals can refer in.

Step Forward Centre, Heights Lane, BD9

This a purpose built 12 bed ward for males and females aged 18-65. It offers a specialised, person centred, rehabilitation and recovery programme for people who are experiencing mental health problems.

Low Secure Services

These provide services for people who have a mental health problem and who may have received input from the criminal justice system. The service is for those whose care and treatment cannot be safely or successfully delivered in local mental health services.

- **Baldon Ward, Moorlands View, Lynfield Mount Hospital**
- **Thornton Ward, Moorlands View, Lynfield Mount Hospital**
- **Ilkley Ward, Moorlands View, Lynfield Mount Hospital**



Bradford Council Mental Health services

Bradford Council provides the majority of the social work staff (72 wte) and all social care services to people with mental health issues. These staff are all integrated into the Acute, Community and specialist teams outlined above with BDCFT, who jointly manage the service with the council.

In addition CBMDC commissions and funds most of the supported accommodation and hostel services for people with mental health issues. The council has a statutory responsibility to provide Approved Mental Health Professionals who have the power to assess people under the mental health act 1983. CBMDC also has a statutory responsibility to assess people under the Care Act 2014 and under s117 MHA 1983 and it provides a range of care and support for people according to their assessed needs including Residential and Nursing care, specialist care, support in the home to keep people independent and personal budgets.

Voluntary and 3rd Sector

A wide range of voluntary and third sector organisations are commissioned to provide mental health and wellbeing support and specialist services – including advice and advocacy, employment support, carer support across the District.

