



**Agenda for a meeting of the Bradford and Airedale Health and Wellbeing Board to be held on Tuesday, 19 December 2017 at 10.00 am in Committee Room 1 - 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

P Akhtar

City Solicitor

**Notes:**

- This agenda can be made available in Braille, large print or tape 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:**

Parveen Akhtar

City Solicitor

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**To:**

<b>MEMBER</b>	<b>REPRESENTING</b>
Councillor Susan Hinchcliffe	Leader of Bradford Metropolitan District Council (Chair)
Councillor Val Slater	Portfolio Holder for Health and Wellbeing
Councillor Jackie Whiteley	Bradford Metropolitan District Council
Kersten England	Chief Executive of Bradford Metropolitan District Council
Dr Andy Withers	Bradford Districts Clinical Commissioning Group
Helen Hirst	Bradford City, Bradford Districts and Airedale, Wharfedale and Craven Clinical Commissioning Groups
Dr James Thomas	Airedale, Wharfedale and Craven Clinical Commissioning Group
Dr Akram Khan	Bradford City Clinical Commissioning Group (Deputy Chair)
Laura Smith	Head of Transformation (North), NHS England
Anita Parkin	Director of Public Health
Bev Maybury	Strategic Director Health and Wellbeing
Michael Jameson	Strategic Director of Children's Services
Sam Keighley	Bradford Assembly Representing the Voluntary, Community and Faith Sector
Sarah Hutchinson	HealthWatch
Bridget Fletcher	Representative of the main NHS Providers
Clive Kay	Representative of the main NHS Providers
Nicola Lees	Representative of the Main NHS Providers

### Non-Voting Co-opted Members

Two Co-opted representatives of the three main NHS Providers (from the list above)  
 Dr Richard Haddad – Co-opted representative of the Community Interest Company (representing primary care)

## **A. PROCEDURAL ITEMS**

### **1. ALTERNATE MEMBERS (Standing Order 34)**

The 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 26 September 2017 be signed as a correct record (previously circulated).**

(Fatima Butt – 01274 432227)

### **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. CONNECTING PEOPLE AND PLACE FOR BETTER HEALTH AND WELLBEING; A JOINT HEALTH AND WELLBEING STRATEGY FOR BRADFORD AND AIREDALE 2018-2023**

The purpose of a Joint Health and Wellbeing Strategy is to help the Health and Wellbeing Board to meet its duties to improve health and wellbeing, reduce health inequalities between people, and provide a shared, public agreement about the focus and direction of the Health and Wellbeing Board as it leads this work. Through the Board members this shared agreement extends across the health and wellbeing sector and to other sectors and strategic partnerships who have important contributions to make to health and wellbeing.

The Strategic Director, Health and Wellbeing will submit **Document “H”** which reports on the final draft of the Joint Health and Wellbeing Strategy 2018-2023 and requests the Board’s approval, subject to any final amendments that the Board may wish to make.

#### **Recommended-**

**That the Joint Health and Wellbeing Strategy be agreed subject to any minor amendments made at the meeting.**

(Sarah Muckle – 01274 432805)

### **6. HAPPY, HEALTHY AND AT HOME - A HEALTH AND CARE PLAN FOR THE BRADFORD DISTRICT AND CRAVEN**

A first draft of a Health and Care Plan for Bradford District and Craven (**Document “I”**) is submitted to the Board for early discussion and feedback.

#### **Recommended-**

**That the Board provides feedback on the draft Health and Care Plan for the Bradford District and Craven and a further draft of the plan be submitted to a future meeting.**

(James Drury – 07970 479491)



## 7. CHAIRS HIGHLIGHT REPORT

The Health and Wellbeing Board Chair's highlight report (**Document "J"**) summarises business conducted between Board meetings. The December report brings: the Future in Mind Strategy for information and agreement; a Quarter 2 performance update from the Better Care Fund for information; updates from the Board's sub-groups which are the Executive Commissioning Board and the Integration and Change Board; a proposed expansion of the Health and Wellbeing Board's membership.

### **Recommended-**

- (1) That the Board approves the update on the Children and Young People's Mental Health Transformation Plan.**
- (2) That the Board notes the progress at Q2 of the 2017-19 Bradford Better Care Fund Plan and compliance with reporting arrangements as set out in Better Care Fund Guidance.**
- (3) That the Board approves the proposal to invite representative of the police service, the fire service, the social housing sector and the Place Directorate of the Council to become co-opted members of the Board and that the changes be included in the Boards Terms of Reference to be considered at a future meeting.**

(Bev Maybury – 01274 432900)

THIS AGENDA AND ACCOMPANYING DOCUMENTS HAVE BEEN PRODUCED, WHEREVER POSSIBLE, ON RECYCLED PAPER



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## **Report of the Director of Health and Wellbeing to the meeting of the Bradford and Airedale Health and Wellbeing Board to be held on the 19<sup>th</sup> December 2017**

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**H**

**Subject:**

**Connecting people and place for better health and wellbeing. A Joint Health and Wellbeing Strategy for Bradford and Airedale 2018-2023**

**Summary statement:**

The final draft of the Joint Health and Wellbeing Strategy 2018-2023 is brought to the Board for approval subject to any final amendments that the Board may wish to see.

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Bev Maybury  
Strategic Director – Health and Wellbeing, Bradford MDC

Report Contact: Sarah Muckle,  
Deputy Director of Public Health  
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E-mail: [sarah.muckle@bradford.gov.uk](mailto:sarah.muckle@bradford.gov.uk)

**Portfolio:**

**Health and Wellbeing**

**Overview & Scrutiny Area:**

**Health and Social Care**

## **1. SUMMARY**

The final draft of the Joint Health and Wellbeing Strategy 2018-2023 is brought to the Board for approval, subject to any final amendments that the Board may wish to see.

## **2. BACKGROUND**

The purpose of a Joint Health and Wellbeing Strategy is to help the Health and Wellbeing Board to meet its duties to improve health and wellbeing, reduce health inequalities between people, and provide a shared, public agreement about the focus and direction of the Health and Wellbeing Board as it leads this work. Through the Board members this shared agreement extends across the health and wellbeing sector and to other sectors and strategic partnerships who have important contributions to make to health and wellbeing.

The Joint Strategic Needs Assessment and other sources such as the Public Health Outcomes data have helped to identify the main health and wellbeing needs, and main drivers of health inequality in the District. Health and Wellbeing Board development meetings in late 2016 and early 2017 have been used to discuss and shape a new draft Strategy for 2018-2023

In 2016 the Better health, Better lives priority of the District Plan was shaped through engagement with stakeholders followed by public consultation. Given this and other recent work the Board agreed that the major health and wellbeing needs and priorities were well-understood and the work to develop the new joint strategy should focus on identifying the priority outcomes that should be the focus for the next five years.

The Health and Wellbeing Board owns the joint strategy and holds its members to account for leading its implementation. The strategy links to and supports other strategies and plans. For example, improving health and wellbeing on a large scale will support economic growth and contribute to the other priorities such as 'A Great Start for all our Children' which are owned and led by other strategic partnerships. The Strategy also supports work to improve health and wellbeing outcomes through the West Yorkshire and Harrogate Health and Care Partnership.

Improving health and wellbeing also relies on the delivery of other strategies and plans to deliver good quality housing, good jobs, safe and inclusive neighbourhoods and better air quality.

An earlier draft of the strategy was received at the Health and Wellbeing Board in July 2017. Board members were asked to share the draft with their own organisations, partnerships and governance arrangements. The draft has also been discussed at the Joint Clinical Board of the Bradford Clinical Commissioning Groups, the Voluntary and Community Sector Health and Wellbeing Forum, the Children's Transformation and Integration Group, and discussion at disability groups has been facilitated by Bradford Talking Media.



### 3. OTHER CONSIDERATIONS

The draft strategy proposes four priority outcomes:

- our children have a great start in life
- people in Bradford District have good mental wellbeing
- people in all parts of the District are living well and ageing well
- Bradford District is a healthy place to live, learn and work

Three high-level delivery actions are introduced and will be developed in detail through a place-based Health and Care Plan and a Healthy Bradford Plan. These are:

- A health-promoting place to live
- Promoting wellbeing, preventing ill-health
- Getting help earlier and self-care

These three approaches to implementing the strategy challenge us all to think in a broader way about health and wellbeing. They start by harnessing the potential for the place where we live, our housing, neighbourhoods, our economy and environment to support and improve health and wellbeing. Rather than focusing on the services that treat us once we are already ill, they ask us to recognise and build on the assets and capabilities of communities and to take greater personal responsibility for our health and wellbeing.

They will require different ways of thinking, a wider commitment to improving health and wellbeing and will need us to consider how best to direct resources in future.

This draft strategy links with and contributes to other key strategies including those that will deliver the other priorities of the District Plan, for example the Children, Young People and Families Plan. Healthier children will do better in school. Our other high-level strategies and plans will in turn contribute to health and wellbeing outcomes because children growing up in secure, well-supported families are likely to have better health and wellbeing. The strategies that address our physical environment can support health and wellbeing through new, better quality homes, better energy efficiency and cleaner, green forms of transport.

The scale of the improvement needed to the District's health and wellbeing is such that the strategy will need the support of many different partnerships and sectors which can also impact on health and wellbeing. The last section of the strategy is a short toolkit to support this approach, it asks people to think through eight guiding principles when planning activities, prioritising resources or when redesigning a service, commissioning a new service, writing or reviewing policy in order to identify opportunities to maximise their contribution to health and wellbeing.

## **4. FINANCIAL & RESOURCE APPRAISAL**

The Joint Health and Wellbeing Strategy sets the direction and provides a broad framework for decisions about the use of resources for the health and wellbeing sector across the District. A finance and resource update will be provided as part of a separate agenda item.

## **5. RISK MANAGEMENT AND GOVERNANCE ISSUES**

Governance of the strategy will be through the Health and Wellbeing Board which owns and leads the strategy. Risk will be managed by the Integration and Change Board through a performance management framework with regular reporting to the Health and Wellbeing Board.

## **6. LEGAL APPRAISAL**

The strategy has a strong focus on improving health and wellbeing outcomes and reducing health inequalities, and will be supported by a delivery plan that will address these aims at a broad, population level. This directly addresses the duties of the Health and Wellbeing Board under the Health and Social Care Act 2012.

## **7. OTHER IMPLICATIONS**

### **7.1 EQUALITY & DIVERSITY**

The draft strategy aims to reduce health inequalities which in some instances can disproportionately affect people with protected characteristics under the Equality Act 2010. As such the Strategy aims to make a positive contribution to people with protected characteristics.

### **7.2 SUSTAINABILITY IMPLICATIONS**

The draft strategy will support and build on the work at local and West Yorkshire-Harrogate level to ensure that services become sustainable within the available budget for health and wellbeing by 2020.

### **7.3 GREENHOUSE GAS EMISSIONS IMPACTS**

No direct implications. Implementation of the strategy will involve co-ordinated action to increase physical activity levels and active travel in the District which may have some impact on greenhouse gas emissions if the number of car journeys were to decrease as a result.

### **7.4 COMMUNITY SAFETY IMPLICATIONS**

No direct implications, however community safety is an enabling factor, allowing people to engage in community activities, and to use streets and neighbourhood amenities for physical activity. Reduced social isolation and increased physical activity will both act to

enhance wellbeing.

## **7.5 HUMAN RIGHTS ACT**

No direct implications.

## **7.6 TRADE UNION**

No direct implications.

## **7.7 WARD IMPLICATIONS**

The proposed approach may have implications for wards. In areas with poorer health and wellbeing and higher levels of health inequalities different approaches may need to be developed to accelerate improvement in health and wellbeing and to reduce health inequalities.

## **8. NOT FOR PUBLICATION DOCUMENTS**

None

## **9. OPTIONS**

No options are provided.

## **10. RECOMMENDATIONS**

**That the Joint Health and Wellbeing Strategy be agreed subject to any minor amendments made at the meeting.**

## **11. APPENDICES**

1. Connecting people and place for better health and wellbeing. A Joint Health and Wellbeing Strategy for Bradford and Airedale 2018-2023

## **12. BACKGROUND DOCUMENTS**

None

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Appendix 1

**Connecting people and place for better health and  
wellbeing**

A Joint Health and Wellbeing Strategy for Bradford  
and Airedale 2018-2023

<Final draft>

DRAFT

## Foreword

The Bradford and Airedale Health and Wellbeing Board is proud to introduce the new Joint Health and Wellbeing Strategy for our District. The title 'Connecting People and Place' reflects that where we live shapes our health and wellbeing as much as who we are and the choices we have about how we live.

This strategy addresses the size of our health and wellbeing challenge and shows how we can build on our strengths and take advantage of our opportunities. We have many strengths to celebrate and build on. **People who live and work here feel passionate about the place, believe in it and want to see it thrive.** A varied mix of city, town and village environments to live and work in, celebrated cultural sites and attractions, numerous parks and beautiful countryside close by.

We also have significant challenges. One of the most important is the large number of people whose lives are made harder and shorter by poor health which could often have been prevented.

Health and wellbeing has not improved quickly enough. Health inequalities between different parts of the District are not disappearing fast enough, so a fresh commitment and new approaches are needed.

**We are beginning to see the benefits of doing things differently.** Many people are making changes - getting more active, eating healthily, and feeling better for it. Community organisations and volunteers are supporting people who face greater barriers or find it harder to make a change in their lives. Health and care professionals and trained volunteers are working with people who want to improve their wellbeing, helping people understand how to stay well even when they have a long-term health condition.

**A radical improvement in health and wellbeing would mean that many more people feel better and live more of their lives in good health.**

We can achieve this by working together and being willing to do things differently. **We ask everyone who lives and works here to support a ten year ambition**

**to reduce health inequalities and improve health and wellbeing.**

**This strategy sets our direction for the next five years** and eight **guiding principles** will help us work towards the same goals and to hold each other to account.

## Guiding Principles

1. We put prevention first and address the wider causes of poor health and wellbeing.
2. People and communities are the District's biggest assets, at the heart of health and wellbeing improvement.
3. We value mental wellbeing and physical wellbeing equally.
4. We work to reduce health inequalities between different people and different parts of the District.
5. People can seek and receive help earlier, plan their care and experience quality joined-up services that work around them.
6. We are collaborative: we work together, we listen, support and challenge each other to improve health and wellbeing.
7. We work systematically to improve outcomes on a large-scale; we evaluate what difference our actions are making.
8. We want to get maximum value from the Bradford pound (£) and ensure that the health and wellbeing sector is sustainable.

We are proud to adopt these principles. We encourage you to adopt them too and to join us in working together to improve health and wellbeing in all our families, neighbourhoods, workplaces and communities.

<photos/ signatures of Cllr Susan Hinchcliffe, Chair, and Dr Akram Khan, Deputy Chair of the Bradford and Airedale Health and Wellbeing Board>

## Leadership, development and links to other strategies and plans

**Who will lead the joint Strategy?** Bradford and Airedale Health and Wellbeing Board owns the joint strategy and holds its members to account for leading its implementation. The Board is a partnership that was established through the Health and Social Care Act 2012. Its members include: senior officers and clinicians from local health organisations (Clinical Commissioning Groups who organise health services for the District, both acute hospitals, the District Care Trust, a GP representative); senior elected members and senior officers from the council and representatives of the Voluntary, Community and Faith Sector Assembly, Healthwatch and NHS England.

**How the strategy was developed?** Our Joint Strategic Needs Assessment (JSNA) has helped us to understand the specific challenges for us as a population and local people helped to shape the Bradford District Plan in 2016. The District Plan's five

priorities matter to local people and to our District. This Strategy implements the 'Better Health, Better Lives' priority of the Bradford District Plan.

**Links to other strategies and plans** Improving health and wellbeing on a large scale will support economic growth and other District Plan priorities such as 'A Great Start for all our Children'. Likewise, improving health and wellbeing also relies on plans to bring good quality housing and better air quality being achieved. The Strategy also supports work to improve outcomes through the West Yorkshire and Harrogate Health and Care Partnership.

The first years of the strategy will take place in a challenging financial context. This makes it even more important to focus on becoming a healthier place to help manage growing demand on health and care services. Many small changes will add up to a big difference to our health and wellbeing in Bradford District. **We can become a healthier place where healthier people live.**

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## Context: Our wellbeing challenge and our ambition

Whilst our District has much to celebrate, we have a higher than average level of challenges that are known to determine our health and wellbeing. We also have a high level of health inequalities, avoidable differences in health between different groups of people and between different areas of the District:

- In 2015 Bradford District was ranked 11<sup>th</sup> highest for overall deprivation in England and Bradford City health area is the most deprived in the country.
- In 2015-16 nearly a quarter (23.6%) of 10-11 year old children were classed as obese, compared to the England average of 20%.
- 8% of adults were recorded as having diabetes in 2014-15 (10<sup>th</sup> highest in England).
- In 2016 22% of adults smoked tobacco compared to the England average of 15.5%

These challenges contribute to life expectancy at birth being almost 3 years below national average for men and 2 years below for women. Shorter life expectancy is largely due to preventable conditions such as most forms of heart and respiratory (lung) disease, type 2 diabetes and some common types of cancer. Many people live more years of their lives with a disability or a long-term illness than in other parts of the country.

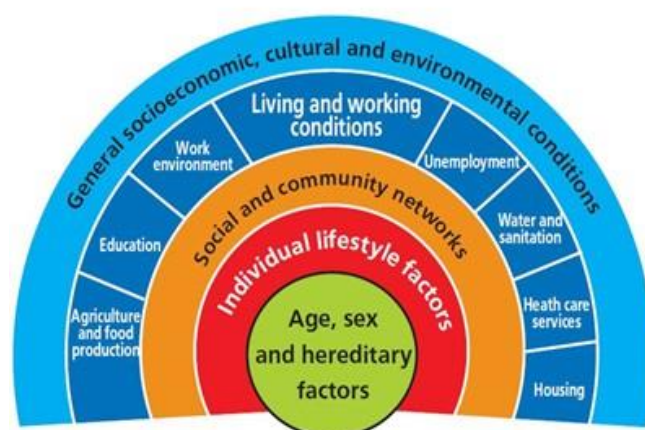
Availability and access to health services are only a small part of what shapes our health and wellbeing. Before we come to use health services we are often already unwell because of many different factors. Realistically, unless there is a significant improvement in long-term health and wellbeing across the District, many of our services will struggle to keep up with rising demand for care and treatment.

### What influences our health and wellbeing?

The diagram on this page shows that our health is determined by a wide range of factors, from our gender, how old we are and the genes we've inherited from our parents and grandparents, to how we live our day to day lives, whether we're active, able to access healthy food or have a good network of

friends, family or other support. Some areas of the District will have **different health and wellbeing needs** simply because more of the population is older or very young.

Health and wellbeing is also determined by our living and working conditions, our housing, our work, our environment, our education or skill levels, unemployment and other socio-economic conditions. All these factors combined are referred to as the wider determinants of health.



The Determinants of Health (1992) Dahlgren and Whitehead

In Bradford District these wider factors and social inequalities also contribute to **significant levels of inequality in health and wellbeing**. In areas of high unemployment, low income, social isolation and poor housing quality we find more people with poor mental wellbeing, more people living with ill-health and dying earlier than they should.

This strategy has a strong focus on the place where we live. It will support new economic, housing and anti-poverty strategies to address the wider social and economic factors that make it much harder for some people to have good wellbeing.

At the heart of this Strategy is **a determination that health and wellbeing improves everywhere, and improves fastest in areas with the worst health inequalities and in some groups of vulnerable people who have much poorer health and wellbeing**. We will work together as communities to support people who are finding it difficult to improve their wellbeing or to manage their health conditions.



## The Strategy: Connecting people and place for better health and wellbeing

This joint strategy is designed to shape how people and partner organisations work together and what we agree to focus on from 2018 to 2023. It will:

- Bring people together around a shared vision of how we can improve our health and wellbeing
- Identify clear outcomes and shared priorities to improve our wellbeing, reduce inequalities and make sure that health and care services are sustainable and high-quality.
- Support effective partnership working that delivers improvements in health and wellbeing.

### A shared vision and outcomes

As a place and as a health and wellbeing sector we have come together to establish **a shared vision** of:

A happy, healthy Bradford District, where people have greater control over their wellbeing, living in their homes and communities for as long as they are able, with the right support when it is needed.

**Four outcomes** describe our aspirations for the district:

- Our children have a great start in life
- People in Bradford District have good mental wellbeing
- People in **all** parts of the District are living their lives well and ageing well
- Bradford District is a healthy place to live, learn and work

Working towards these outcomes will ensure that we think about health and wellbeing throughout our lives, focus on physical *and* mental wellbeing, address health inequalities and ensure that the place where we live supports and improves our health and wellbeing.

For each outcome we:

- say why it is important
- give some key facts about how we are doing
- describe our ambition for what will change
- say who will lead the outcome

### Outcome 1: Our children have a great start in life

Children first and foremost need to feel loved and safe. Every child and young person needs a loving, responsive relationship with a parent or carer, enabling them to thrive. Improving the health and wellbeing of women of child-bearing age, investing in interventions for pregnant women and their partners so they are well-prepared for pregnancy and parenthood and investing in early education are the best ways to improve health and wellbeing for young children and to reduce health and social inequalities, especially for our more vulnerable young children.

Children's health and wellbeing is also shaped by the condition of the housing they grow up in, their neighbourhood and their family income. The place and the home and family environment where a child grows up has a significant impact on their wellbeing, and their life chances during childhood and into their adult life.

**How are we doing?** Some aspects of child health and wellbeing are good and improving. Most parents have their children vaccinated against infectious diseases such as measles and meningitis that can be prevented. Infant mortality rates have reduced so fewer babies are dying in the first year of life. Children's oral health has improved significantly in recent years. However both are still worse on average than in Yorkshire and Humber and in England. Many more children now start school ready to learn with good social and emotional skills, although again we still lag behind national and regional rates. In addition to these areas of improvement, significant challenges remain:

- In 2014 29% of children and young people lived in households below the poverty line (England average is 20%).

- Children in more deprived parts of the District have worse health and wellbeing on average. They are more likely to die in infancy, to have poorer dental health by age five and to be overweight by age 11.
- Children in more deprived areas are more likely to be injured, to have long-term conditions such as asthma and to be admitted to hospital.

**Our ambitions for a great start in life are:**

- Parents are well-prepared for pregnancy.
- Parents and carers form strong bonds with their new baby, knowing how to care for them as they grow.
- Children, young people and families receive early, effective support when issues arise.
- Children thrive, starting school healthy, happy, confident and ready to learn.
- Children and young people live in safe, secure homes and neighbourhoods.

**Lead responsibility** Our Children and Family Trust Board leads the ‘Good Schools and A Great Start for all our Children’ priority in our District Plan, co-ordinating the work through the Children, Young People and Families Plan. This joint Health and Wellbeing Strategy will support and enhance the work of the Trust Board to ensure that health and wellbeing actions in those plans are delivered.

**Outcome 2: People in Bradford District have good mental wellbeing**

The evidence tells us that poor mental wellbeing and poor physical health often go hand in hand. Almost half of people with a diagnosed mental illness also have one or more long-term physical health conditions. People are generally better able to take care of their physical health when they have good mental wellbeing, improving the outcomes of healthcare and increasing life expectancy. People with poor physical health are at higher risk of experiencing poor mental health. There is still a long way to go before mental wellbeing is valued and supported equally with physical wellbeing.

**How are we doing?** Mental wellbeing can suffer when people are isolated, with little support, or when poor physical health prevents people from working or enjoying life. Risk factors for poor mental wellbeing include stress from adverse life events and also relate to the quality of the place and environment in which people live and work. These factors leave relatively high numbers of people vulnerable to poor mental wellbeing, including children and young people. Our challenges include:

- Higher than average levels of risk factors such as child poverty; low income; poor quality housing; unemployment and insecure employment.
- In 2013/14, 5,520 people living in Bradford District and Craven were diagnosed with depression.
- Our suicide rate is above the national level, and rising in line with the national trend.

**Our ambitions for good mental wellbeing are:**

- Risk factors such as low-income, unemployment, debt and poor quality housing are reduced.
- The stigma surrounding mental health disappears so that more people seek early help for their mental health needs.
- We change how we think, talk and behave so mental and physical wellbeing is valued equally.
- People and organisations use accessible tools such as ‘Five Ways to Wellbeing’ to support mental wellbeing.
- More people can recover from poor mental wellbeing, or live well with a well-managed condition.
- Mental wellbeing improves for people of all ages, in all areas of the District.

**Delivering outcome 2:** The Health and Wellbeing Strategy will support delivery of the District’s Mental Wellbeing Strategy and Future in Mind plan for Child Mental Wellbeing to ensure that mental wellbeing and physical wellbeing are recognised as having equal importance.

## Outcome 3: People in all parts of the District are living well and ageing well

We all want to feel well throughout our lives and to stay well enough to live independently in our own homes as we age, close to family, friends and community. This will obviously be more achievable if all our children and young people have a healthy start and we all take steps to stay healthy throughout our lives. Healthy ageing will usually follow a healthy life but we can all decide to make a change, to feel better and get healthier, with support if needed, whatever stage of life we are at.

**How are we doing?** Far too many people are living with one or more long-term health conditions from a relatively young age.

- Smoking, being overweight and/or physically inactive is driving high levels of preventable illness, damaging health and wellbeing.
- Most early deaths in the District relate to preventable heart or lung disease, Type 2 diabetes and some common cancers.
- Half of all people who live in the inner-city area of Bradford die before the age of 75; this is not acceptable.

**Our ambitions for living well and ageing well are:**

- Everyone can improve and maintain their health and wellbeing throughout their lives.
- Reduced levels of health risks, preventable ill-health and health inequalities.
- People enjoy good health and wellbeing into old age
- People are independent, able to live at home and in their communities for as long as they wish.

**Lead responsibility** The Health and Wellbeing Board leads this area, overseeing prevention, early intervention and self-care programmes that tackle the major causes of preventable illness. The Healthy Bradford Partnership, with Active Bradford, will co-ordinate work to enable people to live the healthier lifestyles that will support health and wellbeing and enable healthy ageing, equipping people to care for their wellbeing throughout their lives.

## Outcome 4: Bradford District is a healthy place to live, learn and work

The place where we live, go to school and work plays a central role in our health and wellbeing. Our wellbeing is influenced by the condition of our housing, the air we breathe, our local environment, how safe we feel in our streets and how connected we are to people in our local neighbourhood. We know we have problems with cold, damp houses that increase the risk of falls in some of our residents. Poor air quality in some areas is a risk to people's lung and heart health and to children's healthy start.

**How are we doing?** The economy is showing some signs of improvement, number of businesses increasing by 16% 2014-16, higher than the national increase. More new, better and affordable housing is starting to be built, but we also have enduring risk factors that damage wellbeing:

- 26% of private sector homes have a Grade 1 level hazard (mostly risk of cold or falls).
- 14% of households live in fuel poverty.
- Unemployment remains higher and wages are lower than the national average.

**Our ambitions for a healthy place are:**

- Our homes and neighbourhoods, schools, workplaces maximise opportunities to improve health and wellbeing.
- Improvements to our built environment make it easier to walk and cycle. New urban green space provides places to play and be active.
- The Low Emissions Strategy improves air quality.
- A growing local economy includes and benefits local people through better, higher skilled jobs. Decent wages lift children and adults out of debt and poverty.
- More good quality, affordable housing provides people with healthy, secure homes.

**Lead responsibility** The Producer City Board leads the Economic Growth and Housing Strategies and the anti-poverty work which will help to reduce inequalities and improve health and wellbeing.

## Implementing the strategy

Three main approaches to implementing the strategy are outlined in brief here; they will be developed in further detail with the lead partnerships outlined above. This should also be read in conjunction with our local Health and Care Plan which can be found on the Bradford and Airedale Health and Wellbeing Board webpage <address>.

### We will make the difference by:

#### Creating a health-promoting place to live

#### Promoting wellbeing and preventing ill health

#### Supporting people to understand how to get help earlier, how to better care for themselves and manage their health conditions better

### 1 A health promoting place to live

**Why is this important?** Where we live is part of what determines our health and wellbeing. A health-promoting place will improve physical and mental wellbeing for children, families and communities, and help to deliver our four outcomes. The District's Well Bradford programme is exploring what place-based wellbeing could look like.

#### What can we do?

Work with communities to **identify local priorities and support local action to:** build neighbourliness, reduce loneliness and isolation, and help people to feel safer, involved and included.

**Bring resources together to support community action** (time pledges, donated goods, financial resources) to make **streets and neighbourhoods safe, attractive and greener** for children to play outside and people to walk and cycle more to school and work.

Ensure **healthy, active living is at the core of our work to bring new businesses, improved transport and better public spaces** to the District.

**Build more opportunities into policies, strategies and interventions** to increase the scale and pace of health and wellbeing improvement. Using new **strategies for Economic Growth and Housing** to ensure people can access better, well-paid jobs that an **increased supply of affordable and energy efficient homes**.

**Maximise opportunities to adopt a Healthy Workplace approach** across the District.

**Implement the Low Emissions Strategy** to improve air quality, support healthy child development and good respiratory health by securing investment in greener forms of private and public transport and encouraging people to make fewer short car journeys.

**Increase the supply of accessible and easily adapted housing stock** to meet changing needs and reduce or delay the need for expensive adaptations and for residential care.

### 2 Promoting wellbeing, preventing ill-health

**Why is this important?** To improve health and wellbeing on a large-scale we must make it easier to eat well, get active and have good mental wellbeing wherever we live and at every age and stage of life: in our homes, our neighbourhoods, our schools and in our workplaces.

#### What can we do?

**Use every opportunity to get the health and wellbeing message out and make healthy lifestyles easier.**

**Train more wellbeing champions, volunteers and health and care staff** to support and encourage people to identify the change they would like to make, and to take steps to put it into action.

Support people who are already trying hard to change their lifestyle: make it **easier for everyone, everywhere to eat better, to stop smoking, to be physically active everyday.**

**Co-ordinate the work through our Healthy Bradford Plan, in partnership with Active Bradford.**

**Enable many more people to get involved in neighbourhood activities,** particularly more vulnerable people who may need additional support to access opportunities.

Continue to invest in **interventions for pregnant women and their partners** so they are well-prepared for pregnancy and parenthood. This is the best way to improve health and wellbeing for young children and to reduce health inequalities, especially for our more vulnerable young children.

**Encourage schools to walk or run a Daily Mile with their pupils,** and many more people and families to increase their physical activity in a way that works for them.

**Deliver our Mental Wellbeing Strategy to improve our mental wellbeing and general health.**

### 3 Getting help earlier and self-care

**Why is this important?** Earlier help is usually more successful and effective than a late response. It can prevent our health from deteriorating. It can also be more *cost-effective*. Learning to self-care helps us understand how to look after ourselves when we have common illnesses. If we develop a long-term condition, self-care helps us to stay as well as possible and to know when we need to seek help and how and where to find it.

#### What can we do?

Encourage everyone to register with primary care services to access screening and earlier help. Increase uptake of screening for common cancers, focusing where uptake is low. Ensure people with mental health conditions, dementia and learning disabilities access screening.

**Increase and improve home care and community-based care** to giving greater choice when it is needed, including at the end of life.

**Make greater use of technology** to make it easier for people to access advice and support to stay well as well as maximising opportunities to stay independent.

Continue successful local campaigns to identify and treat people at risk of long-term conditions and to make lifestyle changes to reduce and minimise risk.

Support children, young people and families to access **early help** when difficulties arise.

Support everyone to self-care by:

- **Knowing how to look after ourselves when we have everyday illnesses.**
- **Following professional advice if we develop a health or care need.**
- Use **self-care skills and knowledge to prevent or slow the need for health and care intervention,** knowing when and how to seek help when its needed.
- **Train self-care champions** to support people with long-term health conditions.

Page 9 outlines success measures, and on page 10 our Guiding Principles provide a framework to help us keep the wellbeing of local people at the centre of decision-making.

## What does success look like?

## How do we measure progress?

**Overarching success measures:** Increase in life expectancy and healthy life expectancy. People feeling included in decisions about their lives.

**Progress on health inequalities is shown by :** Closing the gap between the District and national rate for the indicators below

<p><b>Outcome 1: Our children have a great start in life</b></p>	<p>All children have opportunities to play and enjoy early learning with their peers Children have good health and are ready to learn by the age of five Children and young people eat healthily and are active every day Children, young people have good mental wellbeing and cope with life's ups and downs Issues are addressed sooner and prevented from getting worse Child health and wellbeing improves and inequalities reduce</p>	<p>Indicators on smoking in pregnancy, breastfeeding, infant mortality, % of children ready to learn at age 5, excess weight, oral health, fruit and veg intake, child mental health, child poverty and family homelessness.</p>
<p><b>Outcome 2: People in Bradford District have good mental wellbeing</b></p>	<p>Children and young people have emotional resilience and good mental wellbeing People have positive relationships at home and in their schools, communities, and workplaces People are able to cope with life's ups and downs Fewer people are depressed or anxious People with mental health needs have good quality of life and can access employment People with mental health needs are supported at home and in their communities</p>	<p>Child/adult mental health referrals/ admissions. Social isolation, quality of life for carers. Self-reporting of long-term mental health conditions (depression, anxiety) Access to employment Health-related quality of life and under 75 mortality</p>
<p><b>Outcome 3: People in all parts of the District are living well and ageing well</b></p>	<p>Fewer people die early from preventable illness, people are in good health for longer Inequalities in life expectancy and healthy life expectancy reduce People with long-term conditions are able to manage their conditions and stay as well as possible People have good health and wellbeing throughout their lives People age well - staying happy, healthy and living at home for as long as possible People have choice about end of life care and experience excellent end of life support</p>	<p>Rates of smoking and harmful alcohol intake. Unplanned hospitalisation for chronic conditions, annual health check uptake for people with LD or mental health needs, health-related quality of life for people with long-term conditions. Preventable mortality/under 75 mortality. Self-care indicators. Permanent care home admissions, delayed care transfers.</p>
<p><b>Outcome 4: Bradford District is a healthy place to live, learn and work</b></p>	<p>Homes are safe and energy-efficient People live in places where it is safe to walk and cycle People have access to green space and children have safe places to play Air quality improves, particularly in hotspots The District has a healthy workforce People who are absent from work due to ill-health are supported to return to work People with additional needs are enabled to access education, training and employment</p>	<p>% meeting decent homes and energy efficiency standard, excess winter deaths, fuel poverty, employment rates (including for people with learning disability or mental health needs), 19-24 year olds in education, employment or training. Road traffic collision rate. Sickness absence, return to work. Community safety. Access to green space.</p>



## Checklist: Key Questions to support decision-making

The checklist supports decision-makers to use the strategy's eight **Guiding Principles** to identify opportunities to improve health and wellbeing and to reduce health inequalities when planning activities, prioritising resources, developing policy, reviewing or commissioning services.

**Each Guiding Principle is followed by questions and prompts for discussion** (\*the term 'offer' includes any activity, service or policy that you are planning, developing or reviewing)

### 1. We put prevention first and address the wider causes of poor health and wellbeing

Does our offer\* actively seek to improve health and wellbeing and to prevent ill-health?  
 Have we established the root causes of the issue you are seeking to address?  
 What factors are driving wellbeing needs in the population we work with, eg housing insecurity, debt, low-income?  
 How could we work with partners to reduce the number of people facing these issues?

### 2. People and communities are the District's biggest assets, at the heart of health and wellbeing improvement

What are the needs of the people our decisions will affect, what barriers prevent them improving their wellbeing?  
 How will we support and build on the assets of local people and our neighbourhood?  
 Have we engaged with people and taken their views into account to shape our actions?

### 3. We value mental wellbeing and physical wellbeing equally to make the greatest difference to wellbeing

How, when and where can we promote wellbeing and enable people to improve their personal wellbeing or the wellbeing of others?  
 How will we ensure our offer has a positive impact on people's physical and mental wellbeing?  
 Does our offer consider both physical and mental wellbeing at every step?

### 4. We work to reduce health inequalities between different people and different parts of the District

Where in the District will our offer have the most impact and who is most affected?  
 Have we identified and sought to address the wider barriers that would help overcome these factors?  
 Are we targeting our resource at the people and areas with the highest level of need?  
 Is our offer appropriate and accessible for those most in need?  
 Are those with greatest need accessing our offer the most? How have or how can we evidence this?

### 5. People can seek and receive help earlier, plan their care and experience quality joined-up services that work around them

Do our actions support people to have more control, independence and increased resilience?  
 Does our offer take a holistic view of individuals, in the context of their family, carers, community and their life?  
 Do we provide people with accurate, accessible information to help them care for themselves and navigate services?  
 Does our service work together and coordinate with other services that your customers may also be using?

### 6. We are collaborative: we work together, we listen, support and challenge each other to improve health and wellbeing

Are we working collaboratively with the right partners to achieve our intended outcomes, is anyone missing?  
 How could we support our partners to ensure their actions improve wellbeing and help to prevent ill-health?  
 Are we working together to progress difficult or 'stuck' issues rather than avoiding them?  
 Are we identifying and tackling barriers to progress?

### 7. We focus on the difference we want to make and evaluate the impact of our actions

Have we specified the intended outcomes of your activity and identified a way to measure them?  
 Have we identified strong, measurable steps and processes that will lead to delivery of the intended outcomes?

### 8. We seek value for the Bradford pound (£) and ensure that the health and wellbeing sector is sustainable

#### There are three kinds of value

*Value through allocation of resource* – are we allocating resources to different groups equitably (according to need) to reduce need, manage demand for services and deliver better value for everyone.

*Value through quality* - is the quality and safety of our offer based on evidence of effectiveness? Can we show that the resources allocated to it are improving the quality of our offer?

*Value through a personalised approach* - are our decisions and plans aligned with the personal values of the people and communities that we work with, as well as the values of our own organisation and partners?







## **Report of the Chair of the Integration and Change Board to the meeting of the Bradford and Airedale Health and Wellbeing Board to be held on the 19<sup>th</sup> December 2017**

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### **Subject:**

**Happy, Healthy and at Home. A Health and Care Plan for Bradford District and Craven**

### **Summary statement:**

**A first draft of a Health and Care Plan for Bradford District and Craven is brought to the Board for early discussion and feedback.**

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Kersten England, Chief Executive  
Bradford MDC

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### **Portfolio:**

**Health and Wellbeing**

### **Overview & Scrutiny Area:**

**Health and Social Care**

## 1. SUMMARY

The first draft of Happy, Healthy and at Home: A Health and Care Plan for Bradford District and Craven is brought to the Board for discussion and feedback.

## 2. BACKGROUND

This plan is a refresh of our existing place based transformation plan for care and health. The Plan is owned by the Health and Wellbeing Board and responsibility for its delivery is delegated to the Integration and Change Board (ICB).

ICB supports a partnership of local government, NHS and voluntary and community sector organisations to improve the way we plan and deliver health and wellbeing support and services. Increasingly the focus is on the wider determinants of health, and this requires a broader partnership that encompasses factors including economy, skills, housing and communities.

The purpose of the plan is to ensure that we achieve:

- Better outcomes for the people of Bradford District and Craven; more people live longer in better health, and good health is enjoyed by everyone rather than being determined by where you live
- Better services that meet the needs of people; providing access to the highest quality interventions, delivered by teams with the best expertise, at the times people want, through the routes they prefer
- Better use of the resources available to us; by reducing waste, arranging services to avoid delay and duplication, and working together to keep people well because this delivers better outcomes for people and is cost effective.

We are refreshing our place based plan now because our Health and Wellbeing Strategy has been refreshed and we are acting together on the wider determinants of health, as well as on the health and care system itself.

This is a natural evolution of our existing plan that is informed by our greater understanding of what people want and need following the Our Say Counts engagement exercise which took place in Summer 2017 and aimed to hear the views of as many people as possible from all communities across Bradford District and Craven. The independent local Healthwatch organisation led the conversation and produced a summary report which has influenced this plan. Chapter 3 describes what we learnt and how we are using the learning to guide us.

We are also part of the Health and Care Partnership for West Yorkshire and Harrogate, which was formerly known as the West Yorkshire and Harrogate Sustainability and Transformation Partnership. Since we first wrote our plan for health and care this regional partnership has enabled us to work with others to improve care and to access national funds. Chapter 5 includes detail of how Bradford District and Craven contributes to the Health and Care Partnership and what opportunities we see ahead through collaboration across the region.

### 3. OTHER CONSIDERATIONS

The Plan is constructed in eight chapters, the purpose and summary of content in each is as follows;

**Chapter 1 Introduction:** describes that the purpose of the Plan is to show what actions will be taken by partners to achieve the triple aim of 'better health, better quality, and better use of resources'. It set out the principle that health is created by many factors (wider determinants) as well as access to good quality health and care services. Therefore to achieve the 'triple aim' we must act on those wider determinants as well as on the health and care system itself.

Our vision of 'happy healthy and at home' is described, starting with the aim that every neighbourhood in Bradford District and Craven will be a healthy place. The critical elements of our approach are set out:

- working with people not doing things to them;
- neighbourhoods and communities as the basic organising unit;
- whole systems working; and
- being open and honest with people

**Chapter 2 Where we are now:** Recognises the significant strengths that exist locally, and describes the successes achieved through our local partnership work. It also recognises that more is required to achieve the health outcomes that everyone in Bradford District and Craven deserves.

- Notable successes include;reducing the number of unnecessary days spent in hospital by people waiting for the right support to help them return home. City of Bradford MDC rated 4<sup>th</sup> out of 150 local authorities for combined metric on 'NHS adult social care interface dashboard'
- elimination of adult acute mental health 'out of area' placements, helping more people to maintain links to friends and family that support their recovery
- Pioneering programmes such as Bradford's Healthy Hearts and Bradford Beating Diabetes that identify people at risk of heart disease and type 2 diabetes, provide information and support, and where needed early access to treatment. Through these approaches 131 heart attacks and 74 strokes have been prevented.

Results that we must continue to focus on changing for people include;

- 22% adults smoke in Bradford (147<sup>th</sup> out of 150 local authorities)
- Mortality from coronary heart disease. In Bradford City CCG under 75 CHD mortality rates are 208<sup>th</sup> out of 209 CCGs
- The gap in healthy life expectancy between the richest and poorest communities locally is 19.1 years for males and 22.1 years for females.

**Chapter 3 What People Say:** summarises the findings of the Our Say Counts engagement exercise undertaken by Healthwatch on behalf of health and care partners during Summer 2017. This engagement exercise informs this plan. Further engagement will be undertaken throughout the lifetime of this plan. Key findings include;

- People recognise the challenges of rising demand and limited resources
- People most frequently commented on access to general practice

- People support the need to design services around outcomes, and recognise the need to balance access to specialist support with user experience and accessibility
- People are largely willing to take responsibility for their own health and wellbeing

**Chapter 4 Improving Outcomes:** describes our Joint Health and Wellbeing Strategy and other actions needed in order to address the ‘better health’ element of the triple aim. The Joint Health and Wellbeing Strategy is the subject of a separate agenda item and content is not repeated here.

**Chapter 5: Improving Quality and Experience:** describes the work we do together as a partnership to improve the effectiveness and experience of local care and health services.

This chapter also describes how we are improving the alignment and integration of health and care delivery, to better meet the needs of people requiring support from multiple sources. This section describes the ways in which the vision set out at Chapter 1 will be realised.

**Chapter 6 Improving Use of Resources:** this section is to be added. Local health and care organisations are increasingly aligning and sharing planning assumptions to avoid or mitigate unintended consequences on people and services across the system. This section will describe the processes and outcomes of this work.

**Chapter 7 Supporting Change:** describes the way in which the delivery of the plan will be supported. Key aspects include;

- Workforce
- Digital
- Estates
- Self care and prevention
- Communication and engagement
- Support for cultural change and system development

**Chapter 8 Making a Difference:** this section is to be added. It will draw together the measures and improvement trajectories required for all parts of the plan. It will address the major risks and issues in delivery, and will describe how people will be communicated with and engaged in relation to the plan

It is proposed that further development of the plan is undertaken throughout December and January and a final version is prepared for HWB by the end of January 2018.

See Appendix 1 for the full text of the Plan.

#### **4. FINANCIAL & RESOURCE APPRAISAL**

The Joint Health and Wellbeing Strategy provides a broad framework for decisions about the use of local resources for the health and wellbeing sector across the District.

This Health and Care Plan operates within the direction and local framework set by the Joint Health and Wellbeing Strategies for Bradford District and for Craven in respect of

health and wellbeing outcomes, and within the wider priorities of the West Yorkshire and Harrogate Health and Care Partnership for health and wellbeing and care quality.

An update on the financial resources available to the Health, Care and Wellbeing sector will be presented at the December Board meeting.

## **5. RISK MANAGEMENT AND GOVERNANCE ISSUES**

Governance of the plan will be through the Integration and Change Board, a sub-group of the Health and Wellbeing Board. Risk will be managed by the Integration and Change Board through a performance management framework with regular reporting to the Health and Wellbeing Board.

## **6. LEGAL APPRAISAL**

The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 by adding the following section 116A(2) in respect of the preparation of the Joint Health and Wellbeing Strategy, following an assessment of need:

"The responsible local authority and each of its partner clinical commissioning groups must prepare a strategy for meeting the needs included in the assessment by the exercise of functions of the authority, the National Health Service Commissioning Board or the clinical commissioning groups ("a joint health and wellbeing strategy").

The Health and Care Plan outlines in greater detail the plans to improve health and wellbeing and care quality in Bradford District and Craven, including the use of resource.

## **7. OTHER IMPLICATIONS**

### **7.1 EQUALITY & DIVERSITY**

The plan aims to improve wellbeing and prevent avoidable ill-health on a large-scale or population level. Any specific service changes arising from the direction set by this plan will be subject to equality impact assessment processes. The plan is committed to reducing the District's health inequalities and to targeting resource by need and vulnerability. This will help to address the health and wellbeing of protected characteristics groups.

### **7.2 SUSTAINABILITY IMPLICATIONS**

The Health and Care Plan aims to improve wellbeing on a large-scale, or population level, which will help to manage demand for health and care services and to bring local services onto a more sustainable footing through cross-cutting workstreams such as the estates work.

### **7.3 GREENHOUSE GAS EMISSIONS IMPACTS**

No direct implications. Implementation of the plan will involve co-ordinated action to increase physical activity levels and active travel in the District which may have some impact on greenhouse gas emissions if the number of car journeys were to decrease as a result. Similarly the estates work may contribute.

#### **7.4 COMMUNITY SAFETY IMPLICATIONS**

No direct implications, however community safety is an enabling factor, allowing people to engage in community activities, and to use streets and neighbourhood amenities for physical activity. Reduced social isolation and increased physical activity will both act to enhance wellbeing.

#### **7.5 HUMAN RIGHTS ACT**

No direct implications.

#### **7.6 TRADE UNION**

No direct implications.

#### **7.7 WARD IMPLICATIONS**

No direct implications.

### **8. NOT FOR PUBLICATION DOCUMENTS**

None.

### **9. OPTIONS**

None.

### **10. RECOMMENDATIONS**

**That the Board provides feedback on the draft Health and Care Plan for the Bradford District and Craven and a further draft of the plan be submitted at a future meeting.**

### **11. APPENDICES**

1. Happy, Healthy and at Home: A Plan for the future of health and care in Bradford District and Craven.

### **12. BACKGROUND DOCUMENTS**

“Our Say Counts” Report. Healthwatch Bradford.

At the time of drafting this report was due to be published It will be available through the

Healthwatch Bradford website.

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# *Happy Healthy & at Home*

## **A plan for the future of health and care in Bradford District and Craven**

Revised and updated November 2017

# Contents

- 1 Introduction
- 2 Where are we now
- 3 What people say
- 4 Improving outcomes
- 5 Improving quality and experience
- 6 Improving use of resources
- 7 Supporting change
- 8 Making a difference

# 1. Introduction

**Our health and wellbeing is important. The things that help us stay well and support us to recover are many and varied and include our homes, jobs, and relationships, as well as our access to excellent, caring services. This plan describes how we will work together with people to build a healthy future.**

Local leaders of the health service and social care services have been working together to find ways that we can change to ensure that we achieve

- Better outcomes for the people of Bradford District and Craven; more people live longer in better health, and good health is enjoyed by everyone rather than being determined by where you live
- Better services that meet the needs of people; providing access to the highest quality interventions, delivered by teams with the best expertise, at the times people want, through the routes they prefer
- Better use of the resources available to us; by reducing waste, arranging services to avoid delay and duplication, and working together to keep people well because this delivers better outcomes for people and is cost effective.

By listening to people and working together we understand where we need to change, and many improvements have already begun. We now need to engage the whole community – people, neighbourhoods, businesses and public services, in a new relationship where we all agree the role we play in building a healthy future.

This document is the next step in the development of joined up planning by the health and care system partners in Bradford District and Craven. It is owned by the Health and Wellbeing Board and delivery is led by the Integration and Change Board. This Plan complements our Joint Health and Wellbeing Strategy, and it sets out the key actions needed to achieve the three aims above. It replaces our earlier ‘place based plan’ that formed part of the West Yorkshire and Harrogate sustainability and transformation plan (2016), and was in turn based on our local response to the Five Year Forward View (2014).

We are refreshing our place based plan now because our Health and Wellbeing Strategy has been refreshed and we are acting together on the wider determinants of health, as well as on the health and care system itself.

This is a natural evolution of our existing plan that is informed by our greater understanding of what people want and need following the Our Say Counts engagement exercise which took place in Summer 2017 and aimed to hear the views of as many

people as possible from all communities across Bradford District and Craven. The independent local Healthwatch organisation led the conversation and produced a summary report which has influenced this plan. Chapter 3 describes what we learnt and how we are using the learning to guide us.

We are also part of the Health and Care Partnership for West Yorkshire and Harrogate, which was formerly known as the West Yorkshire and Harrogate Sustainability and Transformation Partnership. Since we first wrote our plan for health and care this regional partnership has enabled us to work with others to improve care and to access national funds. Chapter 5 includes detail of how Bradford District and Craven contributes to the Health and Care Partnership and what opportunities we see ahead through collaboration across the region. A summary of progress with the Health and Care Partnership is also available [here](#).

It is also important to recognise that the operating context for care and health organisations has become increasingly challenging, and in line with trends seen across the country, we have increasingly struggled to meet access targets in acute care (e.g. four hour maximum wait in A&E). This reflects increased levels of demand and under supply of workforce in care homes, primary care, mental health as well as in hospitals. Our commitment to the delivery of quality care is steadfast, so this plan gives us an opportunity to reaffirm the actions we are taking as a system to meet present day demand while re-balancing investment towards longer term prevention to respond to projected rising demand and resource pressures in future.

Finally the refresh of this plan allows us to ensure that critical elements of our shared vision are brought to the fore, where they may have been implicit previously. For example;

- It emphasises the importance of community and association between people in creating health and wellbeing within neighbourhoods. This is especially important in developing a 'community assets' approach where populations are empowered to self-care, maintain their own and others' wellbeing and reduce demands on traditional health and social care.
- It recognises that the health of people is mainly determined by socio-economic, environmental and genetic factors on which the NHS alone has limited impact. Our Health and Wellbeing Board includes a wider range of partners that can together influence the wider determinants of health by taking a 'Health in All Policies' approach.
- It describes how health and wealth are connected. In order to address health inequalities we must bring our economic and health strategies closer together.
- It recognises the importance of focusing on behaviours and culture change, as well as systems and processes of care
- Lastly it offers a chance for us to be explicit about our vision for the future of health and care, and to set out the shared values that will guide us in our transformation

## 1.2 Vision for the future

**1.2.1 Our Vision** was established in our 2016 transformation plan and remains our focus today. It is to *create a sustainable health and care economy that supports people to be healthy, well and independent*. We have subsequently summarised this as ensuring people are *happy, healthy and at home*

What this will mean for people is that;

- Every neighbourhood in Bradford District and Craven will be a healthy place. You will have the best start in life, so you can live and age well.
- If you have long term health conditions you will be supported to self-care through primary care, social care, and community organisations working together. You will have the support of peers, and you will be able to use technology to help you stay in control.
- If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
- If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
- Local hospitals will be supported by regional centres of excellence including for cancer and stroke, and by regional specialised mental health facilities including for Secure and Children & Adolescent Mental Health service admissions.
- All of this will be planned and paid for once, with councils and the NHS working together to remove barriers and inefficiencies that are created by planning and paying for services separately. For example community and hospital care working together.
- Communities and staff will be involved in the development and design of plans so that everyone truly owns their health and care services, and understand the increasing importance of self-care and prevention to support a sustainable future health and care system.

**1.2.2 Our Approach** to transformation is guided by a few simple principles;

- **Working with people** not doing things to them. We want a changed relationship with people, built on trust and understanding our respective strengths. They know what they need to make positive change happen in their neighbourhoods. We listen and people lead
- **Neighbourhoods and communities** are the basic building block on which our system is built. Wherever possible, services will be provided at a local neighbourhood level. Only when the safety, quality and cost-effectiveness of care are improved by providing it at a greater scale will services be delivered elsewhere. These are the founding principles for our local place-based and regional health and care partnership plans.
- **Whole systems working** is essential as we recognise the complex web of factors that interact to create health and wellbeing. We will work on the wider determinants of





**Neighbourhood health and care services** will be tailored to meet the needs of people living in a neighbourhood of around 30-50,000 people. They will be delivered through networks like the 'primary care home' which will support extended access to GPs (at evenings and weekends). Networks will also help neighbourhood services work more seamlessly together with hospitals and social care.

**Local hospital services** will be planned based on the needs of Bradford District and Craven. Local hospitals will work with neighbourhood health and care services because people will often move between primary, community and hospital services. To further improve quality and the cost of care, groups of health care professionals will work together as a network of support.

**Clinical Networks across West Yorkshire and Harrogate.** Some hospital services need to be planned and delivered for larger areas and populations than each place, for example those that deliver some cancer care. Although operational management will remain the responsibility of each hospital, clinical networks made up of consultants, GPs and nurses etc will ensure a common approach across West Yorkshire and Harrogate by setting clear standards and procedures. In some cases, this may lead to closer working between two or more hospitals to deliver services by sharing staff, buildings, and the latest technology.

**Specialised hospital services:** The most complex services, such as heart surgery, will be planned, operated and managed as single services for West Yorkshire and Harrogate. Clinicians, for example specialist consultants and nurses, from different hospitals will be brought together as single team to make the most of their skills, expertise and equipment. This will improve care and support high quality research and education. In some cases this may mean reducing the number of sites delivering the more complex care, such as high risk surgery, whilst other parts, for example outpatients, diagnostics and day surgery, will remain as local as possible.

**Mental Health:** Some of our more specialised mental health facilities will also be provided more appropriately for larger areas and populations. This will include inpatient Child and Adolescent Mental Health Services, where collaboration has helped to secure national capital funding to develop a new 22-bedded regional unit; increasing regional capacity by 14 beds. This means that young people currently treated out of area will receive care closer to home. Similar regional collaborations will support low secure mental health services with the aim of standardising and improving care pathways and providing care as close to home as possible.

## 2. Where we are now

We have much to be proud of in Bradford District and Craven, and this gives us a strong base to build on. However many local people do not enjoy the long healthy lives that we believe they deserve. Our ambition is to make all our neighbourhoods healthy places where people are connected and services support them.

Successes to build upon (all need to be described in terms of what difference that makes for people)	Results we want to change
Delayed Transfers of Care performance	Rates of smoking among adults are increasing locally against a trend of fewer people smoking nationally. In Bradford 22% adults smoke, compared with 18.6% regionally. (147th out of 152 LAs) We are committed as part of the West Yorkshire and Harrogate Health and Care partnership to reduce this to 13%  Cancer screening and mortality. Tobacco Control Alliance and Cancer Alliance
Bradford's Healthy Hearts programme has prevented 131 heart attacks and 74 strokes, helped over 6,000 patients to switch statins and reduce their cholesterol risk, and started 1,000 patients with irregular heartbeats on blood clotting prevention medication	In Bradford City CCG area, under 75 years coronary heart disease mortality rates are the second worst in the country (208th out of 209 CCGs), and under 75 stroke mortality rates are the fourth worst in the country (205th out of 209 CCGs).
Bradford Beating Diabetes  The prevalence rate of Type 2 diabetes in England is 6.4%, here in Bradford the prevalence rate is above the national average at 8.7%. Bradford Beating Diabetes (BBD) aims to identify people who are at risk of developing Type 2 diabetes, and make sure they receive the appropriate advice, care and support to delay the onset of Type 2 diabetes. For those people who already have Type 2 diabetes BBD helps them to manage their condition and prevent serious complications.  Since BBD started in 2013, more than 12,000 people in the Bradford City area who are at risk of developing diabetes have taken part in the programme.	Rates of common non-communicable diseases are much higher in Bradford than elsewhere in the country. Diabetes prevalence is the highest in the region at 8.3% of the population, giving Bradford the fifth highest rate of any English local authority; this is likely to be an underestimation of true prevalence, and hides a high level of impaired glucose tolerance
SystemOne used across primary care, acute community nursing and adult social care teams	the gap in life expectancy at birth between Bradford and England has stalled at over one and



and being implemented for mental health services by early 2018/19. BTHFT recently successfully implemented a comprehensive new electronic patient record which will imminently allow information exchange with SystmOne for primary care so we have an increasingly integrated digital care record	a half years, and may even be widening. In addition, within Bradford itself the gap in healthy life expectancy between the richest and poorest citizens is an astonishing 19.1 years for males and 22.1 years for females: one of the worst life expectancy gaps in the UK  Life Expectancy 9 years less than CCG with the highest (NHS Guilford & Waverley)
Born in Bradford research base  Shows that a focus on children and potential mothers would have biggest impact on outcomes.	the mortality rate from causes considered preventable has declined in both Bradford and across the UK over the past 15 years. However, the gap has remained consistent at around 50 more deaths per 100,000 persons in Bradford every year, and recently appears to be growing
Better Start Bradford is a 10 year test and learn programme, testing a range of evidence and science based interventions in the most deprived area of Bradford with a view to establishing what works in improving outcomes for children. Its on-going evaluation of both the implementation of interventions and their impact is informing change across the district.'	Obesity particularly children & Levels of physical inactivity  27% of the (council) population under 18 live in poverty
Community Connectors/ social prescribing	the housing conditions people live in that impact on health including homelessness
Elimination of adult acute mental health inpatient out of area placements supported by strong partnerships between health, social care, police and voluntary sector meaning that people are cared for closer to home.	Case mix – planned/ unplanned use of hospital resources
The Haven – supports people experiencing mental health crisis – reduces demand in other parts of the system – 80% reported that they would have attended at A&E and/ or resorted to self harm if they had not been able to receive help at the Haven	
Physical health checks in MH	Integrate Mental Health and Physical Health including national initiatives to support individuals with Long Term Conditions to manage anxiety and depression
Goldline End of Life care	

## 2.2 Acting on the wider determinants of health

In order to impact on the results reflected in the infographic above we know we must work as a broad partnership of communities and organisations on the underlying conditions that combine to generate these outcomes. These wider determinants include;

**Economic growth** that is shared equitably between people is essential. While our local growth in prosperity and productivity has increased gradually in recent years, we are significantly below national average.

**Social deprivation** affects health and life chances in many ways including housing, education and employment, the availability of healthy food, water and sanitation. Over

40% people in Bradford live in areas classified as being within the 20% most deprived neighbourhoods in England, and over a quarter of local children are growing up in poverty. This is increasing, and places Bradford 25th worst out of 142 local authorities for child poverty. Social disadvantage is defining their health (22% are obese at age 10/11) and their opportunities (only 48.1% of children attending Bradford schools gain 5 GCSEs Grade A\*-C compared with 78.7% in England). Infant mortality is almost double the national average and levels of congenital anomalies and childhood disability are the highest in the UK.

**Climate change and pollution** has far-reaching implications for both physical and mental health. Bradford has experience of flooding due to extreme weather events: for example in winter 2015, when 1000 homes and businesses were flooded. In addition, although air quality in Bradford is improving, Bradford's geography, traffic and industry combine to cause high levels of air pollution in some areas. Air pollution is linked to a number of adverse health outcomes, and disproportionately affects the poorest and most vulnerable in society

## 3. What people say

**A key part of ‘where we are now’ is listening to the views of people about their health and wellbeing, and the services that aim to help them. This section describes some of the big conversations that have taken place recently, what people said, and how they are influencing our work together.**

Throughout July and August 2017, Healthwatch Bradford and District worked on behalf of local health and care partners to create a conversation with local people about the future of health and social care.

A number of different engagement activities took place over a six week period including an on-line survey, three public events where people took part in facilitated, deliberative discussions. In addition the Healthwatch team talked with individuals at outreach sessions in public locations e.g. transport hubs, and encouraged completion of the survey. Focus groups were also held with community groups aimed at ensuring perspectives that aren't always heard were listened to. Groups included; Carers, Older people, BME communities, Young people, and LGBT people. Healthwatch staff also visited VCS groups and held group discussion sessions.

- 112 people took part in focus group discussions
- 123 people attended our three public events
- 330 people had face-to-face conversations to complete the survey
- 355 people completed the survey online

In addition, posts on social media reached a wider audience, raising awareness of the case for change and the involvement of local people in making plans for the future of health & wellbeing – using the hashtag #oursaycounts. On Facebook, posts reached almost 40k people. On Twitter, posts had 113k impressions.

These activities covered the whole of Bradford City, Bradford Districts, and Airedale, Wharfedale and Craven CCG areas. Conversations took place in Bradford city centre, Manningham, Girdlington, West Bowling, Bingley, Keighley, Steeton, Settle and Skipton.

Most people were positive about the opportunity to share their views and have their say on the future of health and care. The level of participation in this project shows that local people are willing to share ideas and take part in an honest conversation about the future of health and care.

In thinking about health and care services, people were not only thinking of their own needs but often considered wider issues and needs of the whole population.

People often raised concerns about the funding of health and care, and fears about central government approach to the NHS and local authorities. There was some cynicism about how much the local and regional system could do in the face of these challenges. To a lesser extent, there was also cynicism about the value of engagement and how we would make sure local people’s views were heard.

It’s important that this project is built upon, and further conversations will be needed as plans are developed. People are keen to be involved and informed.

Local people care about their local services, and want to see them protected. But if there are sound clinical reasons for delivering care in specialist centres, they can support this. People want to see that services are designed for the best outcomes and that they take into account the experience of patients, carers, or service users, so that practical issues like journey time and parking are addressed.

People talked about GP practices more often than any other aspect of health and care, particularly about access to GP appointments.

The majority of people who took part in the engagement were willing to take responsibility for their own health and wellbeing and understood their responsibilities to use services appropriately. Some people told us they needed more support to do this and clearer messages about what’s available.

People came forward with lots of ideas; these were often lively, engaged discussions with people keen to help create solutions about how to make Bradford District and Craven a healthier place to be. People want to see initiatives that help people live healthier lives and therefore prevent ill health and subsequently would reduce the demands on health services. Included in these discussions was a strong theme about the need to look at individual’s whole life – social, emotional, and cultural wellbeing alongside physical health.

Full details of the feedback received is available at [Healthwatch](#) A summary of the major themes of the feedback received is captured in the table below.

<b>Protect</b>	<b>Reduce</b>
<p>Many people listed several services in their survey responses, and felt that all of health and care should be protected</p> <p>Two thirds of people mentioned GP practices in their response</p> <p>People wanted to protect local A&amp;E departments and emergency care</p> <p>Mental health services were high up on people’s priorities</p> <p>Social care support for older people and those with disabilities was also a priority for local people</p> <p>Many people expressed concerns about the</p>	<p>People found it very challenging to think about reducing any services</p> <p>Many felt that by creating a focus on wellbeing or prevention, the system would reduce demand elsewhere</p> <p>People felt strongly that waste and duplication in health and care needs to be addressed</p> <p>People want consistency and to end the ‘postcode lottery’</p> <p>Conversations highlighted changing public expectations</p> <p>People worried about funding, and felt</p>

<p>impact of funding cuts on voluntary sector groups</p>	<p>privatisation was a threat</p> <p>People were open to changing the way they access services – e.g. using technology</p>
<p><b>Grow</b></p> <p>People wanted to see better sharing of good practice across the area, especially on access to GP practices</p> <p>A clear theme emerged of people wanting to see more prevention and early intervention</p> <p>People told us ‘more is needed’ when it comes to mental health</p> <p>Care homes and home care needs to be developed to increase capacity and improve quality</p> <p>People felt that more staff were needed across the system in a range of roles</p> <p>Technology should be used more, both for communication and in the delivery of care and treatment</p>	<p><b>Create</b></p> <p>People had lots of ideas and wanted to help create solutions</p> <p>Health and care working together - people felt integration was talked about but needs to happen in practice at every level (from sharing records to pooling budgets)</p> <p>Improving access and experience in GP practices was a key theme, with new approaches to technology and a wider range of roles in primary care</p> <p>People expressed a strong desire for local community-based services to be set up</p> <p>People want Bradford District &amp; Craven to be a healthier place. They had ideas for schemes to improve mental and physical wellbeing</p>

Throughout this report extracts from the ‘Our Say Counts’ engagement exercise are used to illustrate the need for change and to demonstrate the alignment between this plan and the feedback people have provided.

Engagement is a regular and integral part of how we work. In the New Year we will reconnect with people to show how we have incorporated their feedback into this plan. This will help us to check our understanding and will give people an opportunity to comment on and shape this plan.

### Next Steps

- **Engagement and Communication Plan developed in January 2018 and carried out throughout 2018/19**

# 4. Improving Outcomes

Our Joint Health and Wellbeing Strategy 2018 – 2022 is called ‘Connecting People and Place for Better Health and Wellbeing’. It sets out three key approaches that will have the biggest impact on longer term health outcomes for people in Bradford District and Craven.

- Create a place to live that promotes health
- Make it easier for people to improve their health and wellbeing and prevent ill health
- Support people to better care for themselves and to get help earlier

## 4.1 Actions

These priorities will be supported by the following actions;

<i>A health promoting place to live</i>
Inspire communities to build neighbourliness, reduce loneliness and isolation
Make our streets and neighbourhoods safe attractive and greener
Bring resources together to support local action
Ensure healthy living is at the core of our work to bring new businesses and better public spaces to the District
Use all our policies strategies and interventions to improve health and wellbeing
Adopt a healthy workforce approach
Encourage greener forms of private and public transport to improve air quality
Use strategies for economic growth, housing and poverty reduction to create jobs and increase affordable and energy efficient homes
Ensure more homes are accessible and easily adapted for changing needs

<i>Promoting wellbeing, preventing ill health</i>
Help pregnant women and their partners be well-prepared for parenthood
Make it easier for people to eat better, stop smoking and to be physically active
Enable more people to get involved in neighbourhood activities
Inspire and support more people to improve their health and wellbeing
Train health champions and staff to encourage people to change behaviour
Encourage schools to walk or run a ‘daily mile’
Work with Active Bradford to make healthy lifestyles easier
Deliver the mental wellbeing strategy

## Getting help earlier and self care

Support people at risk of conditions such as heart disease or diabetes to make changes to reduce their risk of deterioration

Use the early help process in children's services to support families

Support people to self care to stay well and prevent illness; including through more extensive use of technology and apps to make it easier to access advice and support

Increase the uptake of screening for common cancers

Encourage people to register with their local health services

Ensure people with mental health conditions and learning disabilities are able to access early help and self care as well as everyone else

Increase and improve home care and community based care through the Home First strategy

## 4.2 Outcomes

Through the delivery of these actions the Joint Health and Wellbeing Strategy will impact on outcomes for people in the following ways;

Outcome 1: Our children have the best possible start in life	
Indicators	Measures
<ul style="list-style-type: none"> <li>All children have opportunities to play and enjoy early learning with their peers</li> <li>Children have good health and are ready to learn by the age of five</li> <li>Children and young people eat healthily and are active every day</li> <li>Children, young people and families have good mental wellbeing and can cope with life's ups and downs</li> <li>Issues are addressed sooner and prevented from getting worse</li> <li>Child health and wellbeing improves and inequalities reduce</li> </ul>	<ul style="list-style-type: none"> <li>smoking in pregnancy</li> <li>breastfeeding</li> <li>infant mortality,</li> <li>% of children ready to learn at age 5</li> <li>excess weight</li> <li>oral health</li> <li>fruit and veg intake</li> <li>child mental health</li> <li>child poverty and family homelessness</li> <li>Gaps between District and national rates and within the District will track inequalities.</li> </ul>

Outcome 2: People in Bradford District have good mental wellbeing	
Indicators	Measures
<ul style="list-style-type: none"> <li>Children and young people have emotional resilience and good mental wellbeing</li> <li>People have positive relationships at home and in their schools, communities, and workplaces</li> <li>People are able to cope with life's ups and downs</li> <li>Fewer people are depressed or anxious</li> <li>People with mental health needs have good quality of life and can access employment</li> </ul>	<ul style="list-style-type: none"> <li>Child and adult mental health referrals and admissions.</li> <li>Social isolation, quality of life for carers.</li> <li>Self-reporting of long-term mental health conditions (depression, anxiety)</li> <li>Access to employment</li> <li>Health-related quality of life and under 75 mortality</li> </ul>



- People with mental health needs are supported at home and in their communities as far as possible

### Outcome 3: People in all parts of the District are living well and ageing well

Indicators	Measures
<ul style="list-style-type: none"> <li>• Fewer people die early from preventable illness and people live more of their lives in good health</li> <li>• Inequalities in life expectancy and healthy life expectancy reduce</li> <li>• People with long-term conditions are able to manage their conditions and stay as well as possible</li> <li>• People have good health and wellbeing throughout their lives</li> <li>• People age well - staying happy, healthy and living at home for as long as possible</li> <li>• People choose where they are cared for at the end of their lives and experience excellent end of life support</li> </ul>	<ul style="list-style-type: none"> <li>• Unplanned hospitalisation for chronic conditions</li> <li>• people with a learning disability receiving annual health check</li> <li>• health-related quality of life for people with long-term conditions</li> <li>• preventable mortality and under 75 mortality from preventable causes</li> <li>• Rates of smoking and harmful alcohol intake</li> <li>• Self-care indicators</li> <li>• Permanent care home admissions</li> <li>• delayed care transfers</li> <li>• National and local gaps on life/healthy life expectancy</li> </ul>

### Outcome 4: Bradford District is a healthy place to live, learn and work

Indicators	Measures
<ul style="list-style-type: none"> <li>• More homes are safe and energy-efficient</li> <li>• People live in places where it is safe to walk and cycle</li> <li>• People have access to green space and children have safe places to play</li> <li>• Air quality improves, particularly in hotspots</li> <li>• The District has a healthy workforce</li> <li>• People are absent from work due to ill-health are supported to return to work</li> <li>• People with additional needs are supported to access education, training and employment</li> </ul>	<ul style="list-style-type: none"> <li>• % homes with (grade x) energy efficiency</li> <li>• excess winter deaths</li> <li>• fuel poverty</li> <li>• employment rates including for people with Learning disability or mental health conditions</li> <li>• road traffic collisions</li> <li>• Sickness absence and return to work</li> <li>• Community safety.</li> </ul>



# 5. Improving quality & experience

By focusing on quality improvement we will achieve better health outcomes, reduce waste and deliver a better experience of care for people. It is also critical for attracting and retaining our skilled and caring workforce.

This section describes the work we are doing together to improve quality and the impact this will have. It also describes the ways in which we think we can organise and deliver care differently to achieve better results. We will need to engage everybody in planning changes to make sure we make the best choices for the future.

In chapter 2 above we described how we are performing in terms of achieving good outcomes for people – essentially aiming to help us live longer in good health, and for good health to be enjoyed by everyone irrespective of where they live in Bradford District and Craven.

In this section we will set out some of the key operational measures that are used to compare the quality of the health and care services we provide e.g. waiting times for treatment, and feedback from people who use services about their experiences. These operational metrics enable us and external bodies to compare how well our system is functioning compared to others. Our assessment leads us to conclude that there are some important changes we should make to improve the effectiveness of our services and the experience of using them. In many cases the things we do to improve quality will also help us to achieve better long term results for people and to use our limited resources more effectively.

## 5.1 Measuring quality

Each part of our health and care system uses measures of quality to understand its performance and focus its efforts. The Health and Wellbeing Board and ICB use an agreed bundle of measures taken from a number of sources in order to generate a balanced view of overall system performance. The measures in the tracker can be summarised as follows:

Since this ‘tracker’ was first developed there have been a number of new additions that will now influence the way we measure quality. These include the CCG Improvement and Assessment Framework; the Single Oversight Framework for NHS Foundation Trusts; and

a dashboard for health and care partnerships such as the West Yorkshire and Harrogate Health and Care Partnership that we are part of. Locally our Accountable Care Programme Boards have adopted a shorter suite of operational measures impacting on system performance. As a result one of our key actions for the year ahead is to review our tracker and ensure the measures remain the most pertinent for us and enable a sufficiently broad view of both social and health provision, and also focus on the wider determinants of health.

### Next Steps

- Review measures used in the tracker of system performance by April 2018

## 5.2 Improving quality

Local health and care organisations are working together on many initiatives to improve the quality of services provided. A summary is provided below of the main areas of work, what they have achieved so far and what we expect each of them to contribute over the next 2-3 years.

Programme	Achievements	Impact in 2018 - 2020
Planned Care		
Urgent Care		
Women, Maternity and Children		
Mental Health	<ul style="list-style-type: none"> <li>• Sustained nil out of area placements for adult acute inpatient admissions through strong partnership collaboration and provision (health, social care, VCS and police)</li> <li>• Alternative to inpatient admission or A&amp;E attendance as a result of VCS initiatives like The Haven (Cellar Trust) and The Sanctuary (MIND)</li> <li>• Improved access to psychological therapies and Early Intervention in Psychosis services</li> <li>• Increased staffing levels in our Dementia Assessment Unit to ensure we can provide</li> </ul>	<ul style="list-style-type: none"> <li>• Work at West Yorkshire &amp; Harrogate level to integrated adult acute commissioning</li> <li>• Provide care closer to home and develop enhanced community pathways for Children and young people – including development of CAMHS 22 bedded unit for WY&amp;H, and development of new collaborative commissioning models</li> <li>• Collaborating at WY&amp;Harrogate level to consider options to improve access to and services for BANDS and Low Secure services</li> <li>• Further improvements</li> </ul>

	<p>high quality, personalised care to people with complex needs</p> <ul style="list-style-type: none"> <li>• Partnership ‘STEP’ bid secured introducing health and VCS work with Job Centres to support individuals to secure employment</li> </ul>	<p>in access to IAPT meaning more people are treated earlier</p> <ul style="list-style-type: none"> <li>• National commitment to invest in IPS model (support to individuals accessing our Community Mental Health Teams to secure employment)</li> </ul>
Learning Disabilities	<ul style="list-style-type: none"> <li>• Hydro and rebound therapy provision re-provided from out dated and remote location to community based facilities</li> </ul>	<ul style="list-style-type: none"> <li>• Learning Disability Transformation Programme to develop community alternatives to admission to Assessment &amp; Treatment Units</li> </ul>
Primary Care and Community/ Out of Hospital Care	<ul style="list-style-type: none"> <li>• Active signposting training for practices, and roll out of the community connectors model to help more people connect to their communities</li> <li>• More practices offering appointments at evenings and weekends</li> <li>• Support for leadership development in primary care using GP Forward View funding</li> </ul>	<ul style="list-style-type: none"> <li>• Development of Primary Care Home Communities – more joined up support for wellness in neighbourhoods including; <ul style="list-style-type: none"> <li>• Additional 230 extended access appointments per week</li> <li>• 100% coverage of direct booking into GP appointments from NHS 111</li> <li>• 100% of practices to offer care navigation</li> </ul> </li> <li>• Develop community beds so that people stay connected to their communities while being supported with rehabilitation and reablement.</li> <li>• Develop a community access network for people to find the right local services for them</li> </ul>

These programmes make a significant contribution. In addition to their impact on quality they also contribute to the delivery of system-wide efficiencies. In 2017/18 these programmes have contributed to CCG QIPP savings, and in 2018/19 they are expected to deliver a further savings.

Whilst the improvements in care described above are necessary they are not sufficient to fully realise the vision we have for the health and wellbeing of Bradford District and Craven. Therefore a number of additional initiatives are underway to support the transformation required.

## **5.3 Provider collaboration**

Across Bradford District and Craven the providers of care and health are working together to deliver more effective services for people which will lead to improved health, and to find additional ways of operating efficiently by sharing expertise and resources.

Collaboration between providers is happening in the following ways;

**5.3.1 Acute hospital providers** in Airedale and in Bradford are working together supported by commissioners in the 'Acute Provider Collaboration'. They have acknowledged the need to work differently in the future and are committed to developing new ways of working underpinned by collaboration.

Following joint work undertaken by clinical teams opportunities have been identified to enhance safety, quality, effectiveness and the experience for patients and staff. Work has already begun on improving the quality of care provided to Gastroenterology patients. Further improvements are being planned in Ear Nose and Throat specialisms and in Stroke care. Other clinical specialties will progress throughout 2018.

The focus of this work is not about future organisational form, it is about how to best organise clinical and support services to provide leading edge clinical practice that is both clinically and financially sustainable and best meets the needs of local people.

Within this overall framework the Acute Provider Collaboration programme will support local clinicians to consider how best to organise clinical services across the two hospitals linking up with care provided in the community.

**5.3.2 General Practices** are working together to improve care and create sustainable business models. They are doing this through a variety of arrangements including; federations, bigger merged partnerships and through the establishment of joint ventures owned by GP partners. These collaborations have already enabled a wider range of services to be offered in primary care e.g. access to therapists employed by several practices working together, where individual practices wouldn't have had sufficient demand. It is anticipated that general practices will work together to offer extended opening hours for patients, and to continue extending the range of expertise they can offer.

In Bradford the Bradford Care Alliance has been formed by 63 GP practices operating as Community Interest Company to improve health and wellbeing in Bradford by supporting new models of care and sustainable general practice. It is currently working on introducing GP streaming in A&E which will help more people access primary care rather than using A&E where this isn't the best choice. The Alliance is also leading the development of groups of GPs, community health and care services and their local community organisations working together to form ten neighbourhood collaborations called 'primary care homes'. The Alliance has been successful in gaining the support of the National Association of Primary Care to introduce new ways of working.

In the next year we will support the emergent primary care homes build strong relationships with local people and communities, so that a true partnership emerges which builds on the strengths and abilities of people to stay well and support each other with illnesses. This focus on wellness as well as treatment of illness is at the heart of this approach. Wherever needs arise for the redevelopment or relocation of premises we will seek opportunities to create welcoming community oriented places that join up activity and sport, access to health and care, with community action and support for community groups.

In Airedale, Wharfedale and Craven GPs are working together in several ways to find sustainable business models and to offer a wider range of services for their patients with increased access to care.

Seven practices in the Airedale and Craven localities have come together and formed a region of the national GP super-partnership, Modality Partnership. Modality Partnership are the first national super-partnership in England, led by GPs with a small centralised management team. The majority of the remaining practices predominantly in Craven and Wharfedale are also coming together under the WACA (Wharfedale and Craven Alliance) banner. The exact form of this potential super-partnership is still being worked on.

Yordales Health, the GP federation covering all but two of the Airedale Wharfedale and Craven practices is working to establish the most appropriate way to support the resilience of general practice, and ensure that general practices are prominent in local accountable care developments. To enable this Yordales will work with practices to find the best way of ensuring their perspective is articulated clearly and coherently. It is anticipated that an agreement will be reached on how to achieve this by the end of this year.

**5.3.3 Voluntary and Community Sector** organisations have worked together locally for many years through the voluntary sector Assembly structure and particularly the Health and Wellbeing Forum. The members of the VCS Assembly have now established Bradford VCS Alliance Ltd. to enable even more collaborative provision. Alongside the Assembly it brings a strong unified voice for the voluntary and community sector. This will help ensure the sector is vibrant, sustainable and can play a leading role in helping people and organisations to be part of providing solutions to improve the health outcomes of our most marginalised and vulnerable communities.

In addition the local voluntary and community sector is working closely with statutory sector partners to develop practical ways in which the sustainability of the sector can be secured. This is critical as many of our policies and strategies include major roles for the VCS to help local communities to thrive. To support sustainability we will work together on building the capacity of the VCS, and developing longer term funding arrangements.

**5.3.4 Provider Alliances** have been developed in both the Airedale Wharfedale and Craven, and the Bradford areas. These bring together all of the providers of health and care services including those listed above along with community and mental health care providers, and social care professionals. In the future the Provider Alliances will extend invitations to local care home and home care providers and to other organisations that contribute locally (e.g. out of hours care). The Provider Alliances will offer a route through which commissioners can contract with local providers in a joined up way to deliver new models of care that focus on the outcomes and experience of care for people.

Already the Bradford Provider Alliance has worked together to develop plans for an integrated diabetes service and support outcomes framework. Once implemented this will give everyone in Bradford access to help to reduce their risk of developing type 2 diabetes, and provide support for people with diabetes to help them to confidently manage their health to reduce the risk of complications. It is anticipated that this new approach will be launched by April 2018.

The Airedale, Wharfedale and Craven Provider Alliance is working together to support the development of three communities across Airedale, Wharfedale and Craven to deliver transformed primary and community outcomes focused services and well as looking to extend the Well North/Bradford social entrepreneurial philosophies into Keighley to help transform neighbourhoods into dynamic communities where people can live, work and thrive.

<b>Next Steps</b>
<ul style="list-style-type: none"> <li>• <b>Map and align localities and neighbourhoods work (primary care, VCS, social care for adults and children etc) – by March 2018</b></li> </ul>
<ul style="list-style-type: none"> <li>• <b>Extend participation in locality based collaboration to include community pharmacies, care homes and homes care providers – by March 2018</b></li> </ul>
<ul style="list-style-type: none"> <li>• <b>Engage Community Pharmacy West Yorkshire to develop a shared plan for the enhanced roles that pharmacies can play – by June 2018</b></li> </ul>
<ul style="list-style-type: none"> <li>• <b>Undertake locality/ neighbourhood needs assessments to identify priorities for local action – by April 2018</b></li> </ul>
<ul style="list-style-type: none"> <li>• <b>Join up locality based collaborations so that health, care and community participants are working together – by June 2018</b></li> </ul>
<ul style="list-style-type: none"> <li>• <b>Develop and test new service delivery models in localities – throughout 2018/19</b></li> </ul>
<ul style="list-style-type: none"> <li>• <b>Develop and test new ways of joining locality based service delivery with system wide governance and planning arrangements – by Sept 18</b></li> </ul>



<ul style="list-style-type: none"> <li>• <b>Implement integrated diabetes pathway in Bradford by April 2018</b></li> </ul>
<ul style="list-style-type: none"> <li>• <b>Extend Well Bradford initiative to Keighley, starting appreciative enquiry by April 2018</b></li> </ul>

## 5.4 Commissioner collaboration

NHS and Local Authority commissioners of health and care services are also collaborating in an arrangement that mirrors the alignment of the provision of care to focus on improving outcomes and using resources to join up pathways of care.

An Executive Commissioning Board has been established to align the commissioning decisions of the three local NHS CCGs and City of Bradford MBC. So far this arrangement has enabled partners to develop a successful plan for the use of the Better Care Fund and Improved Better Care Fund. This has led to fewer people having to stay in hospital after they are medically fit to leave. This is an area in which we have significantly out performed most other parts of the Country. It is better for people and helps make sure we have sufficient hospital beds available.

In the future we will extend the proportion of our health and care spend that is commissioned through this joined up planning arrangement. In the next year we will....

Next Steps
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## 5.5 Whole system collaboration – accountable care

All of the examples above of providers and commissioners working together contribute to the development of two accountable care partnerships for Airedale Wharfedale and Craven and for Bradford. This section describes what we mean by this, and how this will help us to deliver better outcomes, better quality and to use our limited resources as effectively as possible.

We intend to build an integrated health and care system whose purpose is to meet the 'triple aim'

- Improved health outcomes
- Improved experience and effectiveness
- Improved use of resources

To do this we want to agree a new deal with people and communities in which we

- Invest in communities
- Rebalance relationships and share power and responsibility
- Support agency and activity in communities

- Agree together what we need to do/ do differently/ stop doing

We intend to build this future organically from the places where health is created in neighbourhoods. This sets us apart from some other approaches to accountable care which start with the creation of a framework of organisational structures and contractual arrangements. While recognising that changes to governance will be essential in due course, we believe that form should follow function, and the first job we have is to nurture behaviours of trust, innovation and collaboration.

To support these developments much is already underway;

**5.5.1 Local networks of primary care** have been established in both the Airedale Wharfedale and Craven (AWC), and the Bradford areas. In AWC three communities have been formed in which primary care, voluntary and community sector, community health services and social care providers are improving services. In Bradford general practices are forming ten local networks, which will shortly include a range of other partners as per AWC. These developments are learning much from their association with the National Association of Primary Care's Primary Care Home model.

**5.5.2 VCS community anchor organisations** There is an established and growing network of community anchor organisations across the Bradford District, including Royds Community Association, Bradford Trident, Inspired Neighbourhoods and Carlisle Business Centre, which are strongly embedded and connected in their local communities, understanding the needs and challenges of local people, including the wide range of issues that impact on health and wellbeing. Connecting community anchor organisations and emergent primary care homes is a focus for the next year

**5.5.3 People Can and Asset Based Community Development** People Can is a Bradford Council led campaign which actively promotes all the good things that people are already doing in their communities as well as encouraging more people to volunteer and get involved in community life. You can find out more [here](#).

Asset Based Community Development is an approach to working with communities which starts with the assets or 'strengths' in that community and then builds the capacity of citizens to connect their skills and resources leading to citizen-led, sustainable change to improve the quality of life for everyone in that community. In Keighley a group of practitioners from a range of partner organisations including the CCG, Council, Police and voluntary and community groups have recently started meeting to support each other in implementing the ABCD approach across local neighbourhoods. They are supported by Nurture Development which is a strategic partner of the ABCD Institute, and the lead partner in Europe. It aims to support the proliferation of inclusive, bottom up, community driven change by supporting local communities and supportive civic organisations to create the conditions where any neighbourhood can identify, connect and mobilise its assets to the benefit of the whole community.

**5.5.4 Airedale Care Home Vanguard** is part of the national NHS England programme testing new ways of working. This particular initiative links care homes with local NHS



teams using tele-health to enhance the health and wellbeing of people living in care homes, add to the skills of care home teams and to reduce the emergency admission of care home residents into hospitals.

**5.5.6 Accountable Care Programme Boards** have been established for both AWC and Bradford to support and oversee the development of new ways of working. The accountable care programme boards are the groups where interaction between the component parts described above are understood and aligned, and where the balance is struck between neighbourhood level innovation and system wide governance.

#### Next Steps

- **Develop a clear vision and narrative on accountable care, tested with the public and agreed by partner organisations – by March 2018**
- **Agree a development plan towards accountable care which is owned by Health and Wellbeing Board and agreed by all boards of partner organisations – by June 2018**

## 5.6 Wider system collaboration – West Yorkshire

Most of our collaborative work is focused locally on AWC and Bradford as a largely self sufficient system. Not all needs can be met at the local level though, and there are some opportunities where it makes most sense to work with partners across a wider area e.g. for highly specialised services where resources are shared, and where great ideas can be shared between neighbouring towns and cities for everyone's benefit.

We do this through two main routes. We participate in the West Yorkshire Combined Authority and in the West Yorkshire and Harrogate Health and Care Partnership (formerly the West Yorkshire and Harrogate Sustainability and Transformation Partnership)

**5.6.1 West Yorkshire and Harrogate Health and Care Partnership** (HCP) is one of 44 sustainability and transformation partnerships nationally. It brings together the health and care partners across West Yorkshire and Harrogate to achieve the 'triple aim'. Our vision as a Partnership is for everyone to have the best possible outcomes for their health and wellbeing. You can read more [here](#). Bradford District and Craven is one of six 'places' that make up the West Yorkshire and Harrogate Partnership. Work is undertaken through a mixture of local place based plans (such as this document) and West Yorkshire and Harrogate-wide programmes where it makes sense to collaborate at scale. As a place based system within the Health and Care Partnership we focus on prevention of ill health, early help and timely support, plus the creation of networks of community primary and social care provision. Working with our partners across West Yorkshire we focus on priorities including mental health, cancer and stroke.

Our commitments as a West Yorkshire and Harrogate Health and Care Partnership include;

**Mental Health:** Reduce by 40% the number of people experiencing a mental health crisis that attend A&E, by working with people to put in place personalised plans and by

providing alternatives such as the Haven and the First Response service which offers mental health crisis support 24 hours a day, seven days a week, to vulnerable people needing urgent crisis support. A single phone number means that people can self-refer.

Collaborating to secure national capital funding to develop a new CAMHS inpatient facility that will increase beds regionally from 8 to 22. This will allow us to provide care closer to home and by taking responsibility for commissioning budgets and care navigation that is currently managed at a Yorkshire and Humber level we hope to use resources more efficiently and use those resources to develop new community pathways.

Look to establish a single approach to commissioning adult acute inpatient beds that mean we make best use of our beds at WY&H level and mean people receive care as close to home as possible

Eliminate all out of area placements for Mental Health by 2020 through collaboration between providers and commissioners to develop new local community and inpatient services e.g. long stay rehabilitation

We are taking a zero suicide approach to prevention (with an aspiration of 10% reduction in suicides overall, and a 75% reduction in numbers in mental health settings by 2020-21)

**Cancer:** The Cancer Alliance of the Health and Care Partnership has successfully attracted investment of £900,000 from the national Cancer Transformation Fund and will use this support us locally to achieve better outcomes for people in Bradford at risk of/ diagnosed with lung cancer. Together we will help more people to stop smoking; raise awareness to encourage more people to seek advice for symptoms that may be linked to lung cancer; increase the number of people who are scanned and diagnosed early; and improve the speed at which people can access treatment. By taking these actions together we will save lives, improve quality of life and make best use of our resources.

Across West Yorkshire and Harrogate this will;

- Reduce adult smoking rates from 18.6% to 13%, resulting in around 125,000 fewer smokers and preventing around 11,250 admissions to hospital
- Increase 1 year cancer survival from 69.7% to 75%
- Increase the proportion of cancers diagnosed early (stages 1 and 2) from 40% to 62%, offering 3,000 extra people the chance of curative or life extending treatment.
- Improve the patient's care journey delivering a '28 day to diagnosis' standard for 95% of people investigated for cancer symptoms. This means faster diagnosis for around 5,000 people.
- Deliver estimated efficiency savings of up to £12 million over 5 years based on lower treatment costs associated with earlier stage diagnosis for many forms of cancer.

**Stroke** is a life changing event and is the third highest single cause of death in the UK. Evidence shows the care people receive in the first few hours can make a difference to how well they recover. We are working together to make sure everyone has access to the best treatment, and we are ensuring that all parts of the stroke pathway work together effectively for people. By doing this we will;

- Prevent more strokes; by consistently providing people with information and advice to make informed decisions about their health, and improving the detection and management of Atrial Fibrillation (erratic heartbeat) to 89%. This will save 190 strokes over 3 years.
- Reduce variation – so that no matter where people live and what time of day they are admitted to hospital, they are able to receive high quality stroke services.
- Improve use of technology - so that health care professionals can provide earlier assessment and treatment of people, and provide improved access to specialist technology, which we know can save lives.
- Stroke rehab and aftercare - improve health outcomes from prevention to specialist treatment to rehabilitation and after care.

**Smoking:** We want to see a reduction of 125,000 smokers. Recent figures show we have reduced this to 23,300 fewer smokers in 2015/2106. Using recent work by the Healthy London Partnerships on prevention and savings, this reduction will give £17.1m of healthcare savings over the next five years. This is good progress overall but masks differences across our area.

**Alcohol:** Tackling alcohol and substance abuse related harm; including those attending hospital, as well as a focus on early prevention are part of our plan. This requires a joined up approach with all partners and highlights the importance of balancing different people’s circumstances and needs within budget constraints.

**Diabetes:** We are applying the National Diabetes Prevention Programme to reduce the numbers of people at high risk of becoming diabetic. This programme provides education on healthy eating and physical exercise programmes to support people to lose weight – a key risk factor for type 2 diabetes. Locally we have already started to implement this through the Bradford Beating Diabetes programme.

There are 226,000 people at risk of diabetes in West Yorkshire and Harrogate. Our aspiration is that 50% of these are offered diabetes prevention support, with a 50% success rate. We have secured diabetes transformation money of £2.7m to help us do this.

**Developing our partnership:** In the next year the West Yorkshire and Harrogate HCP will work with NHS England and central government towards being recognised as an accountable care system. This will allow greater autonomy and potentially access to some transformational funding in return for commitments to accelerate our achievement of key quality and efficiency indicators. It will be necessary to demonstrate the robustness of our partnership governance arrangements, to demonstrate a track record of improvement, and to show a clear plan for the future in order to earn this autonomy.

#### Next Steps

- Continue to build our ‘accountable care partnership’ within the emerging West Yorkshire and Harrogate ‘accountable care system’
- Work with the Cancer Alliance to deliver additional action to reduce lung cancer and to enhance access to treatment – starting 2018

**5.6.2 West Yorkshire Combined Authority** is a grouping of local authorities, chaired by the leader of City of Bradford MDC. It enables joined up solutions to be developed for common issues. This includes ensuring that the full range of policies and interventions that local authorities make are aligned to the goal of improving health. For example policies on housing and economic growth. We will also use this route to help Health and Wellbeing Boards and Overview and Scrutiny Committees shape the development of accountable care across the region.

# 6. Improving use of resources

The challenges posed by limited resources and increasing demand for health and care services are significant and increasing. Increasing productivity and efficiency is necessary but not sufficient. In addition we must use resources differently to enable people to create health.

We may not be able to determine the quantum of resource available, but we can maximise our impact by deciding together how we will use our total resource.

In this section we need to cover:

- Out put of finance directors shared planning work
  - 17/18 year end forecast – and change from plan (& why changed)
  - 18/19 (and subsequent years) plan for income, expenditure and efficiencies
  - Impact of efficiencies – on people, on each organisation, and plans to mitigate impact
  - Testing feasibility of delivery with service providers and change programmes
- Principles and commitments
  - The money we have individually is viewed collectively for the people of BD&C
  - Spend to maximise outcomes
  - Prevention and early intervention
  - Focus on children – biggest impact
  - Third sector investment
  - Collective decision making (shared, aligned etc)
  - Efficient and effective support resources
  - Collaboration before competition
- Aligning commissioning – ECB development
- Aligning incentives in contracts - common outcomes

- Stabilising and securing the VCS
- Payment mechanisms and risk share

<b>Next Steps</b>
<ul style="list-style-type: none"><li>• <b>Share major change and efficiency proposals, and test impact on people and on other organisations – by December 2017</b></li></ul>
<ul style="list-style-type: none"><li>• <b>Agree a system wide view of use of resources for 2018/19 – by March 2018</b></li></ul>
<ul style="list-style-type: none"><li>• <b>Hard-wire partnership commitments into organisational business plans for 2018/19 – by March 2018</b></li></ul>

# 7. Supporting change

**Our purpose remains consistent; for people to be happy, healthy and at home. To succeed the ways in which we work with people must change significantly, and this transformation requires support and expertise.**

**This section describes how we will support transformation through our approach to system leadership and our expert enabling functions.**

## **7.1 System Leadership and Development**

The Health and Wellbeing Board (HWB) is the partnership forum established by statute to bring together leaders of local health and care organisations to work together to improve health and wellbeing. It owns this plan, the Health and Wellbeing Strategy, and the Joint Strategic Needs Assessment.

The Health and Social Care Overview and Scrutiny Committee (OSC) is responsible for scrutinising the Council's plans and services related to health and care. It also scrutinises local NHS policy and planning, and the impact that these have in meeting local needs and reducing health inequalities. OSC will scrutinise this plan and its delivery.

The Integration and Change Board (ICB) leads the development of this plan and its delivery through linked programmes and actions taken by partner organisations. The members of ICB are visible leaders of system change and delivery, role-modelling the values and behaviours needed to achieve our shared vision.

ICB will support and oversee the delivery of the plan by the accountable care programme boards and the enabling programmes described below. There will be a focus on

- clarifying the vision and engaging people
- creating the right conditions for change across systems, as well as within organisations
- supporting delivery through resource allocation, alignment of effort, removal of unnecessary bureaucracy, and holding to account.

In addition each partner organisation will 'hard-wire' the relevant aspects of this plan into their organisational business plans and ensure their teams are clear on the part they play in contributing to the vision.

## Next Steps

- Implement a 'System Development' (OD) plan based on principles embodied in '[Building Collaborative Places](#)' and '[Transforming Together](#)' – plan drafted by February 2018
- Clarify and align the contributions of programmes linked to ICB, ensuring delivery aligned to purpose and vision – by May 2018
- Align partnership resources to the achievement of this plan, and clarify 'virtual team' arrangements – by March 2018

## 7.2 Enabling Programmes and Networks

To support a sustainable transformation we recognise that there are some key enabling factors that we must attend to. The ICB already has a number of enabling work streams, and this section describes what they do, and how we will support them in the future.

All of the enabling work streams draw together expertise from across our system into a virtual team. We now need to support the enablers to engage with the delivery programmes to inspire them by demonstrating the 'art of the possible', and listen and translate the operational plans of the delivery programmes into clear requirements that shape the focus of each enabler.

Our enabling programmes are;

**7.2.1 Integrated Workforce Programme** This enabling programme has refined its focus through repeated engagement with a wide range of stakeholders. It has four priorities:

- **Attracting and recruiting the future workforce by encouraging young people and new entrants to work in health and care.** This includes developing a health and care Industrial Centre of Excellence (ICE) for 14-16 year olds, shared apprenticeships programmes and a wide range of volunteering opportunities. An ICE provides industry led programmes for 14-16 year olds who want to learn skills, gain experience and develop a career in a particular sector. The development of a health and care ICE in the Bradford District aims to build strong and lasting partnerships between employers, schools, colleges and universities; creating career pathways that will transform the way young people think about working in health and care and developing the skills required by in the system. The ICE programmes provide a platform for apprenticeships, routes into further and higher education and professional training.
- **Developing our staff together** : . Sharing resources, and creating and delivering system wide learning and development opportunities including passports' for stat/mandatory training, joint leadership programmes and collaborative learning opportunities and system wide career pathways.



- **Improve Integration across sectors:** Developing a common set of values /behaviours for the system and applying these from recruitment through to day to day working.
- **Creating the conditions to retain staff across the system :** Engaging, listening and involving staff across the system. Promoting mental and physical health and well-being and supporting healthier lifestyles.

In addition this enabling programme influences the development of regional workforce plans through the LWAB and the West Yorkshire Health and Care Partnership workforce strategy. Key areas identified for regional collaboration include;

- Sharing the learning eg the Bradford ICE and the Leeds National Skills Academy Centre of Excellence Project
- The commissioning and provision of specialised training. Specifically, where economies of scale offer better value for money
- Supporting the development of new roles by collectively influencing the appropriate regulatory bodies

**7.2.2 Digital 2020 Programme** We have a wealth of digital expertise and opportunity in Bradford District and Craven. The support of the University and the Digital Health Enterprise Zone are key assets, as is the renowned development of tele-health solutions led by Airedale FT. Drawing upon this and the skills of all local health and care partners this enabling programme will focus on the following;

- A shared care record across health and care including voluntary and community sector organisations that are integral to local neighbourhood teams
- Innovations in digital service delivery. This will build upon the existing successful use of telehealth and mobile applications in our local care and health delivery.
- Solutions for smart sharing of information that puts people in control, keeps their information secure, and lets people choose what to share with each local organisation.
- Development of business intelligence and analytical capabilities that meet the needs of a joined up health and care system. This includes making sure that;
  - Every clinical/social care conversation with a person is supported by the right technology and information, for safety, effectiveness and to enhance people's experience, including initiatives to support agile working and remote access to systems
  - All neighbourhood teams have access to information that shows which people are at risk of becoming more unwell, and they are able to respond together in a timely way
  - Across the whole system we can see the impact that our health and care services have had on the health of the local population; and we can take

informed decisions about where to spend more or less in future to have the greatest impact on people's health.

In common with the other enablers the Digital 2020 programme will engage with the accountable care programme boards, their delivery programmes, and with the public to ensure that their needs are understood and form the basis of user requirements for the digital solutions that are provided. In addition the Digital 2020 group will identify areas of synergy between local partners and act on them e.g. reciprocal wi-fi, and shared infrastructure and IT services

**7.2.3 Strategic Estates Programme** The way we use our buildings is critical to the delivery of new ways of working, such as community teams reviewing risks together and responding in a joined up way to coordinate their visits to peoples homes. This means that one of the key priorities for this enabler work stream is to engage with the accountable care programme boards and their delivery programmes to understand the future clinical and operational models. The service strategy will drive the development of an estates strategy that supports the neighbourhood and locality hub approach.

The estates strategy will also contribute to the triple aim through the effective use of resources. We can achieve this by better utilisation of properties, more efficient operation, and more shared use of estate. In turn these measures will allow us to reduce the number of buildings we collectively use, and direct a greater proportion of our resource into people and services. The estates strategy will be developed by summer 2018.

This programme will also act opportunistically where there is potential to advance strategic aims. In the next year we will explore potential for the following:

- Keighley public service hub
- Eccleshill hub
- Girington wellness centre

**7.2.4 Self Care and Prevention Programme** This programme helps ensure that we focus on what people can do, rather than what they can't. It does this by working with programmes and services to embed the principles of self care and prevention. It also directly delivers specific interventions to create more capacity for self care. The key principles are;

- Be person centred not service centred
- Increase peoples independence and maintain their dignity
- Work with people and communities, sharing responsibility for improvement
- Stop issues starting, and detect issues early to take action

Through this enabling programme we aim to ensure that

- People feel confident, resourceful and able to manage their own health and wellbeing, with support when they need and want it
- The health and care workforce has the tools, skills and attitude needed to work with people as partners in their care, taking a strength based approach
- Organisations across Bradford District and Craven support self care and prevention by prioritising it in their policies and plans

We achieve these aims through the following delivery projects:

**Workforce Development:** to train health and care staff to support people to self care including taking decisions about their health and care. We have already trained over 10% of the health and care workforce in ways of supporting self care and prevention. In the next year the Programme will continue to build upon this.

**Community Connectors:** a new social prescribing service has been launched in Bradford to deliver social, emotional and practical support to people referred through primary care. In 2017, HALE and partners have supported over 700 people to improve their wellbeing through one to one sessions using motivational interviewing techniques. We will be extending this service in 2018 and linking with the new Primary Care Home model.

**Children and Young People:** Working in partnership with health visitors and children's centres, we have commissioned a new education programme to empower and support parents to manage children's minor ailments. We have also developed a new resource to support frontline workers to promote self care for small children and their families. Next year we will develop a programme to deliver self care in schools.

**Stakeholder and Culture:** From January 2018, Engaging People will be working with people in communities to raise awareness and understand barriers to self care.

**Tools and Resources:** A number of tools and resources to support self care have been developed and will be promoted across the health and care partnership following consideration of stakeholder needs.

**Prevention:** This project focuses on integrating key and consistent messages regarding primary, secondary and tertiary prevention into existing health and care practices, and also on maximising the effectiveness and reach of commissioned prevention services such as Stop Smoking services.

**7.2.5 Networks** In addition to our enabler programmes a key feature of our approach is to support the development of networks across our partnership. Networks may have a more fluid membership and a non-hierarchical approach. We will foster the development of networks between people working on change, organisational development, engagement and communication. These will all be critical to success and will need to draw upon the collective expertise of the system.

## Next Steps

- Facilitate engagement between enabler programmes and between enablers and delivery programmes – by January 2018 then on-going
- Agree contributions and resources with all enablers – by February '18
- Establish networks for system development, change, engagement and communications – by February 2018 then on-going

## 7.3 Maximising Strengths

The AWC and Bradford health and care system has many assets – some of which are unique. The strength of the local research base is one such asset. By working together we can achieve more for people and create a health and care system that systematically contributes to and applies learning from research – so we are always improving. These unique assets also form part of our narrative for policy makers and employers which helps us attract external investment.

**7.3.1 Born in Bradford (BiB)** is a study following the lives of children and their families who were born in the city between 2007 and 2011. Around 12,500 families and almost 30,000 citizens have chosen to take part. Detailed information has been collected about social, economic, lifestyle, and cultural factors, and about physical and mental health; biological samples such as blood are available from mothers, babies and children; and GP, hospital and local authority data have been linked, allowing researchers to measure associations between things such as health, wealth, education, lifestyle, and the environment. Since the study began researchers have identified important reasons for differences in birth size, child growth patterns, obesity and early risk factors for disease in Bradford's children. These early life differences continue into adulthood, contributing to the much higher rates of diabetes and heart disease in the city compared to the average across the rest of England.

**7.3.2 Better Start Bradford (BSB)** is a £49m ten year Big Lottery funded partnership programme aiming to test what works in improving outcomes for children. With a particular focus on nutrition and early social, emotional and language development, it delivers maternity and early years interventions in three Bradford wards with high levels of ethnic diversity and deprivation. It is working closely with parents, communities and local providers to ensure effective implementation and with BiB to gain insight from the world's first experimental birth cohort, and provide a centre for evaluation of cutting-edge early years interventions.

**7.3.3 Active Bradford** The Active Bradford Partnership has recently made a bid to Sport England to take part in an exciting multi-year initiative (2017 – 2021, £130 million shared across 12 places in England) to change the physical activity levels of children and young people aged 5-14. If successful this project aims to improve children and young peoples' physical health and mental wellbeing, individual development, quality of life and reduce health inequalities, through sport and activity. The programme also seeks to enhance social and community development and promote active citizenship. It will be co-produced

with communities, beginning with working to understand their needs, priorities, enablers, opportunities and assets; identifying and working with existing potential projects that meet the needs of the communities; and developing new innovations where there are gaps. The Active Bradford LDP includes an ‘innovation hub’, which will evaluate the interventions, allowing them to be modified where needed and informing commissioning decisions.

**7.3.4 Well Bradford** is a local programme which is part of the ‘Well North’ movement. It is hosted by Bradford Teaching Hospitals and supports community led action for health and wellbeing. Currently operating in Gillington, Well Bradford will expand and begin supporting community action in Holmewood and Keighley.

**7.3.5 City of Research** aims to help Bradford to be a city which discovers and uses research to provide the highest quality health, social and educational services and care, a place where everyone has quicker access to the latest treatments and programmes, where disease and problems are prevented as opposed to treated and where innovative ideas are turned into everyday practice. A new project called Connected Bradford is using data from 500 000 people across the city to redesign how services are delivered and improve access to them, their quality and efficiency. We want to expand on the knowledge and expertise in Born in Bradford, and are working towards a model where:

- Local citizens and organisations set the priorities for research in the city, they work together with researchers to find innovative solutions to problems, and then turn these solutions into everyday practice;
- Excellent health, social and educational practice from here and elsewhere is identified and put in place in Bradford;
- Every citizen of Bradford is invited to become involved in research;
- Every health, social, and education, organisation in Bradford is research active, evaluating their own practice services and using this evaluation to make changes;
- Findings from research are readily available for everyone to access easily;
- Research findings inform decisions about policy and how resources are used;
- Research findings are used by participants to improve their lives.

**7.3.6 DHEZ** the Digital Health Enterprise Zone is a £13 million public-private partnership between industry, local and national government, and academia, led by the University of Bradford and hosted at a state-of-the-art Digital Exchange.

**7.3.7 Connected Bradford** links routine pseudonymised data generated from primary care, secondary care, education and social care; and makes it available for research to drive innovation and improve healthcare delivery.

#### Next Steps

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|--|
| <ul style="list-style-type: none"> <li>• <b>Develop clear narrative on local system assets and strengths and promote collectively via all communications channels</b></li> </ul>   |
| <ul style="list-style-type: none"> <li>• <b>Implement a collaborative approach to maximise the collective impact of all assets – including growing inward investment, and strengthening connectivity between local assets/ programmes</b></li> </ul> |
| <ul style="list-style-type: none"> <li>• <b>Clarify how research, learning and innovation will improve outcomes</b></li> </ul>   |

## *8. Making a difference*

This section describes how we will measure the difference our work makes for people and their health and wellbeing. It also describes how we will learn together and how we will plan for and respond to challenges along the way.

Section in development



## Report of the Chair to the meeting of Bradford and Airedale Health and Wellbeing Board to be held on 19<sup>th</sup> December 2017

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### **Subject: Chair's Highlight report**

Future in Mind: Children and Young People's Mental Health Transformation Plan  
Better Care Fund - Quarter 2 Performance  
Integration and Change Board and Executive Commissioning Board updates  
Proposed expansion of Health and Wellbeing Board Membership

### **Summary statement:**

The Health and Wellbeing Board Chair's highlight report summarises business conducted between Board meetings. December's report brings the Children and Young People's Mental Health Transformation Plan, a summary of Quarter 2 performance from the Better Care Fund, updates from the Board's sub-groups and a proposal to expand the membership of the Board..

**Councillor Susan Hinchcliffe**  
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**Portfolio:**  
Health and Wellbeing

**Overview & Scrutiny Area:**  
Health and Social Care

## 1. SUMMARY

The Health and Wellbeing Board Chair's highlight report summarises business conducted between Board meetings. The December report brings: the Future in Mind Strategy for information and agreement; a Quarter 2 performance update from the Better Care Fund for information; updates from the Board's sub-groups which are the Executive Commissioning Board and the Integration and Change Board; a proposed expansion of the Health and Wellbeing Board's membership.

## 2. BACKGROUND

As the report covers multiple items, the background to each item appears together with the update in Section 3 below.

## 3. OTHER CONSIDERATIONS

### 3.1 Future in Mind: Children and Young People's Mental Health Transformation Plan

#### 3.1.1 Background

The Children and Young People's Mental Health and Wellbeing Taskforce was established by the government in 2014 to consider ways to make it easier for children, young people, parents and carers to access help and support when needed. The purpose of the taskforce was to make recommendations to ministers, and agree actions aimed at achieving better outcomes for children and young people with mental health problems. In March 2015 the taskforce published its report and recommendations: *Future in Mind: promoting, protecting and improving our children and young people's mental health and wellbeing*. Local plans have since been developed.

#### 3.1.2 Update

The vision and summary of the local *Future in Mind* transformation plan and the main achievements since the October 2016 refresh are summarised below. The full plan update forms Appendix 1 to the report.

#### Vision and summary

*Mental wellbeing in Bradford district and Craven: a strategy 2016-2021* was developed through close working with district partners including CBMDC, North Yorkshire County Council and VCS organisations. The local *Future in Mind* transformation plan is embedded within this all age strategy and shares its vision of **hope**, **empowerment** and **support** through a focus on three strategic priorities:

- Our wellbeing,
- Our mental and physical health, and
- Care when we need it.



By 2020, we will work together with partners to ensure that children and young people:

1. will be supported to recognise and value the importance of their mental wellbeing and take early action to maintain their mental health through improved prevention, awareness and understanding
2. can enjoy environments at work, home and in other settings which promote good mental health and improved wellbeing
3. will experience seamless care and have their physical and mental health needs met through services that are integrated and easily accessible
4. can reach their maximum potential through services which are recovery focused, high quality and personalised and which promote independence
5. can expect support to be commissioned and delivered in a way that leads to increases in efficiency and enables transformation of care through reinvestment.

### **Achievements**

Since the October 2016 refresh, some highlights of our main achievements have been:

- ✓ 67 schools now have 86 mental health champions with 100% good or very good evaluations for impact of support provided.
- ✓ Implemented a new self-harm policy across health and education settings
- ✓ Over 50 schools have accessed Living Life to the Full training
- ✓ Our Health Buddies have supported 211 children and young people reducing waiting lists
- ✓ The average waiting time from referral to treatment was 106.8 days, a reduction of 14.5 days from the average of 121.3, for CAMHS services.
- ✓ The number of Tier 4 occupied bed days decreased from 3,401 in 2015/16 to 2,651 in 2016/17.
- ✓ Bevan Healthcare are delivering schemes to provide refugee and asylum seeking children with mental health and psychological support.
- ✓ The main statutory provider is reporting against MHSDS and Data Quality in 8 of the 14 fields monitored by NHS Digital was above 95% in June 2017.
- ✓ 26 courses were held from April 2016 to March 2017 with 555 staff trained across the universal workforce in Bradford District.
- ✓ Launched the Compass Buzz school wellbeing workers project
- ✓ Established formal alignment with programs such as the SEND, B Positive and SEMH group
- ✓ Greater working with the voluntary and community sector to build support when needed

### **3.2 Better Care Fund - Quarter 2 Performance**

A briefing is provided at Appendix 2 to inform Health and Wellbeing Board members of the compliance with the quarter 2 submission requirements to NHS England and to update on the current progress on the BCF Plan.

### **3.3 Working group updates**

#### **3.3.1 Executive Commissioning Board**

The Executive Commissioning Board met on the 13<sup>th</sup> October 2017

- An overview on progress within the Mental Wellbeing Strategy was presented, with a focus of the work under the three main pillars of the strategy – our wellbeing, our mental and physical health and care when we need it. Achievements to date were highlighted. The work of the voluntary and community sector in supporting service users was raised and it was agreed that the Executive Commissioning Board would receive a paper on the potential for closer collaboration between the local authority and the CCGs and aligned commissioning approaches in relation to the strategic commissioning of the VCS.
- An update on the Airedale, Wharfedale and Craven, Bradford City and Bradford Districts CCGs financial position and respective financial challenges was provided. The current position of the QIPP plan (quality, innovation, productivity and prevention) for the CCGs was described – the plan aims to close the gap between growth, expectation and funding received.
- An outline of the different legal and non-legal factors that inform the procurement approaches and the collaboration processes within the CCGs and the local authority was provided to inform a discussion on collaboration vs competition. It was agreed that a ‘risk share’ approach between the CCGs and the local authority should be explored in a future meeting.
- An update was provided on the Better Care Fund (BCF) highlighting that the latest narrative and corresponding requirements had been submitted to NHS England. It was noted that there would be a focus in November on delayed transfers of care. It was requested that more detail is provided on the Improved Better Care Fund to enable the Executive Commissioning Board to ascertain the return on investment, in particular the winter pressure schemes. It was also agreed that the core BCF money (£38m) would be re-examined, particularly the spend badged as ‘reablement’.

#### **3.3.2 Integration and Change Board**

The Integration and Change Board met on 15<sup>th</sup> September and 20<sup>th</sup> October. In September ICB discussed and agreed the following;

- Received an update on the implementation of the Well Bradford initiative which promotes community led action to create and sustain health and wellbeing. Initially Well-Bradford has focused in Girlington, supported by Bradford Teaching Hospitals FT strengthening links with its neighbours. One key output of this collaboration is a project exploring the development of a multi-use community facility promoting wellness and active. In the next year the Well-Bradford initiative will commence engagement with people in Holme Wood and Keighley, to explore the assets that contribute to wellness in these communities.
- Discussed the Acute Provider Collaboration between Airedale Foundation Trust and Bradford Teaching Hospitals Foundation Trust. Noted the early success of work to improve

quality and safety when responding to gastro-intestinal bleeds. Endorsed the intent of the Acute Provider Collaboration to continue the approach of being clinically led and focused on quality.

- Approved a set of ten guiding principles for accountable care (also presented to HWB in September) regarding the way in which the system will transform towards a collaborative way of working where service provision is integrated at neighbourhood level, built around the assets of people and communities, and focused on prevention as well as treatment through action on the wider determinants of health and wellbeing.
- Approved changes to the partnership governance arrangements through which our collective transformation work is conducted. Key changes put the two accountable care programme boards at the heart of arrangements in both Airedale Wharfedale and Craven and in Bradford. ICB remains the system leadership executive forum that links the accountable care programmes and enabling work streams with HWB.

In October ICB discussed and agreed the following;

- A plan for the alignment of 18/19 financial and business plans between local health and care commissioners and providers. This builds on a history of positive engagement between partners, but aims to a) provide an overall 'place' view of income/ expenditure and efficiency requirements in the health and care sector, and b) enable impacts of efficiencies on people and other organisations to be managed effectively.
- Following a review of ICB's focus and ways of working, proposals for change were agreed. In future ICB will focus clearly on system leadership behaviours. It will meet formally on a bi-monthly basis. Between meetings ICB will be visible and active in engaging with people using and delivering health and care services, listening, sharing and encouraging positive system leadership behaviours.
- Agreed a proposal and timescale for the review of our place based plan for health and care
- Commissioned work to scope requirements for Business Intelligence and data analytics capabilities in the future system and to draw together existing work addressing elements of this. Part of an over-arching requirement to create a culture of data driven decision making.
- Reviewed key health and care outcome and activity metrics. As a result requested further clarification of efforts to increase the take up of cancer screening, and to understand better recent changes in the number of adults smoking locally, and efforts to help people to stop smoking.

At the next ICB meeting on 15<sup>th</sup> December the Board will consider the following;

- A local consortium bid to the UK Prevention Research Partnership which would build upon the strength of Born in Bradford and other applied research projects. It would enable us to test primary prevention actions through public and commercial policy and design choices.
- Discuss the learning from the recent 'Big Think' workshop on sustainability of the voluntary and community sector, and the critical role that VCS plays in enabling people and neighbourhoods to lead the creation of health, which underpins many policies.
- Prepare for the next system-wide Learning and Innovation Event on 19<sup>th</sup> January which will generate improvements in the health and wellbeing of children and young people. ICB members will champion the event and sponsor the continued delivery of ideas generated.
- Review the draft refresh of the Place Based Plan, including collective financial modelling work, and prepare for discussion with HWB.

### **3.4 Proposed expansion of Health and Wellbeing Board membership**

At a Health and Wellbeing Board development meeting on 24th October Board members were updated on the progress of initiatives that are working to increase integration across the health, care and wellbeing sector in order to improve the quality of care and improve people's experience of using services when they need them.

The Board also discussed the bigger picture and broader challenge of how to improve health and wellbeing outcomes and prevent avoidable ill-health on a large-scale across the District, as set out in the draft Joint Health and Wellbeing Strategy for 2018-2023, see separate agenda item.

Many Health and Wellbeing Boards around the country have a broader membership than the current membership of the Bradford and Airedale Health and Wellbeing Board in order to address the wider determinants of health such as employment, housing, transport, neighbourhoods and community safety. In Bradford District to date this broader membership has been represented on the Bradford District Partnership Board rather than at the Health and Wellbeing Board.

Board members agreed that the Health and Wellbeing Board should strengthen its focus on the wider determinants of health as routes to improve wellbeing at a population level, and should invite representatives from the social housing sector, the police service, the fire service and the Place directorate of the council to become co-opted members of the Board.

#### 4. FINANCIAL & RESOURCE APPRAISAL

The Better Care Fund (BCF) provides a mechanism for joint health and social care planning and commissioning. It brings together: ring-fenced funds to establish the Better Care Fund that are included in Clinical Commissioning Groups funding allocation from NHS England (NHSE) under NHS Mandate; the Disabled Facilities Grant (DFG) and funding paid directly to local government for adult social care services – the Improved Better Care Fund (iBCF).

The Spring Budget 2017 announced an additional £2 billion to support adult social care in England. This money is included in the iBCF grant to local authorities (LAs) and is now included in Bradford's BCF pooled funding and plans.

<b>Better Care Fund Spend area</b>	<b>Minimum funding 2017/18 £</b>	<b>Minimum funding 2018/19 £</b>	<b>Main use for minimum funding contributions</b>
<b>CCG Contributions</b>			Consistent with national requirement
<b>NHS Airedale, Wharfedale and Craven</b>	7,048,000	7,182,000	
<b>NHS Bradford City</b>	6,257,000	6,376,000	
<b>NHS Bradford Districts</b>	21,886,000	22,302,000	
<b>Out of Hospital Services</b>	16,394,801	16,706,302	Consistent with National requirement
<b>Disabled Facilities Grant</b>	3,857,621	4,195,774	Consistent with National requirement
<b>Care Act 2014 Monies</b>	1,390,451	1,416,870	Consistent with national requirement
<b>Former Carers' Break Funding</b>	£941,558	959,448	Carers offer in line with Care Act duties
<b>Reablement Funding</b>	1,528,886	1,557,935	Consistent with national requirement
<b>iBCF</b>	12,045,821	16,435,418	Consistent with national requirement

#### 5. RISK MANAGEMENT AND GOVERNANCE ISSUES

Governance of the Better Care Programme is through the Bradford Health and Wellbeing Board which, since April 2013, has functioned as a statutory committee of Bradford Council.

Governance arrangements for implementation of the Future in Mind Transformation Plan have been integrated with the all-age mental wellbeing governance structure and delivery group to form an integral part of the governance structure for mental wellbeing in Bradford district and Craven. See governance structure diagram on page 44 of Appendix 1.

## **6. LEGAL APPRAISAL**

The Better Care Fund in Bradford is managed through a Section 75 Framework Partnership Agreement between the Council and the CCGs. The Framework approach was agreed to best reflect where the Council and the CCG are in terms of developing an integrated commissioning approach in that it provides for a dedicated lead commissioner for each scheme. In the event of under spends achieved through prudent fund management, these will be managed in line with the Section 75 agreement.

## **7. OTHER IMPLICATIONS**

### **7.1 EQUALITY & DIVERSITY**

The plans referred to in the report are considered under the terms of the Equality Act 2010 in relation to protected characteristics groups.

### **7.2 SUSTAINABILITY IMPLICATIONS**

The Better Care Fund Plan is a key delivery mechanism for improving health and wellbeing outcomes, supporting people better and for longer in their homes and local communities. It will make a significant contribution to the long-term sustainability of the health and wellbeing sector.

### **7.3 GREENHOUSE GAS EMISSIONS IMPACTS**

No direct implications

### **7.4 COMMUNITY SAFETY IMPLICATIONS**

No direct implications

### **7.5 HUMAN RIGHTS ACT**

No direct implications

### **7.6 TRADE UNION**

No direct implications

### **7.7 WARD IMPLICATIONS**

No direct implications

## **8. NOT FOR PUBLICATION DOCUMENTS**

None

## **9. OPTIONS**

No options are provided

## **10. RECOMMENDATIONS**

1. That the Board approves the update on the Children and Young People's Mental Health Transformation Plan.
2. That the Board notes the progress at Q2 of the 2017-19 Bradford Better Care Fund Plan and compliance with reporting arrangements as set out in Better Care Fund Guidance.
3. That the Board approves the proposal to invite representative of the police service, the fire service, the social housing sector and the Place Directorate of the Council to become co-opted members of the Board and that the changes be included in the Boards Terms of Reference to be considered at a future meeting.

## **11. APPENDICES**

1. Children and Young People's Mental Health Transformation Plan
2. Briefing - Better Care Fund Quarter 2 update and submission

## **12. BACKGROUND DOCUMENTS**

None

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## CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH TRANSFORMATION PLAN

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## 1. Our vision and summary

*Mental wellbeing in Bradford district and Craven: a strategy 2016-2021* (Appendix 1) was developed through close working with district partners including CBMDC, North Yorkshire County Council and VCS organisations. The local *Future in Mind* transformation plan is embedded within our all age strategy and shares its vision of **hope, empowerment** and **support** through a focus on three strategic priorities:

- Our wellbeing,
- Our mental and physical health, and
- Care when we need it.

By 2020, we will work together with partners to ensure that children and young people:

1. will be supported to recognise and value the importance of their mental wellbeing and take early action to maintain their mental health through improved prevention, awareness and understanding
2. can enjoy environments at work, home and in other settings which promote good mental health and improved wellbeing
3. will experience seamless care and have their physical and mental health needs met through services that are integrated and easily accessible
4. can reach their maximum potential through services which are recovery focused, high quality and personalised and which promote independence
5. can expect support to be commissioned and delivered in a way that leads to increases in efficiency and enables transformation of care through reinvestment.

### Achievements

Since the October 2016 refresh, some highlights of our main achievements have been:

- ✓ 67 schools now have 86 mental health champions with 100% good or very good evaluations for impact of support provided.
- ✓ Implemented a new self-harm policy across health and education settings
- ✓ Over 50 schools have accessed Living Life to the Full training
- ✓ Our Health Buddies have supported 211 children and young people reducing waiting lists
- ✓ The average waiting time from referral to treatment was 106.8 days, a reduction of 14.5 days from the average of 121.3, for CAMHS services.
- ✓ The number of Tier 4 occupied bed days decreased from 3,401 in 2015/16 to 2,651 in 2016/17.
- ✓ Bevan Healthcare are delivering schemes to provide refugee and asylum seeking children with mental health and psychological support.
- ✓ The main statutory provider is reporting against MHSDS and Data Quality in 8 of the 14 fields monitored by NHS Digital was above 95% in June 2017.
- ✓ 26 courses were held from April 2016 to March 2017 with 555 staff trained across the universal workforce in Bradford District.
- ✓ Launched the Compass Buzz school wellbeing workers project
- ✓ Established formal alignment with programs such as the SEND, B Positive and SEMH group
- ✓ Greater working with the voluntary and community sector to build support when needed

## **2. Background**

### **Future in Mind**

The Children and Young People's Mental Health and Wellbeing Taskforce was established by the government in 2014 to consider ways to make it easier for children, young people, parents and carers to access help and support when needed. The purpose of the taskforce was to make recommendations to ministers, and agree actions aimed at achieving better outcomes for children and young people with mental health problems. In March 2015 the taskforce published its report and recommendations: *Future in Mind: promoting, protecting and improving our children and young people's mental health and wellbeing.*<sup>1</sup>

**The five key themes articulated in this report were:**

- **Promoting resilience, prevention and early intervention**
- **Improving access to effective support: a system without tiers**
- **Care for the most vulnerable**
- **Accountability and transparency**
- **Developing the workforce.**

### **The Five Year Forward View for Mental Health**

The report of the Mental Health Taskforce, *The Five Year Forward View for Mental Health*, was published in 2016 and builds on the foundations provided by Future in Mind to recommend the system-wide transformation of the local offer to children and young people to achieve improvements in mental health and increased access to high quality healthcare.<sup>2</sup> It also recommends that Children and Young People's Local Transformation Plans should be refreshed and integrated into local area Sustainability and Transformation Plans. This is the refreshed version of the Local Transformation Plan.

The guidance on implementing the Five Year Forward View for Mental Health also emphasizes the need for a joint-agency approach, early intervention and the promotion of resilience, as well as access to high quality, evidence based treatment.<sup>3</sup>

### **Bradford District and Craven Sustainability and Transformation Plan (STP)**

The areas of transformation envisaged by the STP include

- The prevention of illness and the improvement of general health and wellbeing
- The transformation of primary and community services, with the patient at the centre of care
- Implementing a 24/7 integrated care system
- Developing a sustainable system-wide model for urgent care.

Prevention of illness, improved wellbeing, transformation of services and the availability of 24 hour crisis care are all central to this local Future in Mind Children and Young People's Mental Health Transformation Plan.

## West Yorkshire and Harrogate Health and Care Partnership

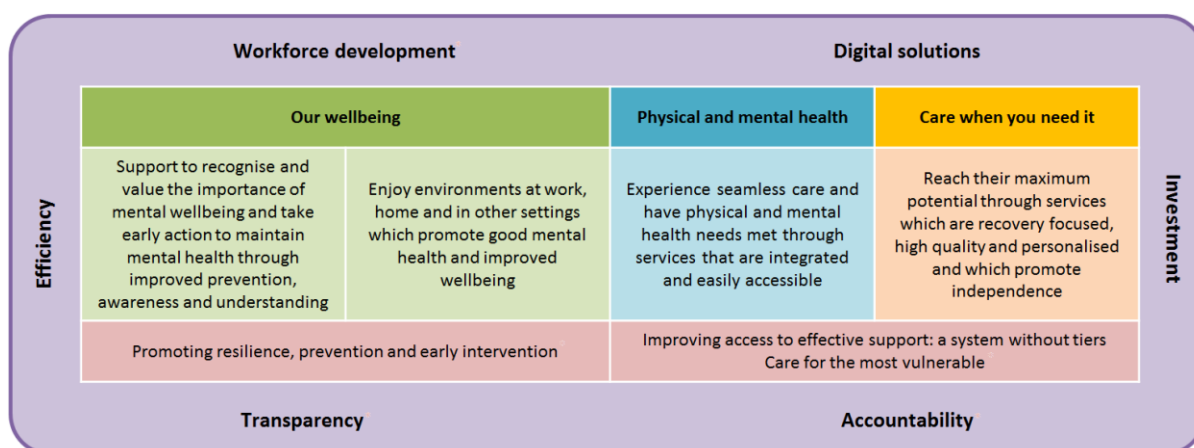
Our local STP aligns to the overarching plans for our region. We want to make sure that mental health services are integrated or combined with physical health services - this will ensure we care and treat the 'whole' person. For example, we will support people with long-term physical health conditions to cope with anxiety or depression.

We are developing services across the area to reduce the difference in the quality of mental health care that people receive in order to improve their wellbeing and make services better.

It is important to us to develop services to improve the experience of care for people in mental health crisis, and we want to reduce the number of people taking their own lives, so we are creating a region-wide multi-agency suicide prevention strategy.

## Mental Wellbeing in Bradford District and Craven: a Strategy 2016-2021

This all age strategy has been developed through extensive and detailed working with partners and stakeholders, and was launched in December 2016. It addresses three principal areas: our wellbeing, our mental and physical health, and care when we need it. These areas are aligned with Future in Mind's work streams and together will help to achieve the five strategic objectives set:



■ Future in Mind objectives set within our strategic objectives of the Mental Wellbeing Strategy.

## Alignment with Partnership Programmes

We work very closely with the Local Authority and other partners in line with our aim to join up services and integrate the way we work.

## Good Health and Wellbeing 2013-2017

*Good Health and Wellbeing 2013-2017* is a strategy to improve health and wellbeing and reduce health inequalities in Bradford and Airedale. Future in Mind is aligned with Priority 7: Improve the mental health of people in the Bradford District.

## **Bradford Children, Young People and Families Plan 2017 – 2020**

Our *Future in Mind* plans align with our districts 'Children, Young People and Families Plan 2017-20 which sets out our vision and our priorities for children, young people and families, how we plan to achieve these, who is responsible, and what success will look like.

The plan will be monitored by [Bradford Children's Trust](#). The trust is the leadership group which brings together all of the partners who work with children and young people. There are 6 priorities of which the following are integral to the Future in Mind strategy.

- Accelerating education and attainment and achievement.
- Ensuring our children and young people are ready for life and work (resilience)
- Safeguarding the most vulnerable and providing early support
- Reducing health and social inequalities
- Listening to the voice of children, young people and families and working with them to shape services

The plan makes specific reference to the need to improve emotional wellbeing for individual young people through the opportunities offered by the Future in Mind Programme.

### **B Positive Pathways (BPP)**

BPP is a £3.2m innovation funded project based on the successful North Yorkshire 'No Wrong Door' project. No Wrong Door seeks to prevent adolescents entering the care system and improve their long term outcomes. The model centres on a hub home with wraparound multi-agency professionals working together.

The BPP service will respond proactively and innovatively to cases that at the moment quickly escalate to full time care. Outreach workers will support young people and families in their own homes responding at the time of crisis and call on the wrap around support to enable families to work through their issues without statutory intervention. The outreach service will be offered 24/7.

BPP is aligned with the Future in Mind work stream for Vulnerable Groups, which includes Looked After and Adopted Children.

### **Special educational needs and disability code of practice: 0 to 25 years**

Future in Mind is aligned with this code of practice, which relates to children with physical and mental health disabilities or impairments.

We have recently aligned the two strategies for SEND and Behaviour and are working to ensure we move towards a sector-led self-improving model of SEND provision where best practice is shared between schools, health and care.

### **Young and Yorkshire 2 (North Yorkshire Children's Trust)**

Future in Mind is aligned with Priority 5: Improve social, emotional and mental health and resilience.

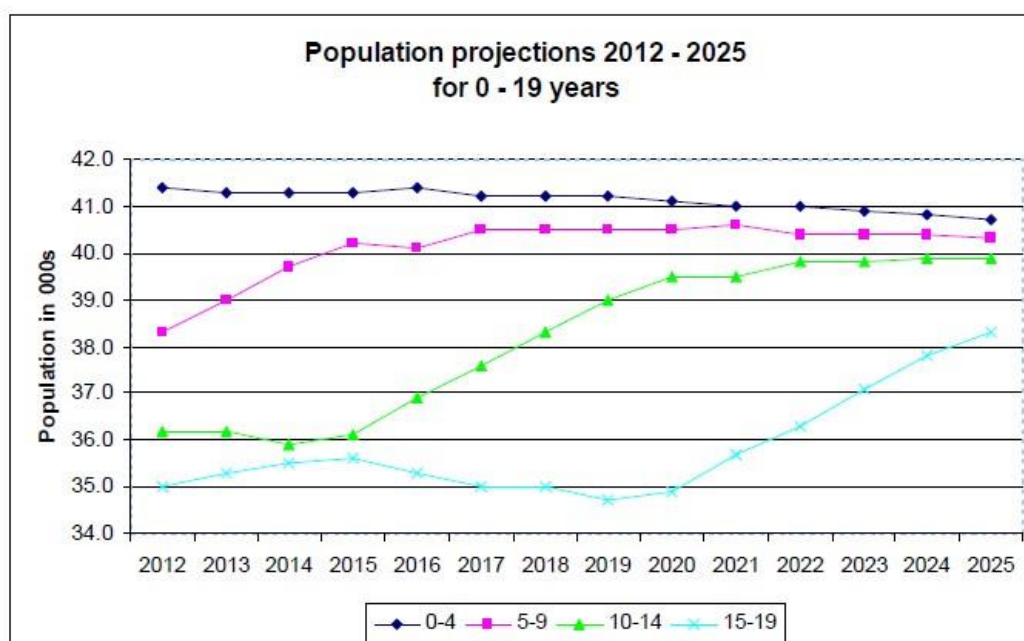
### 3. Health Needs Assessment

A comprehensive health needs assessment for the Bradford district was published in January 2015. It highlighted the fact that Bradford has the third highest population of children and young people in the United Kingdom and that services provided to them are under pressure from national austerity measures. Details of the Health Needs Assessment are in Section 3.

Bradford has the third largest child population in the UK with some risk factors which increase the likelihood of poor wellbeing and mental health, in particular the high numbers of children living in poverty. The overall child population increased by 10.5% between 2002 and 2012, and is projected to grow by a further 5.5% by 2025. This population growth is likely to be concentrated in the most deprived areas of the city where birth rates are currently highest. The 10-14 age group – a key group for the onset of mental health difficulties – is projected to grow by 10.2% in the next 10 years. Bradford’s child population has a number of factors associated with increased risk of emotional or mental health difficulties. The most significant of these is the high number of children living in poverty and disadvantaged circumstances.

Based on data from national surveys, we can estimate that there are currently just under 8,500 children aged between 5 and 15 with diagnosable mental health disorders in Bradford. Between three and four children in every secondary school classroom are likely to have some form of mental health difficulty. However, the number of children with emotional or behavioural difficulties at a lower level is harder to quantify but if we applied the figure in the *Growing Up In Ireland* study to the Bradford child population between 5-15, we could estimate there to be a further 10% of children with lower level difficulties.<sup>4</sup> This would equate to 17,000 children with some level of emotional or mental health difficulty in Bradford. Further, with the expected increase in population in the relevant age bands, we would expect to see a rise to 23,600 children with some level of emotional or mental health difficulty by 2025.

Figure 1: child population and projected increases



These figures suggest that children and young people in many parts of the Bradford district are affected by health inequalities, that is, differences in the health of different parts of the

population.<sup>5</sup> There is convincing evidence that inequalities begin in childhood and widen over an individual's lifetime. By ensuring the best possible mental and emotional wellbeing for children and young people in Bradford district and Craven we intend to reduce inequalities in mental health and also in other areas that can be affected by mental wellbeing, such as physical health and the fulfilment of educational potential.

**Why is children's mental health important?**

An increase in the demand for emotional and mental health services at all levels, including specialist CAMHS services, over and above a rise in proportion with the population, is likely. Prevention, promotion and early intervention will play a very important role in protecting capacity within specialist CAMHS.

One in 10 children between the ages of 5 and 16 has a mental health disorder.<sup>6</sup> For many, this is persistent: successive national surveys show that 25% of children with a diagnosable mental health disorder still had the same disorder three years later.

The majority of adult mental health disorders have their beginnings in childhood. 50% of adult mental health disorders (excluding dementia) have their onset before age 14 and 75% of disorders (again excluding dementia) before the mid-twenties.

*Figure 2: The age of onset for some common adult mental disorders*

<b>Condition</b>	<b>Age group</b>
ADHD	7-9 years of age
Oppositional defiant disorder	7-15 years of age
Conduct disorder	9-14 years of age
Psychosis	Late teens – early twenties
Anxiety disorders	25-45 years of age
Mood disorders	25-45 years of age

(adapted from Kessler et al, 2007)

**Vulnerable groups in Bradford's population**

In every child's history and circumstances there will be factors which may help to build emotional resilience and protect them against mental health difficulties ('protective' factors), or others which, conversely, may make future problems more likely ('risk' factors). We also know that certain groups of children are much more likely to experience mental health difficulties than the population at large.<sup>vi</sup>

*Figure 3: Specific vulnerable groups within Bradford's population*



<b>Vulnerable Groups</b>	<b>Situation in Bradford</b>
Children with learning difficulties and disabilities	A recent needs assessment identified 19,219 children and young people with a SEN or disability. For just over 50% (9,940 children) this need related to learning. Our local <i>Children and Young People's Health and Lifestyle Survey</i> (2013) found that children with SEN were more likely to have low self-esteem.
Refugee and asylum seekers	There are small groups of asylum seekers and refugees who come to the district who have very high levels of need, including mental health needs. Refugees are about ten times more likely than the age-matched general population to have post-traumatic stress disorder (PTSD): 9% of refugees in general and 11% of children and adolescents have PTSD. <sup>7</sup>
Children with chronic physical health problems	Bradford has the highest prevalence of children in the region with complex medical conditions considered 'life limiting' – there were estimated to be 595 such children in Bradford in 2011 (Fraser, 2011). 335 children are currently receiving support through the Children with Complex Health and Disabilities team.
Lesbian, gay, bi-sexual and transgender (LGBT) young people	There are no officially available statistics on the numbers of LGBT young people in Bradford. Between 5% and 7% of the adult population are estimated to be LGBT – this would equate to 1,750 out of the 35,000 15-19 year olds in Bradford.
Looked-After Children	In 2017 Bradford was responsible for 925 Looked-After Children <sup>8</sup> . The rate of Looked-After Children per 10,000 children aged under 18 is similar to the Yorkshire and Humber average. Both rates show an increase from 2016.
Children and young people in the criminal justice system	In 2015/16 the rate of children and young people entering the Youth Justice System for the first time was 425 per 100,000. This was a decrease from the previous two years but above the average of 397 for all English metropolitan boroughs. <sup>9</sup>
Children with Autism	In 2013 local GP data showed that 1061 children (0-18 year olds) were recorded as autistic on the GP clinical system. By 2017 this has increased to 1896 (nearly 80% increase).
Children from BME backgrounds	Black and minority ethnic groups have the youngest age profile, with 65.8% under 25 years of age. Of the South Asian ethnic groups, the Bangladeshi ethnic group has the youngest age profile - 42.2% are under 16 years of age and 57.4% under 24 years of age. We also have new young age residents from Eastern Europe <sup>10</sup> .

## Recommendations of the Health Needs Assessment

The health needs assessment for Children and Young People's Mental Health makes the following recommendations:

1. To review and redesign services to provide maximum capacity in community and school-based interventions, protecting the capacity within specialist CAMHS and responding to what children and young people tell us about their ideal services (Future in Mind: Schools Engagement work stream).
2. To continue to support and expand workforce development and the 'skilling up' of workers in universal services who have day-to-day contact with children, for example through the CAMHS training programme for GP practices and school nurses (Future in Mind: Workforce Development work stream).
3. To continue to promote the role of schools in supporting children's mental health and emotional wellbeing, and as potential direct commissioners of services (Future in Mind: Schools Engagement work stream).
4. To consider the potential of other professionals and organisations to extend the services they offer to meet need, for example VCS organisations, school nursing.
5. To plan and deliver a mental health promotion strategy for children and young people through schools and community settings (Future in Mind: Schools Engagement work stream).
6. To ensure that support for children who present with behavioural difficulties is considered as an integral part of the overall system for children's emotional wellbeing and mental health (Future in Mind: Schools Engagement work stream).
7. To continue to design services in ways that support access for children and young people from black and minority ethnic (BME) communities, particularly the South Asian community and the growing Eastern European community.
8. To create strong links between children's mental health services, early years' services and parenting and family support.
9. To consider representation from health visitors or other early years services at the Mental Health Matters in Schools group.

#### **4. Engagement and involvement**

The development of our children and young people's mental health transformation plan was informed by consultation with a number of key stakeholders including, most importantly, the involvement of children, young people and their families. There has also been involvement from schools, the local authority, health commissioners and providers, voluntary and community sector (VCS) and specialised commissioning colleagues. Involvement with the local Crisis Care Concordat planning group has also been important in establishing the needs of young people within this agenda. A survey of schools in the area has been undertaken to inform the process with regard to local access and experience of mental health services overall. This informs both this transformation plan and our overarching children and young people's mental health commissioning strategy.

We have sought the views of children, young people and their families through the CCGs' 'Grass Roots' system,<sup>11</sup> the People's Board, engagement events with young people about self care and mental wellbeing, consultation with young people who accessed Children and Adolescent Mental Health Services (CAMHS) and psychological therapies, work with local schools, youth and arts projects, work with GP practices and universities, work with young women and children and young people from vulnerable groups, and discussions with parents and carers.

We will continue to involve children, young people and their families in the co-production of our plans and services throughout the transformation that we plan.

North Yorkshire County Council has co-ordinated additional activities covering the Craven area including The Voice, Influence and Participation team (VIP) to facilitate opportunities for Looked After Children and care leavers (Young People's Council), and Flying High for young adults with Learning Difficulties and Disabilities to meet on a regular basis to seek their views and thoughts on services which affect them in North Yorkshire including mental health services. Details of engagement and participation in North Yorkshire are in Appendix 2.

The main themes identified from our engagement to date are:

- Communication
- Access to services
- Experience of services

#### **Providers**

Schools and colleges were seen as core to providing services, with the information, support and direction offered by non-academic staff such as mentors, school nurse and even peer support leaders seen as determining factors in people choosing to access services. The importance of support available during waiting times was highlighted and the role of community support, family involvement was central during this period.

The importance of working with voluntary and community groups in helping young people to understand and access appropriate early support was underlined. They also played a vital role in involving the family and providing carer support.

#### **Local Transformation Plan summary for children and young people, parents and carers (Appendix 3)**

During early 2016 Barnardo's worked with groups of children and young people to develop a version of the Local Transformation Plan that clearly outlines its background and key elements.

The summary is succinct and engaging, and has now been approved for publication through the Future in Mind governance structure. It provides clear information about our plans to this most important audience.

#### **Youth Voice event August 2016 (Appendix 4)**

The Youth Voice event involved children and young people with experience of accessing mental health services, and some parents. It provided an opportunity to ask commissioners and providers about service developments in health and education and influence developments. The views expressed supported information given during previous engagement that some children and young people might hesitate to approach a GP or school nurse about mental wellbeing issues. They also confirmed the overriding importance of being able to access staff with whom they felt comfortable.

#### **Young people's #selfcareeverywhere work**

Children and young people lead a series of workshops and events to explore the experience and service needs of mental wellbeing and physical health services. The workshops enabled young people to work with schools, local authority, NHS staff and commissioners to shape developments for mental and physical health services. Key areas of exploration included long term conditions, body image, self-esteem, confidence, mental health crisis services, stigma and discrimination and having positive relationships.

#### **Youth in Mind**

As we have developed new services as part of our Future in Mind transformation plans, including the establishment of Safer Spaces, Health Buddies and digital tools, we have constantly involved young people in the development. Films and case studies from the work have been shared.

## 5. Promoting resilience, prevention and early intervention (Wellbeing)

### Schools Engagement

Children and young people told us:

*“All staff should be confident in their ability to spot and support emotional and mental health issues. Workers we have day to day contact with and who we trust need to have these skills to help us. It is not good enough to just have individual specialist workers that cover a wide area. These workers have no chance of providing all the support needed.”*

### Planned changes 2015-2020

<b>Develop and implement a collaborative commissioning model with consistent reporting mechanisms and governance structures.</b>
Future in Mind forms an integral part of the governance structure for mental wellbeing in Bradford district and Craven. This structure is reproduced at Appendix 5.
<b>Services working in schools will focus on early intervention and the development of a workforce that can promote resilience and self care.</b>
The Healthy Child Programme (Craven) and school nurses (Bradford) have been providing low level mental health input and have been working in partnership with Primary Mental Health Workers to manage young people’s mental health problems at the lowest level. There is now a School Nursing lead for Mental Health.  The Mental Health Matters in Schools group has been reconvened to provide a forum for commissioners, providers and school staff. It reports to the Future in Mind Project Group.  In addition to the Mental Health Champions project, CBMDC Early Help links with schools to provide access to an appropriate level of social care with input from Primary Mental Health Workers where this is indicated.
<b>PMHWs will be clustered to schools acting as the link to the pathway for support and advice in relation to children and young people’s emotional health and wellbeing. They will work alongside universal services such as health visitors and school nurses being visible in the community offering support and advice to ensure care and support is offered at the right level and at the right time in the right place. PMHWs will facilitate the signposting and transition onto more intensive support in specialist CAMHS or signposting into community-based voluntary services.</b>
Primary Mental Health Workers (PMHWs) continue to work in schools liaising with School Nurses and other staff.
<b>Extend access to WRAP, which has been successfully implemented with children and young people to help manage mental health problems through a solution-based focus.<sup>12</sup></b>
The Wellness Recovery Action Planning ‘WRAP’ programme was developed to support adults to mental wellbeing. In Bradford WRAP has been developed to provide a self-designed prevention and wellness process that all children and young people can use to get well, stay well and make their life the way they want it to be. It has been piloted through Barnardo’s and has had good initial feedback.

## Establish Mental Health Champions in schools.



### Mental Health Matters FIM Schools I

A plan to establish a network of Mental Health Champions in schools has been agreed to build capacity and confidence to address mental health in schools, develop and provide resources and guidance to school staff, parents and community partners, facilitate multi-agency work and enable swift access to specialist CAMHS professionals. The Mental Health Champions will increase capacity to meet low level mental health needs in the school environment and facilitate referral to other services including specialist CAMHS when appropriate. Budget, staffing and lead roles have been agreed. Schools in the Craven area have been invited to participate in the project.

- 86 schools attended Mental Health Champions Launch Conference in February 2017.
- 67 schools have signed up for Mental Health Champions Initiative.
- 67 schools have attended the Mental Health Champions' Network Meetings.
- Over 50 schools have accessed Living Life to the Full training and licence requests are being processed. This is a PHE recommended intervention.

Evaluations have been 100% good or very good for impact of support provided via network meetings to support Mental Health Champions to support pupils in schools.

It is estimated that each Mental Health Champion will provide targeted support to at least 10 pupils experiencing mental health difficulties or distress. This equates to involvement and impact for 670 children and young people across Bradford.

In addition to accessing specialist support from the Educational Psychology Team and CAMHS via shared supervision at network meetings, Mental Health Champions in schools are delivering psychoeducation themed assemblies for pupils with the aim of giving information, exploring self-help strategies, reducing stigma and signposting support

The potential impact on all pupils attending project schools was identified through informal pupil feedback forms and informal response from Mental Health Champions delivering the assemblies as:

- Collecting information on pupils who self harm
- Delivering robust and culturally sensitive information to pupils and parents about self harm
- Using a consistent LA wide approach to addressing self harm
- Supporting parents to have difficult conversations with pupils
- Ensuring that pupils have access to appropriate psychoeducational resources about a range of mental health matters, including 'Getting Through Tough Times'

Attendance at community events such as the 2017 Dragon Boat Festival) and the Bradford Mela helps establish community presence, raises awareness and gives the opportunity to engage with the public, including parents and young people, across a range of contexts.

A task and finish group has been established; one task will be to build in monitoring systems to provide more detail on numbers accessing the resource.

Links have been established with CAMHS for training and built into the programme for the academic year.

The project is working to establish links with parents, carers and pupils in planning and delivery by

exploring existing participation system, holding a stall at young person's engagement event on 18th November and circulating a questionnaire to collect views. Responses are currently being collated.

Momentum for Mental Health Champions has been maintained during a change in coordination of the project and two further meetings took place in October.

Barnardo's and 'Yoomee' have been commissioned to develop a website with information and advice for young people navigating adolescence, with signposting to services and real stories. This website, [Thrive Bradford](#), is now live, providing information to young people on mental health and wellbeing matters and on local services available. A campaign to publicise the site is complete and usage is being monitored.

#### **Outcomes**

- Continued attendance by school Mental Health Champions and positive evaluations of meetings.
- Website launched.
- Press article promoting the initiative and supporting the agenda of de-stigmatising mental health. <sup>13</sup>
- Assemblies available and pupil evaluation available.
- Self harm protocol agreed and shared.

#### **Challenges**

- Project evaluation including measure of usefulness of resources (planned focus of Delivery Group).
- Inclusion of parent and pupil engagement in planning and delivery.
- Extension of offer to wider group of schools.
- Reduced allocation of time from Educational Psychology Team has been allocated to the project.
- Long-term sustainability of project.

#### **Craven: North Yorkshire School Mental Health Project (Compass Buzz)**

The project went live on 1<sup>st</sup> April 2017. Initially monthly meetings are being held to keep abreast of implementation and when established, the meetings will be changed to quarterly.

The project aims to improve and strengthen the support for children and young people's emotional and mental health issues across all schools in North Yorkshire. Further details on the service commissioned are outlined in the service specification and the project implementation report for April (embedded below). The project plan from the provider is also included below.

A key risk for the project is the large geographical area the project will have to cover and service will be offered based on need. The providers plan to complete an audit of schools to identify where the need is.

Key Actions completed by Compass to date (October 2017):

Number of North Yorkshire schools who have accessed Level 1 training	10
Number of staff who have accessed Level 1 training	275
Number of staff reporting increased confidence following training	128*

\*105 evaluation forms have not been included as they remain to be analysed.

In addition to these school staff 28 key partners (Prevention staff and NYCC No Wrong Door staff) have completed the Level 1 training with Compass BUZZ.

Airedale, Wharfedale and Craven CCG commissioners receive papers for Compass contract management meetings and are fully informed of progress.

### Single point of access

Children and young people told us they wanted:

*“someone we can trust,”*

*“access to speak to someone when I need to,”*

*“to be able to book an appointment if I need to in the same week.”*

### Planned changes 2015-2020

<b>Early Help Hubs provide access to care services for families with additional support needs.</b>
The Early Help hubs have been piloted and extended across the CBMDC district. Through Future in Mind investment, Primary Mental Health Workers have been appointed into the Hubs and panels which identify the most appropriate pathway for each family.
<b>Provide single point of access for urgent and emergency mental health needs</b>
The First Response service provides a single point of access 24 hours a day for referrals including self-referrals for urgent and emergency mental health needs for children and young people.



## 6. Improving access to effective support: a system without tiers

### CAMHS

#### Specialist CAMHS

In 2016/2017 1881 referrals were accepted into CAMHS and the active caseload was 2005 at 31 August 2017.

Pathway review and transformation is taking place working alongside [Youth in Mind](#) with a focus on improving access and growing the workforce.

#### CAMHS waiting times

The buddying project to support young people and reduce waiting list numbers expects to support 500 young people during 2017/18. At 30 September 2017 there were 570 children and young people on the CAMHS waiting list, a reduction of 211 from 781 at the end of September 2016.

At 30 September 2017 the average waiting time from referral to treatment was 106.8 days, a reduction of 14.5 days from the average of 121.3 at the end of September 2016.

Numbers on CYP under 18 on waiting list	Baseline 30/09/16	Latest position known 30/09/17	Quarter 3 reduction 31/12/2016		Quarter 4 reduction 31/03/2017		Quarter 1 reduction 30/06/2017		Quarter 2 reduction 30/09/2017	
			Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual
Total number of CYP waiting for treatment	781	570	10 (771 waiting)	78	40 (741 waiting)	-19		252 (529 waiting)		211 (570 waiting)
Average waiting time from referral to treatment (days)	121.3	106.8	1.3 (ave time is 120)	2.1	6.3 (ave time is 115)	4.9		15.5 (ave time is 105.8)		14.5 (ave is 106.8)

	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18
Number of children and young people referred in quarter	616	708	837	691	469
Average waiting time from referral to treatment (days)	121.3	119.2	116.4	105.8	106.8
Number of CYP waiting for treatment for 4 - 6 weeks	48	60	58	47	30
% waiting for 4 -6 weeks	2.1%	2.6%	2.4%	2.1%	1.4%
Number of CYP waiting for treatment for 6 - 8 weeks	44	55	69	54	39
% waiting for 6 - 8 weeks	1.9%	2.3%	2.8%	2.4%	1.8%
Number of CYP waiting for treatment for 8 - 10 weeks	34	36	50	38	33
% waiting for 8 - 10 weeks	1.5%	1.5%	2.0%	1.7%	1.6%
Number of CYP waiting for treatment for more than 12 weeks	488	412	439	245	332
% waiting more than 12 weeks	21.6%	17.6%	18.0%	11.1%	15.7%

## Buddy Scheme

Trained 'buddies' will be allocated to children and young people on waiting lists for specialist mental health services. The buddies will maintain contact with and support young people until specialist therapy can begin. We anticipate that this will reduce the number of appointments that are not attended, improve use of clinical time and therefore reduce the lengths of waits. The project is based on a proposal originating with children and young people who worked with Barnardo's during 2015/16.

Since launch in April 2017 CAMHS have referred 227 young people to the Buddy Scheme. In quarter 2, onward referrals started being made to Youth in Mind partners; 4 referrals to Yorkshire Mentoring for ongoing one to one support with volunteer mentors, 40 referrals made to Barnardo's for 10-week WRAP group programmes being run at 5 venues across the district.

MYMUP Version 2 has launched; giving access to a wide range of online interventions that promote resilience, empowerment, life skills and self-care. The updated system produces comprehensive reports detailing engagement and distance-travelled. MYMUP are providing targeted one to one support around use of the digital platform; consequently there has been a surge in engagement with online interventions and profile-building.

All partners submit quarterly reports detailing progress with KPIs. The steering group meetings 3-weekly to efficiently track progress, identify and address challenges and ensure the model remains responsive and adaptable to changing need. Summary data for quarter 2 has been submitted for Buddies and WRAP. Quarter 2 data for Yorkshire Mentoring and MYMUP to be submitted end of October 2017.



KPI Monitoring  
Q1&2.docx

Partners are working closely to build trusting relationships, streamline referral pathways and embed the model. At a recent full service event, attended by 60 members of staff from all partners; CAMHS, Youth Service, Yorkshire Mentoring, MYMUP and Barnardo's, successes were shared and celebrated, challenges addressed and forward planning put in place. Additionally, partners meet one to one, attend each other's team meetings, arrange locality based multi-agency lunch breaks and co-train to continue shared learning and relationship-building.

Buddies currently accept Wave 1 and 2 referrals, targeting CAMHS wait times for treatment and initial assessment, respectively. Furthermore, the flexibility and adaptability of the model allowed for an unanticipated cohort of referrals from CAMHS, of young people already receiving treatment. Buddies support this cohort in partnership with allocated CAMHS practitioners to target the reduction of DNAs and impact waiting times by facilitating move on from specialist CAMHS.

The model will open to Wave 3 referrals in quarter 3; initial plans in place to target schools with support from Sharing Voices Bradford to address underrepresentation of referrals from BME backgrounds.



Buddy Referral  
Demographics Q1&2.docx

The model is currently based on 5 virtual access hubs across the Bradford District and Craven; preliminary plans are in place for a crisis café in Holmewood that will be the first physical hub, offering crisis support but with a strong focus on building resilience and promoting emotional wellbeing, to reduce the need for crisis services.

Buddies provide support with building resilience, learning self-care techniques, reducing barriers to accessing local community-based services and activities, exploring interests and hobbies, building support networks, becoming more physically and socially active, getting back into education, engaging with other professionals and services and much more.



Q1 17-18 Buddies Case Studies.docx



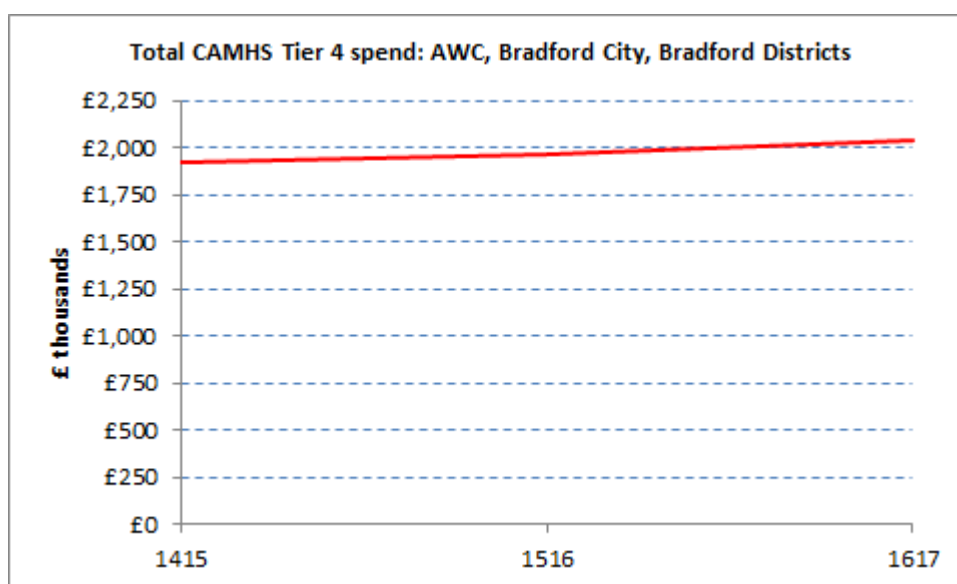
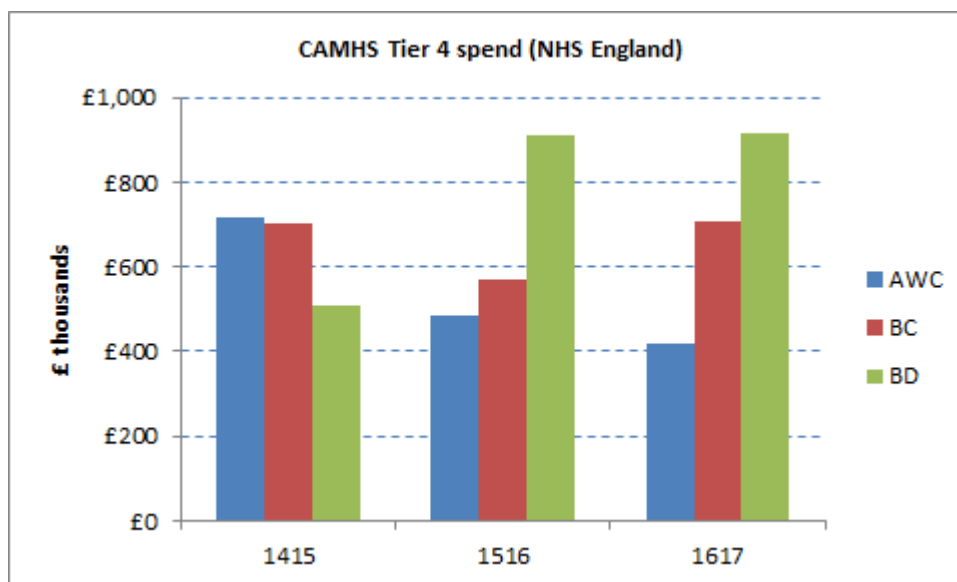
Buddies Case Studies.docx



Q2 Case Studies with Video Links & Distane

#### CAMHS Tier 4:

#### Spend and activity

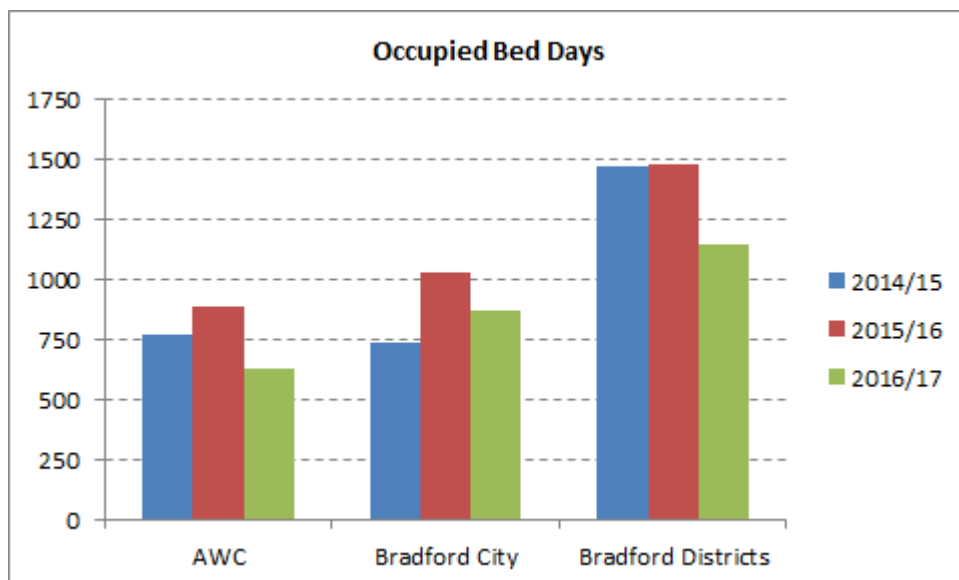


The National Specialised Commissioning Oversight Group (SCOG) decided in March 2016, that a single national procurement would not be in the best interest of patients and the approach taken

would need to strengthen the requirement for regional planning and delivery. It would need to align with, and support the move to population based commissioning and the outputs of this work would need to be embedded in local systems. To reflect this, NHS England revised its approach to one of local ownership and delivery under the umbrella of national co-ordination and oversight and is now referred to as the Mental Health Service Review (MHSR) programme.

A key factor and driver in the service review has been a lack of capacity in some areas that has led to out of area placements. The proposed changes in bed numbers aim to address this and ensure that for the majority of services, the right number of beds are available to meet local demand in each area. It is predicated on the principle that there is regard to patient flows so each local area should “consume its own smoke”. As these services are specialist in nature, there is national oversight of this process but with a strong emphasis on local engagement and ownership.

The implementation of local plans will see the re-distribution of beds across the country so patients will be able to access services closer to home rather than having to travel to access appropriate services, except for a few particularly specialist services that it is uneconomic to provide in each area. NHS England is collaborating with local commissioners on the CAMHS Tier 4 bed changes in Yorkshire and the Humber to ensure the interdependencies between localities are managed effectively.



### Expected reduction in admissions

Investment in First Response Service and expansion of Intensive Home Treatment as an all age service (working with CAMHS out of hours service) will have an impact on use of Tier 4. Also the development of the Safe Space through the West Yorkshire UAE Vanguard as an alternative placement in order to de-escalate crisis presentations will have a positive impact on use of Tier 4.

### Crisis intervention

First Response Service developed as an all age open access crisis response service operational on a 24/7 basis. It has had a positive impact on Adult Mental Health reducing OOA placements to zero for 18 months. With access to age appropriate First Response Service, Intensive Home Treatment and Safe Space we anticipate a similar impact in Children and Young People’s Mental Health.

## **Eating disorders**

Further development of the specialist eating disorder and Intensive Home Treatment service (formerly known as SPEEDIHT) will reduce the need for inpatient treatment of eating disorders establishing a dedicated team of professionals to deliver home based packages of care.

## **Children and young people with Learning Disabilities**

BEST project in Bradford has been successful in providing timely assessment for children and young people with Learning Disabilities and has prevented escalation of crises to Tier 4. This service continues to be jointly commissioned between LA and CCGs.

## **New Care Models**

Bradford District Care Foundation Trust in partnership with Leeds and York Partnership Foundation Trust, Leeds Community Healthcare Trust and South West Yorkshire Partnership Foundation Trust have been successful in a bid to NHSE to be part of the CAMHS Tier 4 New Care Models programme. This will see the alliance take control of current spend on Tier 4 provision for our local areas with a view that we will transform the community offer to children and young people in crisis and look to reduce length of stay and use of tier 4 beds thus reinvesting in community services. We are adopting a Care Navigator approach across the locality providing robust gatekeeping, bed management and facilitating of pathways and transitions. We will also ensure that across our footprint children and young people will have consistent and robust access to crisis care and home treatment. Particular focus will be given to those young people who experience high levels of emotional distress and dysregulation, potentially from the Looked After system who can often become 'stuck' within the inpatient estate. Across the alliance we are establishing a clinical network of experts to look at developing robust community pathways for this group of young people. The pilot is set to mobilise in October 17 lasting for 2 years.

Across Bradford we will look to refocus our offer of Home Treatment to young people at the point of crisis utilising both existing capacity and also reinvestment via the New Care Model successes. Key activities across 18/19 and 19/20 are

- Identify senior clinical leadership and capacity to oversee service development and pathway management for Home Treatment
- Embed the Care Navigator role into the local CAMHS pathway; creating networks, promoting best practice in managing young people in crisis across the CAMHS workforce
- Re-align and ring-fence capacity within existing CAMHS creating clear job plans around Home Treatment thus increasing flexibility and capacity to offer enhanced/intensive support at home
- Develop an offer of evidence based interventions available to young people in crisis and requiring home treatment to include the use of group based interventions
- Develop a training strategy to support the delivery of interventions
- Utilise New Care Models reinvestment to recruit additional staffing for Home Treatment from across the MDT with a breadth of skill mix acknowledging workforce challenges. This includes the recruitment of band 4 staff, PWP type roles and Allied Health Care Professionals.
- Recruit Parent Support Worker; acknowledging the importance of Parental involvement and Parent specific support. Learning from the Rollercoaster Parent Support Group available in the North East.

## **Early Intervention in Psychosis**

Bradford and its three CCGs have a fully commissioned and NICE Compliant EIP service in line with the Better Access and Waiting Time Standard. Additional investment to expand the age range and offer of interventions were agreed in April 2016 (separate to the Future in Mind transformation developments). A full recruitment plan has been implemented with staffing now all in place. The pathway is self-referral and can be accessed across all internal and external sources.

The Service pathway is for age 14 upwards again in line with Better Access and Waiting time standards. EIP have 3 EIP practitioners co-located within specialist CAMHS embedding the pathway and ensuring referrals are expedited.

The full BDCFT offer of EIP with fidelity to the model has been in place for 11 years including EIP practitioners being embedded within specialist CAMHS. In 2015 after the announcement of the Better Access and Waiting Time standard BDCFT completed a gap analysis based on the commissioning guidance to look at workforce and service development to provide a NICE compliant offer of service, expansion of the age range and ability to meet the waiting time target. All recruitment has now been realised and capacity for the 14-18 age range is protected. Additional Psychological therapy provision has been provided to offer the extension of service to the at risk mental state group (ARMS), again in line with the Better Access and Waiting Time Standard. The service reports in line with national requirements on the waiting time standards and have completed the EIP Network Self-Assessment.

During Q2 2017/18 60 of 94 people who started treatment for a first episode of psychosis were treated within two weeks of referral.<sup>14</sup> The age range has been extended and the team has been fully recruited to meet the NICE requirements and are meeting the 50% Better Access waiting time standard.

## Crisis Care

Children and young people told us:

*“No waiting list – we should get help when we need it. Not months down the line when we have to rake it all up again. More services that we trust and work with should be able to refer into specialist services such as CAMHS. GPs and school nurses are the referral route but some of us will not use these as we do not know them, they may be a community GP and know our family and we worry about confidentiality, so how do we get the help we need?”*

*“When I need to talk, services should be made available.”*

## Planned changes 2015-2020

Through development of an established intensive home treatment approach in the Bradford district and building on the success of the Crisis Care Concordat and First Response service, the transformation plan can help the service to reach any children and young people in crisis wherever and whenever they present, reducing inpatient admissions and providing care closer to home.

BDCFT CAMHS offer 24/7 cover to existing CAMHS clients via the CAMHS consultant on call 7 days per across the 24 hour period and CAMHS Community Mental Health Nurses at weekends 9am-5pm. The service responds to young people supported by CAMHS and requiring home treatment and to young people presenting at A&E following self harm.

The 24/7 First Response Service (FRS) provides a co-ordinated point of access and response 24/7 for crisis referrals across all ages and is a direct access point for all professionals, children and young people and families. All interview panels for posts with the FRS include representatives from children’s and young people’s services. CAMHS specialist practitioners are being recruited through Future in Mind to ensure that the needs of children and young people are supported when in crisis across the 24 hour period. This includes specialists with autism and learning disabilities experience so that unnecessary escalation to admission can be avoided. The FRS ensures a response that is rapid and proportionate, and provides signposting to the most appropriate setting.

### First Response Service workforce

- 1.0 Band 7 Team Manager
- 14 WTE Band 6 First Responders (3.0 WTE CYP)
- 18 WTE Band 5 Tele-coaches (PWP qualification)
- 6 WTE Band 7 Advanced Nurse Practitioners
- 3.8 WTE Band 3 Support Workers

All FRS staff are beginning a period of induction and shadowing in CAMHS. This will offer FRS staff an opportunity to work alongside core CAMHS clinicians, understand the pathways and offer of interventions within the service. This will support relationships and smoothing of transitions for young people accessing the crisis pathway and ensure care is offered at the right time, in the right place by the right person.

### First Response Service activity

Between January and July 2017 FRS offered triage and crisis assessment to 283 children and young people under 18.



## **Youth in Mind**

Airedale, Wharfedale and Craven, Bradford City and Bradford Districts CCGs are working in partnership with Bradford District Care NHS Foundation Trust, Bradford Metropolitan District Council's Youth Service and four VCS providers, Creative Support, MYMUP, Barnardo's and Yorkshire Mentoring, to create an alternative offer to crisis through promoting resilience and emotional wellbeing, demonstrated by the following outcomes:

- Improve access and quality care standards for CYP in crisis
- Improved experience and quality of services for young people and their families in crisis
- Treat people closer to home
- Reduce unnecessary A&E attendance, police custody and Tier 4 / paediatric admissions for young people in emotional distress
- Improve access to CAMHS, reduce DNA appointments and maximise workforce capacity by diverting Tier 1 & 2 information and signposting into VCS
- Work more closely with the Early Help agenda, strengthen promotion of emotional wellbeing emotional resilience of children and young people in schools to shift away from crisis.

Children and young people have been involved in all recruitment into CAMHS including the development of these recent initiatives (Safer Space, Buddy scheme) and assisting with research, branding and design of information.

## **Safer Space**

A Safer Space is open 22:00 - 10:00 seven days a week, however, following requests from referral partners and young people, 6-month trial provision Mar-Sep 2017 was put in place for a 24hr Referral Coordinator and opening hours were extended to 19:00 - 10:00. During this time referrals increased considerably; 13 admissions October 2016 to March 2017, 35 admissions April to October 2017. 65% of referrals over the latter period were made between 16:00 and 22:00. On average, young people arrive on site with 90 minutes of the initial referral enquiry.

Primary referral pathways into Safer Spaces are First Response, CAMHS and the Local Authority's Emergency Duty Team. Work is currently being undertaken to open the pathway further, to daytime Social Workers. Stakeholder engagement is ongoing with GPs, School Nurses, Mental Health Champions in schools and the VCS. Plans are in place to establish a firm, two-way referral pathway between Safer Space and Buddies, to support the integrated model.

The Safer Space is staffed by 4 WTE mental health support staff, has a team of 3 regular relief support staff and 1 PT Project Manager. Support staff have significant, wide-ranging mental health experience with children and adults, on wards, in supported accommodation and community-based/outreach. Service-specific training is provided by the Local Authority and Bradford District Care NHS Foundation Trust. A joint training programme for Safer Spaces and Buddy Scheme partners is in place, supporting upskill of the workforce. CAMHS plan provide ongoing training and clinical group supervision around risk management and staff resilience and wellbeing. Additionally, third sector partners are providing training around LGBTQ Awareness and Dependency Reduction.

## **Activity**

The Safer Space had 20 admissions 1st July - 30th September 2017, a total of 46 admissions since opening.

Monthly updates completed for the Safer Spaces Steering Group cover referral statistics, demographics, case studies, referral source, presenting needs, feedback and challenges.



Towerhurst Update -  
Sept 2017.docx

### **Participation by children and young people**

Consultation is provided by Barnardo's Youth on Health Participation Group. The group provides guidance about service provision (referral pathways, opening times), physical environment, evaluation and involvement of service users and their families.



Safer Spaces & YIM  
Participation Report -

### **Perinatal mental health**

Building on CCG investment which was utilised to support the development of perinatal mental health pathways and training for professionals such as Midwives, Health Visitors and mental health providers to enable earlier detection and intervention for vulnerable individuals, Bradford District Care Foundation Trust were successful with their bid to NHSE for Perinatal Mental Health Community Development funding. This funding is being utilised to develop a specialized team to offer:

- specialised early assessment by a consultant perinatal psychiatrist
- early and preventative interventions using a biopsychosocial approach
- intensive intervention, specific care planning, a women- and family-centred approach
- greater continuity of care so that the women's families' experience is one of a seamless service which is flexible to the needs of service users and families.

The CCGs sponsored this proposal and will, subject to positive evaluation, continue to fund the service once the NHSE Community Development Fund allocation ends.

Colleagues in Better Start Bradford (a Big Lottery funded programme working within Bradford) have developed a number of initiatives to support women with perinatal mental health issues. The CCGs are working with Better Start Bradford to learn from their projects with a view to mainstreaming evidence based practice which is proven to improve health outcomes in this area.

### **Autistic spectrum**

Access to FRS and IHTT is not restricted by condition. Children and young people with ASC, ADHD and other developmental disorders will have access to crisis intervention around the clock in the event of a mental health crisis.

Work has also been undertaken to review the pathway for Neurodevelopment across the CCGs and Bradford District Care Trust. A new model and costings have been proposed.

## Eating disorders

Children and young people told us:

*“People working with children and young people should know how to respond to eating disorders.”*

## Planned changes 2015-2020

### Clients receive prompt access to a NICE-approved package of care

BDCFT CAMHS already has a well-established pathway to provide intensive care at home for children and young people with Eating Disorders. This service is recurrently funded by Airedale, Wharfedale and Craven CCG, Bradford City CCG and Bradford Districts CCG. To respond to the new Access and Waiting Time Standard to be implemented from April 2016, the service reviewed the current pathway and provision and completed a gap analysis of required provision and associated investment. The gap analysis identified a recruitment and workforce plan to expand and develop the service between 2015 and 2020, including recruitment of a team manager, dietitian, additional consultant psychiatry, psychological therapy and assistant psychologist. Recruitment to Eating Disorders service is partially complete and phased implementation is taking place.

All referrals are being seen within the better access and waiting time standard. Information systems are in place to measure waiting times and NICE-concordant interventions in line with commissioning guidance. The Community Eating Disorders service is affiliated to the QNCC / CCQI.

Additionally as part of CYPIAPT development outcome measures related to evaluating interventions for Eating Disorders are being added to the RiO system.

The team have developed their clinical pathway in line with The Maudsley model and clinical pathway. This includes mapping outcome measures and qualitative feedback tools to support ongoing service development. The team are delivering training to the wider workforce and supporting early detection and identification within schools via the MH Champions in Schools Project and Workforce Training plan with Sue Sykes.

Junior MARSIPAN groups are in operation across the Acute Hospital Sites led by ED Consultants and Paediatrician.

The Children and Young People’s Eating Disorders service is affiliated to the Royal College of Psychiatry (RCPSych) Centre for Quality Improvement (CCQI) and Quality Network for Community CAMHS (QNCC).

### Activity

From October 2016 –October 2017 there has been 83 new referrals. This is exceeding predicted referral rates and trajectory is being monitored across 17/18 for review with commissioners in 18/19.

There is an active caseload of 86 clients.

## Workforce

The team staffing structure has been developed in line with the commissioning guidance and consists of:

Role	WTE	Additional Skill set, Offer & training
Consultant Psychiatry	1.1	Multi Systemic Family Therapy
Team Manager/Nurse	1	
Specialist ED Nurse	2.6	CYPIAPT Family Therapy for ED
Support Worker	1	Evidence Based Practice Module CYPIAPT, Phlebotomy
Specialist ED Dietctian	0.6	
Family Therapist	1.8	Supervisor for FT.
CBT	1	Also Nurse by background.
Clinical Psychologist	1	CBT & FT skills.
Assistant Psychologist	1	
Team Admin	1	

## 7. Caring for the most vulnerable: Vulnerable Groups

Children and young people told us:

*“You feel left out and isolated at school and in lessons. You get left behind because you cannot keep up and teachers are not bothered about this as long as you do not cause trouble. If you are quiet and struggling you do not get noticed.”*

*“People pick on me because of my condition so I don’t go to school. Make it safe and I will go. Bullying is massive in schools. It is more online now and it is hard for schools to control. This leaves us scared, unsafe and vulnerable.”*

### Planned changes 2015-2020

#### **To establish specialist mental health workers with looked after children teams to promote seamless access to services.** <sup>15</sup>

CCG funding was agreed for £186,000 per year for 5 years in addition to the existing provision of 2.6 WTE (Whole Time Equivalent) Psychological Therapists. These funds have been used to create four new additional WTE posts.

In addition, CBMDC Be Positive Pathways Programme will fund a Speech and Language Therapist, an Occupational Therapist and Life Coaches.

Appointees are expected to be in post at the beginning of December and the model is expected to be fully operational from 1 January 2018. They will work with the wider multi-agency Be Positive Programme. The role is to work closely with teenagers at the edge of care or in care and is based on North Yorkshire ‘No Wrong Door Model’. Working in a therapeutic way based within the 3 of the Bradford Specialist Children’s Homes. Referrals will be made by the Social Workers.

Access has been improved through the addition of a Consultation Clinic model that is available to all, regardless of presentation or severity of need. The broader range of therapists and therapies on offer means that the most appropriate therapeutic approach can be considered based on client need rather than service availability. Therapies offered by the members in team include Art Psychotherapy, Cognitive Behaviour Therapy, Dyadic Developmental Psychotherapy, EMDR, Filial Therapy, Family Therapy, Play Therapy, Solution Focused Therapy, Theraplay, and Therapeutic Parenting. The team is composed of:

- Clinical Lead – Clinical Psychologist (0.71)
- Art Therapist (0.80)
- Assistant Psychologist (1.00)
- Clinical Psychologist (1.00)
- Play Therapist (0.40)
- Play Therapist (0.50)
- Psychological Therapist (1.00)
- Therapeutic Social Workers (2.7) (Assimilation into the team to be complete by July 2017)
- Psychological Therapists (1.2)

#### **To align Primary Mental Health Worker capacity with child sexual exploitation services to provide access to young people who have suffered sexual abuse.** <sup>16, 17</sup>

The Child Sexual Exploitation hub liaises with CAMHS specialist workers to advise on cases relating to children who are victims of grooming and other exploitation as they are unlikely to take

up mainstream services.
<b>To establish services for children and young people who do not access schools or education and may be vulnerable through homelessness or falling in with bad crowds or gangs.</b> <sup>18</sup>
The Youth Offending Team accesses a dedicated CAMHS nurse and consultant psychiatry time.
<b>To develop links with statutory and voluntary Autism Services to promote interventions after diagnosis</b>
Two transition nurses are based in CAMHS for Autistic Spectrum Disorder and Learning Disabilities.
<b>Provide specialist programmes to meet the mental health care needs of refugee and asylum-seeking children</b>
<p>Bevan Healthcare are in the second year of their children and young person’s mental health programme, and are delivering a number of schemes to engage with the mental health and psychological support needs of refugee and asylum seeking children in Bradford. The one-to-one counselling sessions have been extremely successful with 30 children seen and discharged, receiving positive feedback from both schools and families. The antenatal programme engaged 28 women in the first year, and due to changes in the allocated midwife for BHC and the renovation work to the group wellbeing space, the next round is due to start at the end of this month (Nov 17). 39 children attend the After School Club in the Wellbeing Centre, offering educational and socialisation support for refugee and asylum seeking children between 5-12 years old, run by qualified teachers who volunteer their time. The Country Trust has partnered with us in taking 57 children and their parents on Farm Experience Days at Gazegill Organic Farm; here children are able to experience the British countryside, learn about animals and utilize English language skills. During the summer, Bradford City Community Foundation provided two days of football coaching sessions to unaccompanied asylum seekers between 14-17 years old, with some accompanied children also involved.</p> <p>The main challenges for the service relate to being able demonstrate quantitatively the change made through these structures of mental health support, though the service often makes use of more qualitative mechanisms including case studies and interviews. Bevan Healthcare have been looking to partner with a locally-based children’s mental health organisation as previously we have worked with CHUMS based in Bedford and this distance has proved challenging. Thus far, we have been unable find an organisation with the capacity to work with us to provide more group-based psychological therapies. Issues with language barriers are eased by the use of high quality interpreters provided by Enable2, though we continue to grapple with the concept of ‘mental health’ which often comes as a foreign concept or with associated stigmatisation – this can often require significant input whilst trying to engage a family or child initially. Timely and appropriate levels of care can be seen as a challenge, with considerable waiting lists for CAMHS. Reimbursement of travel costs is also a significant issue which can often secure attendance and engagement for these vulnerable groups.</p>

## Activity for the Looked After and Adopted Children’s Team

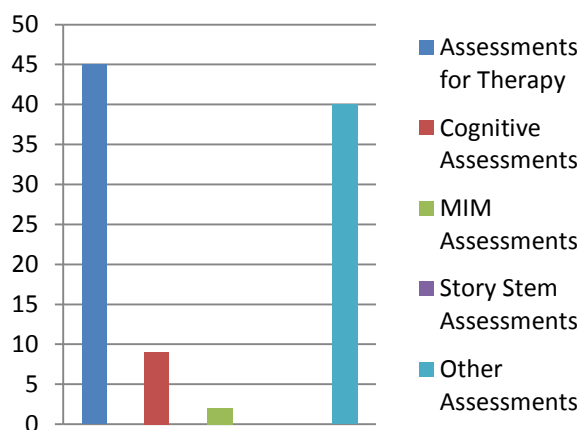
### Direct Clinical Work

Referrals for Direct Work can be made from Social Workers, School/LAC Nurses, GPs and Paediatricians. The LAAC Team received 59 referrals for direct work from the 1<sup>st</sup> November 2016 to the 30<sup>th</sup> April 2017; the breakdown of this is shown in Table 1. Twenty-seven of these were accepted for consultation in the LAAC consultation clinic and twelve were redirected to other services. Twenty referrals into the LAAC team were accepted for assessment.

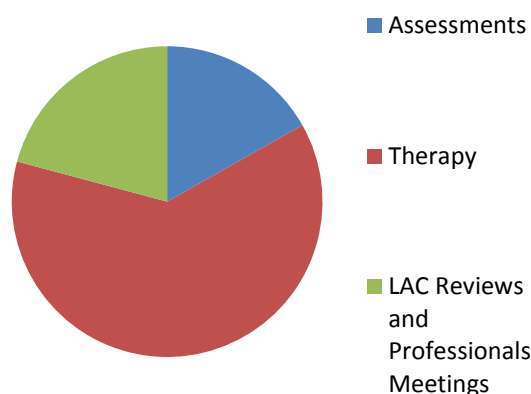
Table 1. Direct Referral Information

1 <sup>st</sup> November 2016-30 <sup>th</sup> April 2017	
<b>Total Number of Referrals for Direct Work</b>	<b>59</b>
Number of Referrals Accepted for Assessment	20
Referrals Redirected to Other Services	12
Referrals Accepted for Consultation Only	27

1 <sup>st</sup> November 2016-30 <sup>th</sup> April 2017 (Number of Sessions)		
	No.	%
<b>Assessments</b>	<b>96</b>	<b>17</b>
Assessments for Therapy	45	47
Cognitive Assessments	9	9
MIM Assessments	2	2
Story Stem Assessments	0	0
Other Assessments	40	42
<b>Therapy</b>	<b>356</b>	<b>62</b>
Art Therapy	39	11
Dyadic Developmental Psychotherapy	19	5
Family Therapy	4	1
Filial Therapy	0	0
Individual Therapy	59	17
Other	71	20
Play Therapy	94	26
Therapeutic Parenting	70	20
Theraplay	0	0
<b>LAC Reviews and Professionals’ Meetings</b>	<b>119</b>	<b>21</b>



Bar Chart displaying the number of different assessments completed by the LAAC team from the 1<sup>st</sup> November 2016 to the 30<sup>th</sup> April 2017



Pie Chart displaying the distribution of different sessions completed by the LAAC team from the 1<sup>st</sup> November 2016 to the 30<sup>th</sup> April 2017

## Indirect Clinical Work

### 1) Consultation Clinic

The consultation clinic can be accessed by *any* professional or carer working with a looked after child, an adopted child, or a child on a Special Guardianship Order (SGO). The team offer 4-5 consultation slots per week, across Fieldhead and Hillbrook. These take place over an hour and a half and are usually offered by two members of the CAMHS-LAAC team. Consultations offer an opportunity to think in depth about a child's difficulties or presentation, reflect on a child's experiences and early development and draw on psychological expertise. They can also be utilised to think about the network of care around a child and to consider plans for the child with regard to home and school placements and psychological therapy needs.

Clinicians provide a written summary on the consultation for all attendees and all attendees are asked to complete a feedback form at the end of every consultation.

#### *Breakdown of Consultation Data*

<b>1<sup>st</sup> Nov 2016 – 30<sup>th</sup> April 2017</b>	
<b>Number of consultations attended</b>	<b>58</b>
Number of consultations cancelled	14
Number of cases discussed in Consultation Clinic	51
Number of cases attended for a second consultation	7
Total number of professionals and carers who attended	131

### 2) Children's Home Staff Consultation

Consultations were offered to all eight mainstream Local Authority Children's Homes in Bradford District. In addition the team began offering consultation to a Children's Home which also provides a Residential Service for children with Learning Disabilities from February 2017. These consultations were offered on a monthly basis. In total, 32 Children's Home Consultations took place in the six month period. Two Child and Adolescent Psychotherapists also contribute to this service from the wider CAMHS team. Group Supervision for this work takes place monthly with Ben Lloyd (Head of psychological therapies in CAMHS).

*Table 10. Number of Consultations delivered by the LAAC team to Children's Homes in Bradford*

<b>Children's Home</b>	<b>Number of Consultations Nov 2016 – April 2017</b>
The Hollies	0
First Avenue	5
Meadowlea	6
Newholme	6
Owlthorpe	2
Rowan House	5
Sky View	4
Valley View	3
The Willows	1

### 3) Consultation to LAC Social Work Teams

Consultation to LAC Social Workers took place monthly at Sir Henry Mitchell House. These 30-minute consultations slots offer an opportunity for the screening of cases that might need a direct referral into the LAAC Team. They can also offer support and advice at a general level. When a more in depth consultation is required to think psychologically about a child's presentation or issues within the system around the child, social workers are encouraged to book into the CAMHS-LAAC Consultation Clinic (described above).

Between 1<sup>st</sup> November 2016 and 30<sup>th</sup> April 2017, five consultation sessions took place at Sir Henry Mitchell House. During these sessions, a total of 25 young people were discussed.



## 8. Accountability and transparency

### Current position

Nationally there is a challenge around the significant gaps in data and information, delays in the development of payment mechanisms and other incentives and the complexity of current commissioning arrangements

With a number of providers and commissioners, it is difficult to get a consistent picture but there is opportunity and expectation we will do so through implementing the lead provider framework and reviewing data collected through the MHSDS.

There is an opportunity to commission jointly with the appointment of a joint commissioner across the CCGs and the Local Authority. We have now established new governance and frameworks for reporting. Maintaining transparency and accountability through joint working with the People's Board and the delivery group partners, will ensure shared understanding and learning.

### Priorities for change

- Commissioner access to robust data on demand, activity and outcomes.
- Analysis of data and measurement of Local Transformation Plan impact.
- Effective joint commissioning to transform services and improve outcomes across Bradford district and Craven, with shared ambition, robust governance, and clear communication between commissioners, statutory and VCS providers.
- Demand in schools for emotional support needs is not routinely monitored.

### Progress to date

- Work stream outcomes, milestones and metrics drafted.
- Children and Young People's Mental Health Local Transformation Plan aligned with Sustainability and Transformation Plan (CCG), all-age mental wellbeing strategy (CCG) and B Positive Pathways (Local Authority).
- Governance arrangements for implementation integrated with all-age mental wellbeing governance structure and delivery group.

### Planned changes 2015-2020

<b>To establish lead commissioner arrangements across all services</b> Current commissioning governance arrangements are detailed at Appendix 5.
<b>To work with all services providing care for mental health and emotional wellbeing in preparation for incorporating the children and young people's mental health minimum data set into MHSDS, including the establishment of data collection systems.</b>
The main statutory provider is reporting against MHSDS. Data Quality in 8 of the 14 fields monitored by NHS Digital is above 95% in June 2017. 90% of records have a valid entry in Ethnic Category Code and only 2% of records have a valid entry in Primary Reason for Referral (31% in England).
<b>As part of CYPIAPT much work has been done within Specialist CAMHS to promote and embed the use of Routine Outcome Measures. Significant amounts of work have gone into developing IT systems to ensure that outcome measures are available within the electronic patient record.</b>
A navigable map of outcome measures has been developed guide clinicians in their use. IT systems have been developed to ensure that Routine Outcome Measures are available within the electronic patient record. An outcome measures champion has been identified by BDCFT. The outcomes measures champion will support the roll out of team training and education in the use of outcome measures for co-production, feedback and transparency.

## 9. Developing the workforce

Children and young people told us:

*“All workers (especially GPs and teachers) in contact with children and young people and families should have a better understanding and knowledge about emotional and mental health needs. Emotional and mental health training should be mandatory for all staff to be able to do their job and meet our needs.”*

*“Someone I can relate to.”*

*“Someone who understands.”*

*“Someone who talks to you on a level that you are comfortable with.”*

*“The right person.”*

*“Everyone should be trained because if only one worker is trained then the young people may not feel comfortable with that worker and they would then have no-one else to go to that is knowledgeable enough to help.”*

### Planned changes 2015-2020

#### **New CAMHS Training programme**

The journey begins with a CAMHS e-learning package of core universal emotional wellbeing education providing more staff with awareness of universal level actions that meet the well-being needs of children and young people. Content also covers when to contact colleagues who are competent in targeted approaches and who can support universal action. Following piloting of the draft package with key stakeholders, the final version is planned for launch within the wider workforce in November 2017. A new rolling programme of three ½ day face-to-face skills based courses will commence in December to follow-on from the e-learning using innovative whole systems tools to protect CYP emotional well-being and promote resilient relationships. With input from PMHWs, helpful practice will be learnt surrounding referral routes and supporting targeted approaches. Schools and vulnerable groups (looked after children and young people) settings are becoming increasingly interested in the tools. Finally, topic based CAMHS courses will continue to be a vital part of the programme with input from specialist CAMHS and voluntary sector partners e.g. Family Action and Barnardo's.

The NHS England Schools Competency Framework has informed the new multi-agency CAMHS programme by providing clear recommended activity for core competency groups working at a universal level within the setting. The e-learning will reach the areas of the workforce who traditionally have not accessed universal CAMHS training. The multi-agency offer of the CAMHS training programme will continue to ensure that good practice is shared among the wider Comprehensive CAMHS workforce.

#### **Mental Health Champions/Schools Engagement**

The school setting is where the schools engagement and workforce development work streams converge. The whole school approach is consistent with the whole systems approach of this CAMHS training programme and includes the well-being of staff. From November 2017, Mental Health Champions will receive the face-to-face training to inform the Senior Leadership Team and

support access by their colleagues in the wider workforce. Collaboration with the Schools Engagement work stream has begun on a shared MHCs online platform to support practitioners in the wider workforce. Discussions have also begun for a more large scale audit of training needs.

### **Resilience Passport**

The Resilience Passport Pilot has been successful in securing charitable funding for the production of 50 passports. The Passport is a tool for use with pupils in year 5 approaching their SATS to help them develop helpful everyday habits and communication skills to meet their resilience needs including those surrounding cultural identity. The Passport uses an innovative well-being battery conceptualisation designed in partnership with the Barnardo's Participation group including children and young people who continue to provide positive feedback on its usefulness. Training linked to the Passport focuses on how to use the tool in order to maximize the benefit to pupils on this emotionally demanding journey. A parental and staff well-being feature to the tool will support the use of the tool within the home as well as the workplace. Project management and evaluation is being undertaken in partnership with the BDCNHSFT business support team – iCare. Roll-out is planned for June 2019 and will consider the use of the Passport for other significant life transitions such as entering and leaving care.

### **Support to other work streams (Vulnerable Groups, Crisis Care and Eating Disorders)**

Training needs identified within Crisis Care have resulted in Safer Spaces staff joining the Buddies in receiving tailored topic based CAMHS training following previously delivered core competency training. Looked after children practitioners have benefited from tailored training in adolescent brain development and risk taking behaviour and will receive tailored self-harm training in October 2017. The training will support activities aimed at developing CYP resilience and will increase staff confidence. Discussions are underway with the eating disorders team to develop a universal training strategy to support early intervention activities.

To extend roll out of CYPIAPT training to incorporate the voluntary and community sector, school nurses and counsellors with financial support from NHS England during Q3 and 4 2016/17. In Wave 6 The partnership are seeking to send 5 candidates from a breadth of services onto the evidence based practice module which will widen the skill set of the wider. Supervision will be provided by trained CYP IAPT supervisors within specialist CAMHS.

To incorporate principles of CYPIAPT into workforce training programmes.

To align workforce training programmes to ensure equal coverage and access to all providers of children's services.

BDCFT is currently mapping current pathways against NICE guidance to look at skill gaps. A workforce and training plan will be developed in response to this in early 2018.

### **Develop the CYP IAPT workforce**

Bradford and Airedale were successful in applying for the fourth wave of children and young people's improving access to psychological therapies (CYP IAPT), the training for which has been completed. Trainees have been recruited for this year's CYP IAPT course.

There is also an established programme of workforce development training in mental health delivered across schools and primary care with a dedicated programme coordinator.

Specialist CAMHS services provided by Bradford District Care NHS Foundation Trust in partnership

with Barnardo's are members of the North West CYP IAPT collaborative. The partnership have been engaged since Wave 4 of the programme and have successfully trained 6 specialist CAMHS staff in CBT, Family Therapy and parenting. These skills are being utilized within specialist CAMHS services widening the offer of evidenced based interventions. In Wave 5 the partnership supported a voluntary sector organization in sending a member of their workforce on the CYPIAPT Programme with specialist CAMHS offering supervision and support throughout. The partnership are now targeting the wider workforce outside specialist CAMHS to address the need for skills and understanding around promoting emotional health and wellbeing at all levels thus ensuring that resilience is built and help is sought at the earliest stage.

Wider CAMHS and VCS staff continue to be supported to access CYPIAPT training including:

Evidence based practice: 2 colleagues from VCS services completed and practising, 2 Core CAMHS staff currently undertaking, 6 staff from across core CAMHS and VCS services are attending the next planned course.

Service Lead Course: 3 core CAMHS managers have completed and 2 more managers are enrolled on the next course starting October 2017.

Family Therapy for Eating Disorders: 1 Eating Disorders team member is enrolled on the course commencing January 2018.

#### **Routine outcome monitoring with improved supervision**

CYPIAPT outcome measure are being mapped to the clinical pathways alongside NICE guidelines for interventions. All core CYPIAPT outcome measures are now available on RIO. A set of core standards around the use of outcome measure are now in place. Staff are engaged in a rolling programme of training and support around the use of outcome measures to include the use within team meetings, case load management, supervision and appraisal. Outcomes Champions are in place across the Core CAMHS teams.

CAMHS Workforce

**For Community CAMHS only**

**SUMMARY OF CAMHS WORKFORCE**

All figures by WTE for 2016/17 gear end outturn staffing

	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	Consultant Psychiatrist	Other Medical	Total wte
Medical												5.62		5.62
Qualified Nursing					25.83	10.00								35.83
Support worker / Unqualified Nursing Staff		4.55												4.55
Clinical Psychology			2.00			0.67	1.63		1.00					5.36
Psychotherapy				1.00	4.80	4.24	3.54							13.58
Therapists				0.60	2.73	1.51								4.84
Allied health professionals						0.60								0.60
Social worker														-
Education (staff employed by CAMHS)														-
Inpatient Operational Management														-
Other														-
Admin								0.63	0.07	0.07				0.78
<b>Total</b>	<b>-</b>	<b>4.55</b>	<b>2.00</b>	<b>1.60</b>	<b>33.36</b>	<b>17.02</b>	<b>5.23</b>	<b>0.63</b>	<b>1.07</b>	<b>0.07</b>	<b>-</b>	<b>5.62</b>	<b>-</b>	<b>71.16</b>

**Family Therapy**

Of the staff included in the matrix above, how many are trained in family therapy? (Meriden level or equivalent)

Family Therapists	0.6	WTE
Other Staff e.g. Clinical Psychologists	7.7	WTE

## Workforce planning

BDCFT services will develop to extend provision originally focused on Adult Mental Health to work with specialists in Children and Young People's Mental Health and extend access to people of all ages (crisis care), or to develop structures specific to children and young people (Schools Engagement, Vulnerable Groups), thus increasing the skill base and service access to children, young people and their families. This will maximize the contribution of the current workforce and extend access to skilled care to wider populations.

Service	Staff group	wte	Timescale
First Response (crisis)	CAMHS specialist	3.0	August 2016 (complete)
Eating Disorders	Team manager		
Eating Disorders	Dietitian		
Eating Disorders	Consultant psychiatrist		
Eating Disorders	Psychological therapy lead		
Eating Disorders	Psychological therapist		
Eating Disorders	Assistant psychologist		
Schools Engagement	Primary Mental Health Workers (additional)	4.0	Complete
Single Point of Access (Early Help Hubs)	Primary Mental Health Workers	2.4	Complete
Vulnerable Groups	CAMHS social workers	3.0	Complete, ring-fenced from current workforce
Vulnerable Groups	Lead LAAC therapist	0.71	Complete
Vulnerable Groups	LA social workers	tbd	From current workforce, September 2016
Vulnerable Groups	Psychological therapist	2.0	September 2016
Vulnerable Groups	Assistant psychologist	tbd	September 2016
Schools Engagement	Project administrator	0.5	tbd
Schools Engagement	Educational psychologist	0.3 (0.2 Future in Mind, 0.1 core funding)	tbd
Vulnerable Groups (CSE hub)	Primary Mental Health Worker	0.4	Complete
Vulnerable Groups (Youth Offending Team)	Nurse specialist and consultant psychiatry	1.0	Complete

## 10. Finance

### Funding allocation 2016/17

<b>Scheme</b>	<b>Allocation</b>
Primary Mental Health Workers	352,000
Schools Links Project	91,000
Community Eating Disorder Service	298,000
Crisis Care	109,500
Model of therapeutic integrated care for vulnerable children and young people including LAAC	186,000
Single Point of Access: PMHWs appointed to Early Help Hubs and Panels	100,000
<b>Total</b>	<b>1,136,500</b>

### Funding allocation 2017/18

<b>Scheme</b>	<b>Allocation</b>
Primary Mental Health Workers	350,000
Schools Links Project	91,000
Community Eating Disorder Service	298,000
Crisis Care	109,500
Model of therapeutic integrated care for vulnerable children and young people including LAAC	188,000
Craven (schools)	30,000
Bevan House	50,000
Other	20,500
<b>Total</b>	<b>1,137,000</b>

## **11. Governance**

Commissioning governance arrangements are detailed at Appendix 5.

The Future in Mind Project Delivery Board consists of commissioners (NHS and Local Authority including Public Health), contracting and engagement representatives, the principal statutory provider and representatives from schools and the VCS. Its role is to implement the Local Transformation Plan. It reports to the Joint Mental Health Commissioning Board, whose role is to provide strategic direction, monitor progress in implementing the plan, and perform a 'scrutiny role' for the oversight of service quality.

The Mental Wellbeing Partnership Board is accountable to District-wide bodies representing both health and social care (Bradford Health and Social Care Commissioners, Health and Wellbeing Board).

The Local Transformation Plan has a Programme Lead (Head of Mental Health Commissioning, CCGs and LA) and a Senior Responsible Officer (Director of Strategy, NHS Bradford Districts CCG). As well as reporting to the Joint Mental Health Commissioning Board it makes bi-monthly reports on risks and progress against milestones to the Programme Office of Bradford City and Bradford Districts CCGs and monthly reports to the Programme Office of Airedale, Wharfedale and Craven CCG.

The programme milestones and risk register form Appendix 6 of this refreshed plan.

## **12. Measuring impact**

Local and national metrics are listed in Appendix 7.

In addition to these overall metrics each work stream will develop and use indicators to monitor progress of implementation.



## 13. APPENDICES

### Appendix 1: Mental Wellbeing in Bradford district and Craven: a strategy 2016-2020

#### [Mental wellbeing in Bradford District and Craven: a strategy 2016-2021](#)

Or type the following address in to your browser

<http://www.bradforddistrictscg.nhs.uk/seecmsfile/?id=1131>

#### [The easy read version of the strategy can be found here.](#)

Or type the following address in to your browser

<http://www.bradforddistrictscg.nhs.uk/seecmsfile/?id=1184>

## **Appendix 2: Engagement with children and young people in North Yorkshire including Craven**

The Voice, Influence and Participation team (VIP) facilitate opportunities for looked after children and care leavers (Young People's Council), and young adults with Learning Difficulties and Disabilities (Flying High) to meet on a regular basis to seek their views and thoughts on services which affect them in North Yorkshire

The Flying high group have met with managers to look at ensuring CYP have access to therapists who know how to work with someone with a disability such as autism. They have also discussed the issue of older young people with SEND being asked to access CBT Mental Health services online and the difficulty of this for young people with visual impairment or learning disability.

The Young People's Council have met with Children's Social Care Senior Managers to discuss how looked after young people and care leavers are supported by mental health services. The YPC also told looked after children health nurse managers about their experiences of being supported by their General Practitioners (GP's). Their recommendations about what works well for them was fed back to GP's. Members of the Youth Executive have shared their thoughts with the Health and Wellbeing Board in July 17 and have also met with senior managers from Tees, Esk and Wear Valley to see how they can work together to help support initiatives aimed at helping young people deal with mental health problems.

The YPC and Flying High, along with representatives from other youth voice groups across the county, are represented on the North Yorkshire Youth Executive which was formed in February 2017 and which now meets to campaign on issues important to young people.

Other groups represented -

- Harrogate and District NHS Foundation Trust - Young Peoples Panel
- Harrogate Youth Council
- LGBT+
- Military Kids Club
- Police and Crime Commissioner - Young Peoples Panel
- Young Advisors
- Young Carers

The Youth Voice Executive are currently focussing on 3 topics, they are:

1. Developing Resilience and Emotional Wellbeing
2. Transport
3. Curriculum for Life

The VIP are supporting the running of both area youth voice groups and county wide meetings which will take place throughout the year, where young people can meet with others to work together locally and to meet with local managers and senior decision makers.

British Youth Parliament – to enable the views of young people in North Yorkshire to be heard regionally and nationally we also work with and support our 3 members of the youth parliament (MYPs) who meet regularly with other MYPs from across Yorkshire and the Humber and who attend the annual sitting in the House of Commons along with over 600 young people from across the United Kingdom in November each year.

October 2017

**Appendix 3: Local Transformation Plan summary for children and young people, parents and carers**



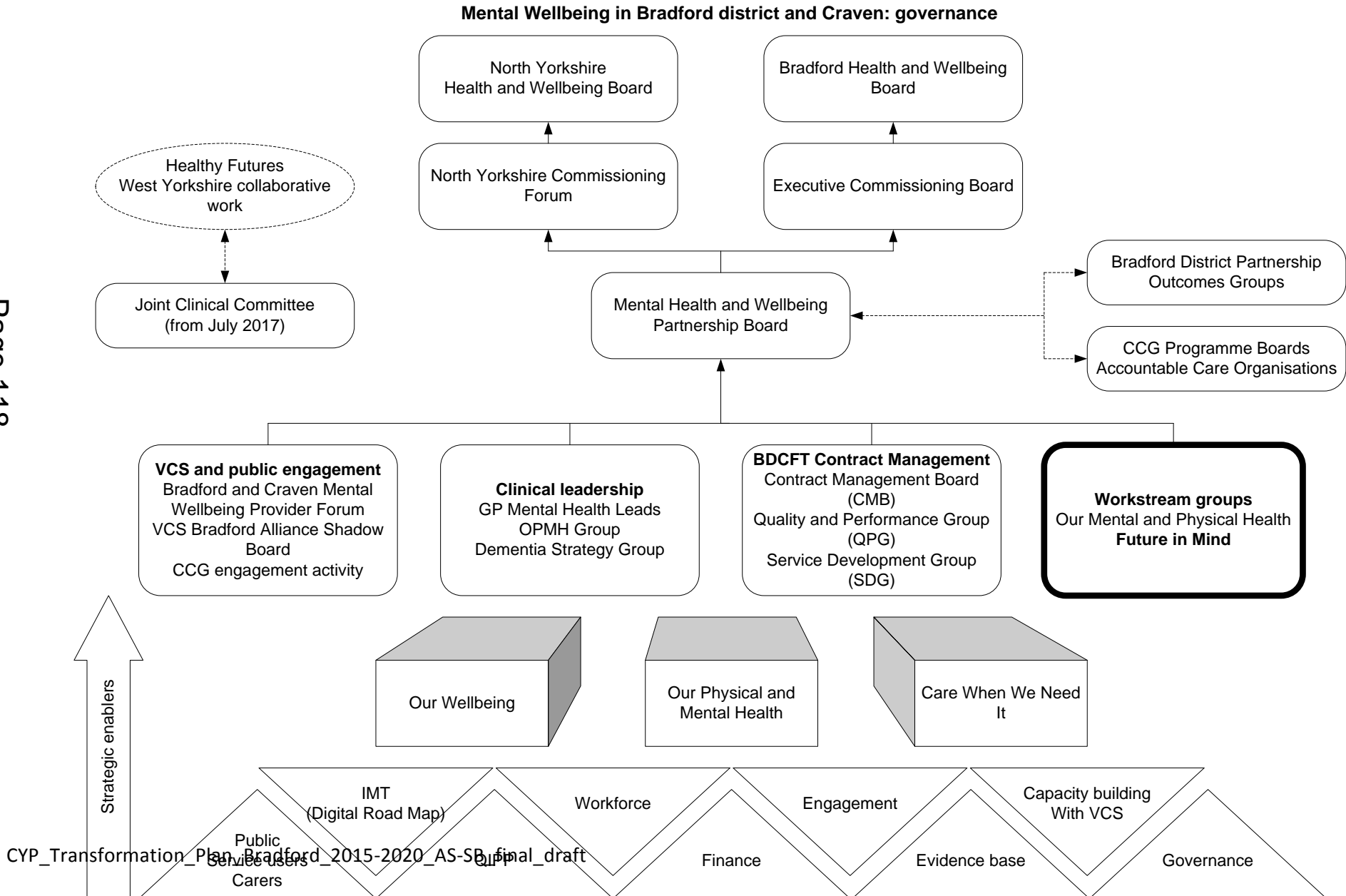
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**Appendix 4: Bradford Youth Voice event findings**



FiM Youth Voice  
Event Consultation Fi

Appendix 5: Governance structure



## Appendix 6: Outcomes and milestones

### Outcomes and milestones

CYP1.0 Schools Liaison and Prevention		
<b>Outcomes</b>	PMHWs provide specialist support working closely with school staff and children	
	Increased awareness among schoolchildren and school staff of mental health and wellbeing	
	Improved mental health and resilience for children and young people	
	Reduction in stigma attached to mental health issues	
	Schools are supported to identify children and young people at risk of mental health issues	
	Children with low level need are supported in school environment	
	Clear access routes to specialist services where need for these is identified	
	Easier access to appointments	
	Clearly defined roles with regard to MH responsibilities for staff groups in schools	
	Choice of routes of access to mental health services	
	School Nursing Mental Health lead with clearly defined role	
Implement relevant recommendations from School Nursing review		
		Timescale
<b>Milestones</b>	CYP1.1 Clinical resource freed to contribute to work stream - complete	Apr-16
	CYP1.2 Reconvene Mental Health Matters in Schools Group - BMDC + key partners	Jun-16
	CYP1.3 Review MH promotion materials from other areas and develop action plan for production of materials to meet local needs	
	CYP1.4 Go Live for Thrive Bradford website and publicity campaign	Jun-16
	CYP1.5 Identified mental health champion in every school to link into CAMHS	Apr-16
	CYP1.6 Identify relevant recommendations from School Nursing review	Sep-16
	CYP1.7 Every school to have access to a named school nurse: <b>complete</b>	
	CYP1.8 Deliver self-harm strategies and prevention of self-harm in schools	
	CYP1.9 Develop a mental health pathway for schools	
	CYP1.10 Design One Stop Shop or Drop In facility to enable access for young people who cannot access statutory provision	Mar-17
	CYP1.11 Embed specialist workers with services for vulnerable children and young people (Looked After Children, Youth Offending Teams): <b>links with Special Needs schools complete. CAMHS also have direct links with YOT and Drug and Alcohol services for children and young people</b>	Mar-17

	CYP1.12 For referrals to CAMHS and VCS for children and young people, map sources of referrals and type of care need. Obtain intelligence on demographic of demand	Dec-16
	CYP1.13 Define referral routes to VCS providers	
	CYP1.14 Ensure training and resources available to schools	Mar-17
	CYP1.15 Design processes for ongoing involvement in work stream development and implementation by children and young people	Sep-16
	CYP1.16 CYP IAPT available in schools	Dec-17

<b>CYP2.0 Single Point of Access</b>		
<b>Outcomes</b>	Need is identified as early as possible	
	An appropriate level of support is provided at the earliest and most convenient opportunity	
	Children and young people have access to one stop shops with staffing from a range of agencies	
	Children and young people have access to an age-appropriate safe space	
	People working with children and young people in a wide range of organisations can access training and advice	
	Parents and families can access support and advice	
	Clear pathways from Single Point of Access to services for different care needs and levels of acuity including specialist CAMHS	
		<b>Timescale</b>
<b>Milestones</b>	CYP2.1 Implement Early Help Hub pilots in Keighley and East Bradford	April 2016
	CYP2.2 Evaluate Early Help Hub pilots	
	CYP2.3 Identify learning from Early Help Hub pilots	
	CYP2.4 Review Early Help Hub pilot model to identify elements supporting emotional wellbeing	
	CYP2.5 Receive national guidance on Single Point of Access	
	CYP2.6 Agreement on local Single Point of Access model	

<b>CYP3.0 First Response Service</b>		
		<b>Timescale</b>
<b>Milestones</b>	CYP3.1 Revised FRS service specification included in contract with BDCT	
	CYP3.2 Recruit interim staff through agency	Ongoing
	CYP3.3 Utilise existing resource to staff service pending recruitment to full team	

CYP3.4 Recruit specialists in children's and young people's mental health	November 2016
CYP3.5 All FRS employees receive training in CYPMH	Ongoing
CYP3.6 Align Children's IHT workers with Adult IHT	January 2017
CYP3.7 Co-locate LA Emergency Duty Team with FRS	
CYP3.8 Consider regional age appropriate s136 suite with other localities	
CYP3.9 Agree model for all-age Intensive Home Treatment service	September 2017

<b>CYP4.0 Community based Eating Disorders</b>		
<b>Outcomes</b>	Prompt access to care	
	Clients receive NICE approved package of care	
	Timescale	
<b>Milestones</b>	CYP4.1 Complete team by recruitment to posts	Sep-16
	CYP4.2 Full service operational	Mar-17
	CYP4.3 Communication with stakeholders (roadshows, events with GPs)	Mar-17
	CYP4.4 Report against waiting times standards by Q1 1617	Mar-17
	CYP4.5 Direct access and self-referral to service	Mar-20

<b>CYP5.0 Vulnerable Groups</b>		
	<b>Timescale</b>	
<b>Milestones</b>	CYP5.1 Submit proposal for Specialist Looked After and Adopted Children team	Complete
	CYP5.2 Revise proposal with reference to allocated budget	Complete
	CYP5.3 Decision on whether to progress project	Complete
	CYP5.4 Utilise existing resource to staff service pending recruitment to full team	Ongoing
	CYP5.5 Recruit to specialist team of therapists	March 2017
	CYP5.6 Develop service to provide extended support for looked after children identified as vulnerable	March

		2017
	CYP5.7 Align with specialist services from CYP MH provision to provide specialist support where need is identified	
	CYP5.8 Identify services towards other vulnerable groups	

<b>CYP6.0 Transparency and accountability</b>		
<b>Outcomes</b>	MHSDS data of an agreed level of data quality is available to eMBED analysis team	
	Reports derived from MHSDS data are available to contract management forums	
	Data from Social Care and Education is available to inform service design and client outcome monitoring	
		<b>Timescale</b>
<b>Milestones</b>	CYP6.1 Map information available for Social Care and Education	Jun-16
	CYP6.2 Identify any obstacles to availability of Social Care and Education data	Jun-16
	CYP6.3 Providers commence reporting against MHSDS - complete	Jan-16
	CYP6.4 HSCIC publish provider level DQ reports - complete	Apr-16
	CYP6.5 eMBED consolidate access to MHSDS submissions	
	CYP6.6 Yorkshire DMIC make MHSDS data available to eMBED analysis team	
	CYP6.7 eMBED analysis team identifies Data Quality areas for improvement (i) BDCFT (ii) sub-contracted providers	
	CYP6.8 Data Quality improvements agreed with providers	
	CYP6.9 eMBED analysis team develops methodology to report against performance indicators	
	CYP6.10 eMBED analysis team develops methodology to monitor PbR and other commissioning requirements	
	CYP6.11 Data Quality improvements achieved	

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<b>CYP7.0 Workforce</b>		
<b>Outcomes</b>	Menu of flexible training options developed for universal settings staff	
	CYP workforce aware of the recommendations regarding emotional well-being knowledge and skills relevant to different levels of employment practice and service provision e.g. Common Core of skills and knowledge	
	CYP workforce able to negotiate an appropriate plan of professional development with their managers based on practitioner and service need	
	CYP workforce aware of the variety of settings where it is possible to develop relationships that foster resilience	
	CYP workforce aware of the range of emotional well-being knowledge and skills development opportunities within Bradford District	



	CYP workforce benefit from support of peers engaged in similar resilience building activity	
	CYP workforce aware of the benefits of early intervention in emotional well-being	
	Improved access to training for school staff and others who work with children and young people	
	CYP workforce has increased awareness of choice of routes of access to mental health services	
	CYP workforce has more awareness of strategies to provide support	
	CYP workforce is supported to provide effective care to children and young people with mental health care needs	
		<b>Timescale</b>
<b>Milestones</b>	CYP7.1 Establish what constitutes Universal Services CYPMH training	
	CYP7.2 Map current training and identify gaps	
	CYP7.3 Map training requirements for CYPMH across children's workforce	
	CYP7.4 Design process for children and young people to influence Workforce work stream	
	CYP7.5 Identify CYP MH workforce development champions across mainstream services and specialist CAMHS	
	CYP7.6 Develop plan to ensure full coverage of training requirements across children's workforce	
	CYP7.7 Expand opportunities for WRAP training (Wellness Recovery Action Plan)	Ongoing
	CYP7.8 Expand training opportunities for community and faith organisations to raise awareness of services available	
	CYP7.9 Expand opportunities for training in cultural competence for staff working with children and young people	
	CYP7.10 Extend CYP IAPT training to School Nurses	

## Appendix 7: Metrics

### Local metrics

Work stream		Measure	Rationale
Overarching		Has the CCG developed and published a local transformation plan which has been assured, includes baseline data and is this plan updated and republished annually?	National requirement: CYP MH transformation milestone
		Are the Children and Young People's Eating Disorder Team commissioned by the CCG providing a service in line with the model recommended in the access and waiting time standard?	National requirement: CYP MH transformation milestone
		Are the Children and Young People's Eating Disorder Team commissioned by the CCG part of the relevant quality assurance network?	National requirement: CYP MH transformation milestone
		Does the CCG have collaborative commissioning plans in place with NHS England for tier 3 and tier 4 CAMHS?	National requirement: CYP MH transformation milestone
		Has the CCG published joint agency workforce plans detailing how they will build capacity and capability including implementation of Children and Young People's Improving Access to Psychological Therapies programmes (CYP IAPT) transformation objectives?	National requirement: CYP MH transformation milestone
		CCG spend of additional funding for CYP MH	National requirement: NHSE finance tracker
		Number of children and young people commencing treatment in NHS-funded community services	National requirement from Q3 2016/17
		Recovery metric to be developed pending introduction of national requirement	National requirement from 2018/19
		Number of children accessing CAMHS who self harm	Monitor trend in numbers accessing CAMHS who self harm
	School readiness - % achieving a good level of development at the end of reception	Monitor well-being and development in early years	
CYP1.0	Schools Liaison and Prevention	Referrals from school staff to specialist CAMHS as a percentage of school staff contacts with an emotional wellbeing component	Estimate the proportion of emotional and mental health support need that is met in schools
		State-funded primary and secondary schools: % of persistent absentees, having 38 or more sessions of absence	Identify change in numbers absent from school

Work stream		Measure	Rationale
		New cases of "children in need": rate of new cases identified during year, per 10,000 aged <19	Children who require additional support from LA to maintain health/ development/ prevent harm
		Rate of 16-18 year olds not in education, employment or training	Monitor numbers of young people unable to reach their full potential
CYP2.0	Single Point of Access	To be determined	Awaiting national guidance
CYP3.0	First response: crisis care	First response clients aged under 19 receiving assessment within 4 hours as a proportion of referrals for people aged under 19	Monitor prompt access to care
		Total bed days in CAMHS tier 4 per CYP population	National requirement; monitor effectiveness of crisis care in supporting unwell CYP in the community
		Total CYP in adult in-patient wards/ paediatric wards	National requirement; monitor effectiveness of crisis care in supporting unwell CYP in the community
		Mortality from suicide <19 years	Trends in suicide prevention
CYP4.0	Community based Eating Disorder service	Percentage of clients (routine) who start treatment within 4 weeks from first contact with a designated healthcare professional	Monitor prompt access to care
		Percentage of clients (urgent) who start treatment within 1 week from first contact with a designated healthcare professional	Monitor prompt access to care
		Service provides NICE-concordant care (y/n)	
		Recovery metric to be determined	Effectiveness of service in treating eating disorders

Work stream		Measure	Rationale
CYP5.0	Vulnerable Groups	Emotional wellbeing of looked after children (PHOF 2.08)	Well-being of vulnerable groups
CYP6.0	Transparency and accountability	NHS number CCGs percentage completeness	Monitor data quality
		Ethnic Category Code CCGs percentage completeness	Monitor data quality
		CCGs Source of referral for mental health percentage completeness	Monitor data quality
		Programme governance structures are in place and evidenced by (1) Terms of Reference and (2) Minutes	Provide assurance that programme governance structures are in place
		Number of complaints (upheld?) to children's mental health services	Acceptability of services to service users and their families
CYP7.0	Workforce	Schools, colleges and academies where a member of staff has completed training in [tbd] as a percentage of all schools, colleges and academies	Monitor access to training for school staff

### Local dashboard



cyp\_dash\_AS\_2.0.xlsx

## National metrics

*Implementing the Five Year Forward View for Mental Health* includes additional nationally reported metrics to demonstrate progress at CCG / STP level:

<b>Metric</b>	<b>Source</b>	<b>Availability</b>
CYP MH transformation milestones	CCG IAF / Unify From Q1 2016/17	CCG IAF / Unify From Q1 2016/17
CCG spend of additional funding for CYP MH	NHSE finance tracker	From Q1 2016/17
Number of CYP commencing treatment in NHS-funded community services	MH SDS From Q3 2016/17	MH SDS From Q3 2016/17
Proportion of CYP with an eating disorder receiving treatment within 4 weeks (routine) and 1 week (urgent)	MH SDS / Unify From Q1 2016/17	MH SDS / Unify From Q1 2016/17
Proportion of CYP showing reliable improvement in outcomes following treatment	MH SDS 2018/19	MH SDS 2018/19
Total bed days in CAMHS tier 4 per CYP population; total CYP in adult in-patient wards/paediatric wards	MH SDS From Q2 2016/17	MH SDS From Q2 2016/17

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## Appendix 2 - Briefing Note

**Subject: Better Care Fund Quarter 2 Submission**

**Confidential: No**

### 1. Purpose

This briefing is to inform Health and Wellbeing Board members of the compliance with the quarter 2 submission requirements to NHS England and update on the current progress on the 2017-19 BCF Plan as outlined in the submission.

### 2. Decision required

To note progress at Q2 and compliance with reporting arrangements as set out in BCF Guidance.

### 3. Background

The Bradford Better Care Fund Plan 2017-19 was formally approved by NHS England on 27/10/2017 (see 2c below). Following this signoff process the Q2 submission was announced with a very tight timescale of 2 weeks for submission.

The return for Q2 focused upon the following areas:

- Compliance with the BCF National Conditions
- Progress on achieving the mandated performance metrics for BCF
- Progress on implementation of the High Impact Change Model (HICM)
- Progress towards integration

### 4. Progress at Q2

#### National Conditions

The submission confirms compliance with the following National Conditions: Jointly agreed plans, including the use of the Disabled Facilities Grant; contribution to social care from the CCG minimum contribution is in line with the planning requirements; agreement to invest in NHS commissioned out of hospital service; process for managing delayed transfers of care.

#### Metrics

Targets are forecast to be met for 3 of the 4 metrics – Delayed Transfers of Care, Permanent Admissions to Care and Reablement (see 2a below), whilst the target for Q2 for Non Elective Admissions has narrowly been missed and as such it is likely that the target for 17/18 year end may not be met. Provisional data suggests we are currently 2% above plan YTD. Performance is viewed as part of a wider set of multiple system pressures regarding urgent care including a general increase in A&E attendances, increasing non-elective admissions and added complexity of patient needs, delayed transfers out of hospital and available bed capacity .

## High Impact Change Model & Red Bag Scheme

The high impact change model offers a practical approach to manage transfers of care. It can be used to self-assess how local care and health systems are working now, and to reflect on, and plan for, action they can take to reduce delays throughout the year.

The model identifies eight system changes which will have the greatest impact on reducing delayed discharge:

- early discharge planning
- systems to monitor patient flow
- multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector
- home first/discharge to assess
- seven-day services
- trusted assessors
- focus on choice
- enhancing health in care homes.

The **High Impact Change Model** includes an editable action plan and can be used to support collaborative conversations across local systems. It is recognised by the sector as a valuable resource / practical self-assessment tool to enable care and health systems to examine current practices and look at where and how improvements can be made to manage transfers of care. Plans are in place that all the 8 stages will be implemented in Bradford by the end of 17/18.

The **integrated Red Bag Pathway** is designed to support transition between care homes, ambulance services and the local hospital. A red bag is used to transfer standardised paperwork, medication and personal belongings and stays with the resident throughout their hospital episode and is returned home with the resident. It is still at the planning stage and is not anticipated to be implemented this year.

The progress on both the HICM and the Red Bag Scheme are shown in 2b below.

### Progress towards local plan for integration

Bradford : A common diabetes outcomes framework has been agreed across partners applicable to and for inclusion in all relevant contracts. The initiatives for implementation during 2017/18 are now becoming embedded These are:

Medicines Support at Home (MESH)  
Multi-Agency Integrated Discharge Team ( MAIDT)  
Home from Hospital (HFH)  
Proactive Care Local Incentive Scheme (LIS)

The impacts of these initiatives are reviewed and overseen by the Bradford Out of Hospital Programme (BOHP) Board. The BOHP now has a third 'long term conditions' work stream including diabetes new models of care, cardiovascular (Bradford's Healthy Hearts) and respiratory (Bradford Breathing Better). A revised operating model and

business case for the future provision of community beds is in development, with a view to implementation during 2018/19. Across Bradford, GP practices and other primary, secondary and community health service providers, along with social care and third sector partners are coming together to form 'Primary Care Home' communities to serve populations of around 30 – 60k people. These communities, with wrap around services at a larger locality hub level are expected to form the building blocks of our future accountable care system.

Airedale: At the October AWC programme board each of the 3 communities (Airedale, Wharfedale & Craven) presented a comprehensive update on progress being made towards developing the AWC model of care. The presentations demonstrated the great commitment and energy from the range of multi-agency clinicians and care professionals involved and each group expressed that solid foundations of trust and relationships were already forming. The 'Primary & Community Transformation Group' is bringing together the developments at each community level and considers the '1 system' elements for AWC. Other areas of work include: An intermediate care review is underway and each community will identify representatives to contribute to this work. This will develop into a clinical modelling group involving broader stakeholders; Work has been undertaken to define the 3 AWC communities and align with local authority boundaries and practice population; A needs assessment profiles programme of work is ongoing; There is recognition that wider system wide workstreams e.g. mental health, maternity and children's, learning disability, medicines optimisations need to be connected into and aware of the AWC developments and priorities to ensure that each workstream is contributing to the developments and there is a common message around the agreed delivery model; and Work has been initiated to develop a common narrative around accountable care.

## 2a BCF Quarter 2 Metrics

Metric	Definition	Q2 Outturn
NEA	Reduction in non-elective admissions	Provisional data suggests we are currently 2% above plan YTD Performance is viewed as part of a wider set of multiple system pressures regarding urgent care including a general increase in A&E attendances, increasing non-elective admissions and added complexity of patient needs, delayed transfers out of hospital and available bed capacity .
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	As the new operating model for social care is embedded we are seeing a reduction of long term admissions to care. The ethos of no decision for long term care to be made in an acute setting is becoming embedded.

<b>Reablement</b>	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	The target of 90% of people who use the service being at home 91 days later is being achieved at Q2 at 94.2%, showing good outcomes for those who enter the service. As such we do not anticipate any challenges meeting the target if the current level of performance is sustained.
<b>Delayed Transfers of Care*</b>	Delayed Transfers of Care (delayed days)	Q1 data showed an improvement on the Q4 2016/17 position. Going into November the enhanced target set by NHS England is proving challenging due to increased pressure within the hospital system. The system was on high alert going into the weekend of 4/5th November due to ward closures due to D&V and Norovirus. The additional pressure in the system affecting flow is proving challenging. However, DTOC is being effectively managed..

## 2b – High Impact Change Model & Red Bag Scheme

	Maturity assessment			Milestones met during the quarter / Observed impact
	Q2 17/18 (Current)	Q3 17/18 (Planned)	Q4 17/18 (Planned)	
<b>Early discharge planning</b>	Established	Established	Established	Bradford: SAFER in place ( See endnote for explanation). Implementation of readmission flagging of complex patients at pre-assessment to the MAIDT (Multi-agency integrated discharge team) and Home from Hospital is in place. The Electronic Patient Record (EPR) will improve visibility of the discharge process. Airedale: SAFER in place. Plans need to expand to ensure community identification of complex cases before admission. Executive oversight now in place to improve metrics
<b>Systems to monitor patient flow</b>	Established	Established	Established	Bradford: Implemented EPR and the capacity management system in EPR will support oversight of patient flow in the hospital Airedale: In place
<b>Multi-disciplinary/multi-agency discharge teams</b>	Plans in place	Plans in place	Established	Bradford: the team should start operating 7 days a week when the discharge nurses commence working weekends in early November. Work is required to strengthen the operating model and move discharge to assess

				<p>forward, including using the 5Q streaming tool to identify the most appropriate place for a person to be assessed.</p> <p>Airedale: Airedale are strengthening the multiagency team working and using the operating model agreed in Bradford as the basis for change. Staff in Airedale have been trained in the use of the 5Q streaming and this will be incorporated into the MAIDT operating model to implement discharge to assess</p>
<b>Home first/discharge to assess</b>	Plans in place	Plans in place	Established	<p>Bradford: There are some final issues to resolve in the process between Continuing Health Care (CCG ) and the local authority this includes ensuring we have the right level of assessment staff in the right place so that assessments are undertaken in a timely manner.</p>
<b>Seven-day service</b>	Established	Established	Established	<p>Bradford: Multi-disciplinary team work across 7 days – work to ensure discharges remain across all 7 days needs completing. Assessment of gaps in place.</p> <p>Airedale: Elements in place Frail Elderly pathway (FEP), social services, 7day Acute Medical Unit ward rounds, community)- key work stream is criteria lead discharge over weekends.</p>
<b>Trusted assessors</b>	Established	Established	Established	<p>Currently in both hospitals we operate a trusted assessor for nurses on wards who are able to restart a domiciliary care package as long as it is not increased. Increased packages of care will go to the MAIDT.</p> <p>Nurses on wards are also able to agree the transfer plan for people returning to their care home as long as there is no change to the care package, increases in care packages will be arranged by the MAIDT.</p> <p>The MAIDT operating model in both hospitals will include joint training opportunities such as the 5Q training which will enable trusted assessor roles to develop. At the recent Care home provider forum the role of a trusted assessor was raised with Care Home owners, further discussion will take place in the Care Home provider</p>

				development group
<b>Focus on choice</b>	Plans in place	Established	Established	Bradford: Policy in place this is being revised due to EPR. As part of the Commissioning for Quality and Innovation scheme (CQUIN) the three Trusts BTHFT, ANHSFT and BDCT are working collaboratively to develop integrated discharge policies. Anticipated completion Dec 17. Implementation of the multiagency (including LA and carers support). Airedale: Home of choice policy in place
<b>Enhancing health in care homes</b>	Established	Established	Established	Many different services in place including community integrated teams, telemedicine and goldline . A piece of work is underway to map areas of input

	<b>Q2 17/18 (Current)</b>	<b>Q3 17/18 (Planned)</b>	<b>Q4 17/18 (Planned)</b>	<b>Achievements / Impact</b>
<b>Red Bag scheme (see end note)</b>	Plans in place	Plans in place	Plans in place	Engagement with all stakeholders has taken place Workshop taking place 16/11/17 Commencing a test from Dec 1st across 6 homes to map out the process and check the effectiveness of the paperwork A pilot study to commence, with those care homes 'signed up' to the national CQUIN, from Jan 2018 Implementation across all care homes is likely to be from April 2018

## Notes

### SAFER patient flow bundle

The SAFER patient flow bundle blends five elements of best practice. It's important to implement all five together for cumulative benefits. It works particularly well when used with the 'Red2Green days' approach.

The five elements of the **SAFER** patient flow bundle are:

**S** – Senior review, **A** – All patients have an expected discharge date and clinical criteria for discharge, **F** – Flow, **E** – Early discharge, **R** – Review

<https://improvement.nhs.uk/uploads/documents/the-safer-patient-flow-bundle.pdf>

## **Red Bag Scheme**

The integrated Red Bag Pathway is designed to support transition between care homes, ambulance services and the local hospital. A red bag is used to transfer standardised paperwork, medication and personal belongings and stays with the resident throughout their hospital episode and is returned home with the resident.

<https://www.nice.org.uk/sharedlearning/hospital-transfer-pathway-red-bag-pathway>

**2c Better Care Fund Plan 2017-2019 – NHS England Approval Letter.  
See following page**

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NHS England  
Skipton House  
80 London Road  
London  
SE1 6LH

27 October 2017

To: *(by email)*

Cllr Susan Hinchcliffe  
Kirsten England  
Helen Hirst  
Julie Lawreniuk  
Ali Jan Haider

Chair, Bradford Health and Wellbeing Board  
Chief Executive, Bradford Metropolitan District Council  
Chief Accountable Officer, NHS Bradford City CCG  
Chief Finance Officer, NHS Bradford City CCG  
Director of Strategic Partnerships, NHS Bradford District CCG

Dear Colleagues

## **BETTER CARE FUND 2017-19**

Thank you for submitting your Better Care Fund (BCF) plan for regional assurance. We know that the BCF has again presented challenges in preparing plans at pace and we are grateful for your commitment in providing your agreed plan. The Better Care Fund is the only mandatory policy to facilitate integration of health and social care and the continuation of the BCF itself. It brings together health and social care funding, with a major injection of social care money announced at Spring Budget 2017. For the first time, this policy framework for the Fund covers two financial years to align with NHS planning timetables and to give areas the opportunity to plan more strategically.

Your plan has been assessed in accordance with the process set out in the *Better Care Fund 2017-19: Guide to Assurance of Plans*.

In determining and exercising further powers in connection with your application, NHS England has had regard to the extent to which there is a need for the provision of health services; health-related services (within the meaning given in section 14Z1 of the NHS Act 2006); and social care services.

I am delighted to let you know that, following the regional assurance process, your plan has been classified as '**Approved**'. In summary, the assurance team recognises your plan has been agreed by all parties (local authority, Clinical Commissioning Groups (CCGs), and your Health and Wellbeing Board), and the plan submitted meets all requirements and the focus should now be on delivery.

Your BCF funding can therefore now be released subject to the funding being used in accordance with your final approved plan, and the funding being

transferred into pooled funds under a section 75 agreement.

These conditions have been imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These sections allow NHS England to make payment of the BCF funding subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG(s) in your Health and Wellbeing Board area as to the use of the funding.

Amounts payable to the CCG in respect of the BCF are subject to the following conditions under section 223GA of the NHS Act 2006:

1. That the CCG will meet the performance objectives specified in its BCF plan; and
2. That the CCG will meet any additional performance objectives specified by NHS England from time to time.

If the CCG fails to meet those objectives, NHS England may withhold the funds (in so far as they have not already been paid to the CCG) or recover payments already made; and may direct the CCG as to the use of the amounts payable in respect of the BCF.

In addition to the BCF funding, the Spring Budget 2017 increased funding via the Improved Better Care Fund (IBCF) for adult social care in 2017-19. This has been pooled into the local BCF. The new IBCF grant (and as previously the Disabled Facilities Grant) will be paid directly to local authorities via a Section 31 grant from the Department for Communities and Local Government. The Government has attached a set of conditions to the Section 31 grant, to ensure it is included in the BCF at local level and will be spent on adult social care.

You should now progress with your plans for implementation. Ongoing support and oversight with your BCF plan will be led by your local better care manager.

Once again, thank you for your work and best wishes with implementation and delivery.

Yours faithfully,



Simon Weldon  
**Director of NHS Operations and Delivery and SRO for the Better Care Fund  
NHS England**

Copy (by email) to:

Bev Maybury	Strategic Director, Bradford Health and Wellbeing Board
Elaine James	Head of Adults Social Care, Policy and Strategy, Bradford Metropolitan District Council
Jo Farrar	Director General, Department for Communities & Local Government
Jonathan Marron	Director General, Department of Health
Sarah Pickup	Deputy Chief Executive, Local Government Association
NHS England North	
Richard Barker	Regional Director
Moira Dumma	Director of Commissioning Operations
Louise Auger	Locality Director
Tim Barton	Regional Lead
Jenny Sleight	Better Care Manager
Better Care Support Team	
Anthony Kealy	Head of Integration Delivery
Rosie Seymour	Deputy Director

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