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Agenda for a meeting of the Health and Social Care Overview and Scrutiny Committee to be held on Thursday, 5 October 2017 at 4.30 pm in Committee Room 1 - City Hall, Bradford

Members of the Committee – Councillors

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT AND INDEPENDENT
Gibbons Rickard	Greenwood A Ahmed Akhtar Johnson Shabbir	N Pollard

Alternates:

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT AND INDEPENDENT
Barker Poulsen	Berry S Hussain T Hussain H Khan	Griffiths

NON VOTING CO-OPTED MEMBERS

Susan Crowe	Strategic Disability Partnership
Trevor Ramsay	Strategic Disability Partnership
G Sam Samociuk	Former Mental Health Nursing Lecturer
Jenny Scott	Older People's Partnership

Notes:
- This agenda can be made available in Braille, large print or tape format on request by contacting the Agenda contact shown below.
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- 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: **To:**

Parveen Akhtar
City Solicitor
Agenda Contact: Palbinder Sandhu/Claire Tomenson
Phone: 01274 432269/432457
E-Mail: palbinder.sandhu/claire.tomenson@bradford.gov.uk

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 6 July 2017 be signed as a correct record (previously circulated).

(Claire Tomenson – 01274 432457)

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.

(Claire Tomenson - 01274 432457)

5. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

Any referrals that have been made to this Committee up to and including the date of publication of this agenda will be reported at the meeting.

B. OVERVIEW AND SCRUTINY ACTIVITIES

6. CLINICAL COMMISSIONING GROUPS' ANNUAL PERFORMANCE REPORT 1 - 26

The Director of Quality NHS Bradford City Clinical Commissioning Group (CCG) and Bradford Districts CCG and the Deputy Chief Officer and Chief Finance Officer, NHS Bradford City and Bradford Districts CCG will present a report (**Document "G"**) that presents performance against the NHS England Clinical Commissioning Group Improvement and Assessment Framework for 2016/17 for Bradford City (BCCCG), Bradford Districts (BDCCG) and Airedale, Wharfedale and Craven (AWCCCG) Clinical Commissioning Groups.

Members are invited to comment on the report.

(Michelle Turner/Julie Lawreniuk – 01274 237796/237642)

7. ADULT AND COMMUNITY SERVICES ANNUAL PERFORMANCE REPORT 2016/17 27 - 40

The Strategic Director, Health and Wellbeing will submit **Document "H"** which sets out a summary of the Adult and Community Services Department for the financial year 2016/17 across a range of national performance indicators.

Members are invited to comment on the report.

(Imran Rathore – 01274 431730)

8. THE HEALTHY BRADFORD PLAN: SHAPING THE SYSTEM, IMPROVING LIFESTYLES 41 - 52

The “Healthy Bradford Plan: Shaping the System, Improving Lifestyles” (**Document “I”**) will be presented by the Deputy to the Director of Public Health and sets out the four core activities to be undertaken to ensure that Bradford is at the forefront of the national challenge to help people improve their lifestyles through delivering a system wide approach addressing poor lifestyle behaviours at their roots.

Recommended –

It is recommended that the Committee:

1) **Accept the broader lifestyle behaviours approach set out in the Healthy Bradford Plan.**

2) **Support the development of the system wide Partnership and the implementation of the actions it identifies as priority areas for improving lifestyles.**

3) **Encourage and support officers, other public sector organisations, business owners and community groups to use the Healthy Bradford Charter within their own organisations to identify and achieve the potential to make healthy lifestyles easier for everyone.**

(Rose Dunlop – 07834 062144)

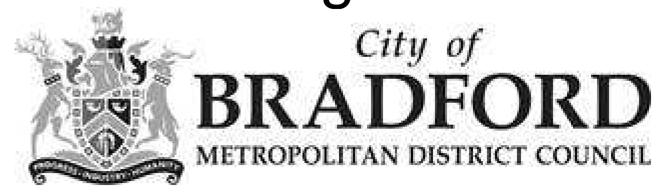
9. HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME 2017/18 53 - 60

The Overview and Scrutiny lead will present the Committee’s Work Programme 2017/18 (**Document “J”**).

Recommended -

That the Committee notes the information in Appendix 1 and 2

(Caroline Coombes – 01274 432313)



Report of Bradford City, Bradford Districts and Airedale, Wharfedale and Craven Clinical Commissioning Groups to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 5 October 2017

G

Subject: Clinical Commissioning Groups' Annual Performance Report

Summary statement:

This report provides an update on Clinical Commissioning Groups' performance for 2016/17

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Portfolio:

Health & Wellbeing

1. Summary

This report presents performance against the NHS England Clinical Commissioning Group Improvement and Assessment Framework for 2016/17 for Bradford City (BCCCG), Bradford Districts (BDCCG) and Airedale, Wharfedale and Craven (AWCCCG) Clinical Commissioning Groups.

2. Background

Clinical commissioning groups (CCGs) are clinically-led statutory NHS bodies responsible for planning, buying (commissioning) and monitoring health care services in their local area. Commissioning is about getting the best possible health outcomes for the local population, by assessing local health needs, deciding priorities and strategies, and then buying services on behalf of the population from a range of organisations including hospitals, clinics and community health bodies. CCGs are responsible for the health of their entire population and their performance is measured by how much they improve outcomes.

NHS England has a statutory duty (under the Health and Social Care Act (2012)) to conduct an annual assessment of every CCG. For 2016/17 NHS England introduced a new CCG Improvement and Assessment Framework (IAF) to replace both the existing CCG assurance framework and CCG performance dashboard. This new framework provides a greater focus on assisting improvement alongside the statutory assessment function.

The framework is intended as a focal point for joint work and support between NHS England and CCGs, and was developed with input from NHS Clinical Commissioners, CCGs, patient groups and charities. It draws together the NHS Constitution, performance and finance metrics and transformational challenges and will play an important part in the delivery of the Five Year Forward View.

3. Report issues

An overview of CCG IAF performance is presented in Appendix 1.

3.1 Overall IAF Performance

The CCGs have demonstrated improvement over 2016/17 in a number of areas and overall all three CCGs have been rated as “GOOD”. This is an improvement for AWCCCG from 2015/16 when it received a rating of ‘REQUIRES IMPROVEMENT’. These ratings compare to an overall national position as presented in the table below:

CCGs rating	2016/17		2015/16	
	Number	Percentage	Number	Percentage
Outstanding	21	10.0%	10	4.8%
Good	99	47.4%	82	39.2%
Requires improvement	66	31.6%	91	43.5%
Inadequate	23	11.0%	26	12.4%

NHS England commended us on our performance during 2016/17. In particular, BCCCG and Bradford Districts BDCCG share the Best in England position jointly for Quality of Leadership and AWCCCG are ranked among the best quartile in England. Ratings of 'OUTSTANDING' were achieved in some areas. The ratings for three of the six national clinical priorities were published for cancer, mental health and dementia (CCG performance is shown in the table below) with the ratings for maternity, diabetes and learning disabilities to follow later in the year.

	Cancer	Mental health	Dementia
AWCCCG	Outstanding	Requires improvement	Good
BCCCG	Requires improvement	Requires improvement	Outstanding
BDCCG	Good	Good	Good

Key points to note are:

- There were no extreme results for AWCCCG and the CCG saw improvements for maternity, learning disabilities and one year survival rate for cancer;
- Although overall AWCCCG experienced improved results for mental health services, implementation of the children and young people's transformation plan has seen slow progress;
- Across all three CCGs there are metrics associated with long term conditions, non-elective admissions for urgent care sensitive conditions and for chronic ambulatory conditions which require improvement. Our transformation programmes for urgent care and new models of community provision are addressing these issues;
- BCCCCG appears in the 10 worst CCGs for cancer survival and GP patient experience, although the latter has substantially improved;
- Other areas of BCCCG poor performance are quality of life for carers, cancer early diagnosis and cancer patient experience;
- BCCCG has delivered improvements in diabetes, although delivery of NICE recommended treatment targets for diabetes remains a challenge. The Bradford Beating Diabetes (BBD) programme has focused its attention on supporting people who are at high risk of developing type 2 diabetes and has identified about 38,000 people who are classed as being at risk. During 2016/17 we have continued to raise awareness and identify individuals who have been diagnosed at high risk and refer them to the intensive diabetes prevention programme. Going forward BBD will form part of an integrated

new model of care for diabetes;

- Improvements have also been seen for mental health and learning disabilities;
- There is still work to be done to improve provider staff engagement across Bradford providers. Evidence suggests that the more engaged a workforce is, the better the outcomes for patients. Work across the District to develop a system wide integrated workforce is being led by the Bradford Integrated Workforce programme. There is a focus on developing new skills and improving supply of key staff, improving integration through a common set of values and engaging, listening and involving staff across the system, whilst also promoting mental and physical wellbeing;
- Childhood obesity across the district is worsening and whilst Public Health commission a range of services, work is needed to create a joined up strategy and true partnership working across the district to tackle the wider issues of obesity e.g. poverty and the environment;
- Both Bradford CCGs performed poorly against the maternity metrics due to the rate of neonatal mortality and still births, and high levels of smoking in pregnancy for BDCCG. We have established a maternity programme board to support local implementation of Better Births five year forward view for maternity services and made a successful bid to the perinatal mental health services development fund to extend community psychiatric nurse provision across adult mental health services;
- Improvements in BDCCG have been seen in diabetes, mental health and learning disabilities;
- Poor performance against some of the constitutional targets had an impact on performance for all three CCGs;
- Across the board, CQC ratings for the main providers and for primary medical services (GP practices) have improved this year. However, inspection of the adult social care sector remains a cause for concern. As part of our Better Care Fund (BCF) work, in order to stabilise and improve the quality of care in the care homes sector, targeted support has been offered by the system. This has included training, support with CQC inspection processes, specialist equipment provision and use of technology. This has enabled improvements in setting with fewer homes being rated as inadequate and more homes being rated as good or outstanding; and
- Financial performance across all three CCGs has been challenging in 2016/17. Particularly as a result of the risks associated with achievement of our Quality, Innovation, Productivity and Prevention (QIPP) work and associated savings.

3.2 Constitutional Target Performance

The NHS Constitution sets out a number of standards which have been translated into a range of targets for waiting times and patient care. Performance against a number of these has impacted upon the CCGs IAF assessment. The latest CCG scorecard is presented as Appendix 2.

18 weeks Referral to Treatment (RTT): Airedale Hospital Foundation Trust (AHFT) delivered the RTT target overall in 2016/17 but did experience

pressures at a specialty level, in particular Urology (demand and urgent/cancer work impacted on delivery) and Orthopaedics (longer term capacity challenges in line with the position nationally). The Trust actively reviews speciality level issues closely through their weekly RTT meetings and is working with stakeholders to look at sourcing additional orthopaedic capacity.

Failure of the target at CCG level is primarily affected by the ongoing poor performance at Bradford Teaching Hospitals Foundation Trust (BTHFT). Improvements have been noted in a number of specialties but the positions for Urology, Vascular Surgery and Ear, Nose & Throat (ENT) remain a concern as a result of a combination of increases in demand and service capacity. The Trust is in the process of recruiting additional consultants and is in early discussions with AHFT regarding Vascular services, whilst also securing additional capacity from the independent sector.

All three CCGs are continuing to work on a number of initiatives to manage demand including reviewing the ratio of first to follow up appointments in a range of specialties where these are higher than national norms, reviewing referral pathways and variation amongst GP practices and investigating the potential to cease commissioning of a range of nationally identified Procedures of Limited Clinical Value. We have redesigned the pathway for the treatment of lower back pain so that patients are now reviewed by community-led musculo-skeletal services. As a result, outcomes for patients have improved and pressures on secondary care reduced.

Diagnostic 6 week wait: AHFT delivered the 6 week diagnostic target in 2016/17. Poor CCG performance is a result of ongoing demand pressure at BTHFT, in particular demand for Computer Tomography (CT) tests, with the Trust utilising its capacity to the full. Additional activity is being contracted by the Trust.

With our implementation of new NICE guidance for the identification and referral of patients with suspected cancer, the resulting lower threshold for referral has inevitably resulted in an increase in the number of patients being seen for diagnostic testing. However, more cancers will be found at an earlier stage and therefore treatment outcomes will be improved.

Cancer waits: In the main, the majority of the national cancer waiting times standards were achieved in 2016/17. Performance against the two month wait standard from urgent GP referral to start of 1st treatment remains the biggest concern, with ongoing under performance at BTHFT as a result primarily of increased demand. Specific pressures remain for Urology and Head and Neck and Lung specialities. Although backlogs are reducing slowly, issues continue with late inter provider referrals and patient compliance.

We continue to work at both a local and regional level on cancer pathways:

- At West Yorkshire Alliance level, the bid for early diagnosis funds has been approved and further monies may be available for transformational

work to support this;

- Locally, BTHFT held a workshop in July 2017 (attended by Trust staff from all levels and cancer sites as well as CCG representation) to look at where efficiencies could be made across the whole cancer pathway;
- To address patient compliance, a bid was submitted to Yorkshire Cancer Research (YCR) to fund a pilot scheme to use the Enable2 interpreter service to contact non-responders to the national bowel screening programme and encourage their engagement. The bid has passed the initial stage and is through to an “Excellence Test”; and
- During 2016/17, cross organisational work between different hospital sites has included a review of inter provider transfers to ensure that, where a patients care pathway requires a referral between different organisations, there is no additional delay in treatment and there is timely transfer of clinical and administrative information between providers; and
- A ‘Living with and Beyond Cancer’ project is also underway which includes a work programme to introduce the new national Risk Stratification mechanism by Tumour sites work. The concept is that by risk assessing people living with cancer, a more appropriate and personalised care package can be developed. As a result, patient experience and outcomes will improve, and hospital outpatient attendances and unplanned admissions will reduce. It is being piloted for patients that meet the criteria across a small number of tumour sites initially.

Accident & Emergency (A&E) 4 hour wait: Both Trusts failed the national target overall in 2016/17. 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 and the impact of delayed transfers out of hospital for patients who are medically fit for discharge which impacts on available bed capacity in the hospitals on a day to day basis.

The district wide Urgent Care Programme, overseen by the A&E Delivery Board, continues to work on system wide solutions to these pressures and initiatives include:

- The West Yorkshire Accelerator Zone funding and support was continued into quarter 1 of 2017/18, with three schemes in Airedale being key to continued and sustained improvement: Streaming to primary care, Streaming to ambulatory care and Clinical support for out of hospital beds;
- Additional out of hospital physical bed capacity at Thompson Court and Homewood is continuing to be provided through local authority funding;
- A&E GP streaming is being implemented at both Trusts;
- There is ongoing work to look at ambulatory care pathways (those covering a set of health conditions e.g. diabetes and asthma, where care would be better managed in community settings) as an alternative way of managing patients presenting to hospital who would traditionally be admitted; and
- Winter planning has been reviewed at a system level with a test of our surge and escalation processes being planned for early October.

Work also continues across the CCGs on pathways and new models of care in the community setting, to see improved outcomes for patients and reduced non-elective demand on acute services.

In Airedale:

- The Phase 2 Wrap Around Care Programme provides alternatives to hospital admission by streamlining pathways and reducing unnecessary/emergency hospital admissions. Work on this model is currently being developed and implemented as a phased approach due to the complexity and scope of service provision;
- The use of intermediate care, as an alternative to hospital admission where appropriate, continues to mature with, in 2016/17, the Intermediate Care Hub receiving 3,908 calls (18.86% of these referrals were from GP's and 7.09% from the Ambulance Service); and
- The Telemedicine service received 2,136 calls in 2016/17 and, as a result, 1,842 patients remained in their place of residence and 162 refrained from calling an ambulance or attending A&E.

In Bradford:

- The Bradford Breathing Better programme was launched in 2016/17, focussing on chronic obstructive pulmonary disease and asthma which are the two respiratory conditions which result in the largest number of unplanned admissions to hospital;
- We have established a Bradford community complex care team to support people who are at risk of becoming unstable. Previously they could have been admitted to hospital but now they will be supported in their own homes;
- Bradford's Healthy Hearts programme has helped reduced non-elective admissions by 10% and prevented 74 strokes and 137 heart attacks; and
- The expanded home from hospital service supports patients in their own home following their discharge from hospital, making sure they have everything they need to stay well and independent and avoid any unnecessary return to hospital.

In addition, our Primary Medical Care Commissioning Strategy sets out how we will work with GP practices and commission services within primary medical care over the next five years. As a result, we are delivering plans for extended weekday opening and training and development of our workforce.

Ambulance response Times: Yorkshire Ambulance Service (YAS) have been participating in the national pilot looking at improving Ambulance Responses (ARP pilot), which has been developed by listening to feedback from ambulance staff, GP and healthcare professionals. The results have been impressive and demonstrated that, should these changes be adopted nationally:

- Early recognition of life-threatening conditions, particularly cardiac arrest, will increase. Based on figures from London Ambulance Service, it is

estimated that up to 250 additional lives could be saved in England every year;
- Up to 750,000 patients every year would receive an immediate ambulance response, rather than joining a queue; and
- The differences in response time between patients living in rural areas and those in cities would be significantly reduced;

All of this has been achieved with no patient safety or adverse incidents attributed to the ARP in those 14 million calls. The results of this pilot have informed the decision taken by the Health Secretary to change the current clinical standards and operating targets. As a result, Call Handlers will have more time to triage the calls as they come in to ensure the right response is sent to the scene of the incident rather than to just "stop the clock". If these recommendations are accepted then the intention is to fully implement these new standards by the beginning of winter 2017.

Mental Health: More than 50 percent of people experiencing a first episode of psychosis commence treatment with a NICE approved care package within two weeks of referral and performance continues to good in terms of identifying patients with dementia. Services are assessed, planned, co-ordinated and reviewed for people with mental health problems within 7 days of discharge from inpatient care and the end of year position demonstrated achievement against all the Improving Psychological Therapies (IAPT) access and waiting times' targets for 2016/17.

However, delivering the 50% recovery rate remains challenging for BCCCG. The national evidence is that it is harder to achieve recovery within black and minority ethnic communities and in areas of high deprivation. Bradford District Care Foundation Trusts (BDCFT) is undertaking a piece of work relating to cultural sensitivity, working with the Bradford City team as a pilot and the recovery rate has significantly improved over the last 12 months. Work they have been doing to further improve recovery rates includes:

- Repeating the Recovery Masterclass as an annual update (this covers effective use of clinical measures, analysis of data from measures, using data in clinical practice e.g. to determine session agenda);
- Introduced StressControl, a low-intensity group therapy course with improved recovery rates;
- Development of low-intensity psychoeducational workbooks for patients, with guidance/reviews from Psychological Wellbeing Practitioners;
- Roll-out of an online computerised cognitive behaviour therapy (cCBT) tool which has recovery rates of 60%; and
- Review of high intensity staff supervision arrangements, to ensure adherence to brief high intensity interventions.

At a system level, we have launched our local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy. Our Mental Wellbeing Partnership Board is driving forward our programme work to implement of our strategy for the

next five years. It focusses on three work streams: our wellbeing, our physical and mental health, and care when we need it.

Quality of Care: Risk assessment of adult hospital admissions (aged 18 and over) for Venous Thromboembolism (VTE) is recommended to allow for the administering of appropriate prophylaxis based on national guidance from the National Institute for Health and Clinical Excellence (NICE). Deterioration in reported performance at both Trusts has coincided with the introduction of the new electronic data capturing systems. As a result, there was renewed focus by clinical teams and a range of actions implemented, which has seen performance improve and AHFT are now achieving this target. Whilst improvements have been seen at BTHFT in the Daycases, Surgical Assessment and Elderly Assessment units, further work is required in the Acute Medical unit.

BTHFT is in the process of a whole systems approach to VTE driven by a lead Consultant (once in post). A VTE assurance group has been re-established (reporting directly to the Patient Safety Committee) and the VTE policy and Root Cause Analysis (RCA) tool will be revised to reflect national guidance and support learning and governance associated with the outcome of the root cause analysis investigations. A CCG deep dive quality review of VTE systems and management is planned for late Autumn 2017.

The CCGs continue to work with all providers across the system to minimise the number of healthcare acquired infections and CDifficile cases remain below CCG target levels. Cases of MRSA also remain low, but against a challenging zero tolerance target, and we continue to utilise Post Infection Review (PIR) panels to review cases and feedback their findings to providers, to enable further improvements. Further reviews of health care associated infections such as e-coli have commenced and we aim to achieve a 10% reduction in e-coli by the end of 2017/18.

Nationally, the number of breaches of the mixed sex accommodation standard has increased over the past two years. However, breaches remain rare across the three CCGs and all are subject to an internal review (both breaches at BTHFT, were based on the clinical need of the patient, who required treatment on a specialist ward). Data is reported nationally and CCG's and providers review all breaches collectively and internally via existing quality governance structures with contractual financial sanctions in place.

Delayed transfers of care (DTOC): Performance across the Bradford & Airedale system in general continues to be good, maintaining the national requirement of no more than 3.5% DTOCs/100,000 population. However, there are periods when increases in delays have impacted upon patient flow and performance, and therefore work continues to further improve processes, and trajectories have been agreed as part of the BCF planning process,
AHFT have hosted a Multi-Agency Discharge Event (MADE) to help facilitate the discharge of medically fit patients into the right care setting and in November held a Rapid Improvement Week focused on the SAFER bundle, a set of simple rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients. Community Advanced Nurse Practitioners (ANPs) are working in the Trust’s A&E department to support the

team and wherever feasible get people back home with support and AWCCCG is piloting a discharge to assess model in a local care home who are working in collaboration with the acute Trust.

By contacting a single number to arrange care, Bradford GPs can now help patients who need extra support to leave hospital or short-term support to stay at home. Support is provided in their own home, or a community intermediate care bed, by an integrated team of nurses, social workers and therapists – for example, by helping people regain their former levels of health and provide them with self-care skills. The service supports more than 120 people leaving hospital each month, and more than 50 people who would otherwise have been admitted to hospital. In addition, we have been working with providers to improve discharge processes from acute settings and the onward referrals to intermediate care and community services through the development of a multi-agency, integrated discharge team. The team creates a person-centred focus in discharge planning, using needs-based assessments to determine the level of support required to help a patient return to their own home following an admission to hospital.

3.3 The financial challenge and QIPP (Quality, Innovation, Productivity and Prevention)

Nationally, the NHS is going through one of the most challenging periods in its history. As well as achieving the best possible patient outcomes through high quality, clinically effective services, we must also ensure that the NHS lives within its financial means.

In the past we've managed money well and our books have been in the black. However, for AWCCCG, BCCCG and BDCCG, the gap between our annual budgets and the increasing cost of providing healthcare to local people was £5m, £2.6m and £10.4m respectively in 2016/17. Whilst we have started to address this, realising savings of £2.4m in AWCCG, £0.9m in BCCCG and £3.5m for BDCCG, if we don't close this gap and get to a more manageable position, the outlook for future years remains challenging.

QIPP 2017/18: Our QIPP programme is all about making sure that each pound spent brings maximum benefit and quality of care to the public. Our approach to QIPP delivery is that the majority of schemes are delivered through our system change programmes which include representatives from across the system.

The amount of QIPP that we need to deliver is driven by the gap between anticipated income and planned spend. For 2017/18 the three CCGs have the following QIPP targets that they are aiming to deliver:

- AWC CCG £6.0m
- Bradford City CCG £3.5m
- Bradford District CCG £13.3m

As part of the new joint management structure the CCGs are working

collaboratively around QIPP schemes to ensure that there is a joint approach around saving schemes where appropriate. In 2016/17 the Bradford CCGs stopped the prescribing of gluten-free foods, following a public consultation, and changed the way repeat prescriptions are ordered. In 2017/18 AWC CCG have now started the journey to stop gluten free prescribing and changing the way repeat prescriptions are ordered to ensure there is a consistent approach over our communities.

To assist with delivering our plans to reduce waste we have launched a major communications campaign, "It's your NHS, don't waste it". The campaign is aimed at working together with the public to ensure we can meet increasing demand with local services meeting local needs. In addition there are examples of reducing waste and improving sustainability by increasing recycling where it is appropriate, for instance refurbishing equipment such as wheelchairs. The campaign looks at how to be more innovative, more productive while helping people use NHS resources better, ensuring services are still of the highest quality.

In addition, resources are wasted when patients feel the need to visit A&E when they could have been dealt with in primary or community settings or seek treatment when self-care would have been appropriate. To avoid this we are concentrating on areas, such as accessible patient information, access to GP services and having the right services in the right places.

The table below includes details for each CCG of the breakdown of savings required against the major programme areas.

QIPP Schemes Financial Year 2017/18

CCG	Airedale Wharfedale and Craven	Bradford District	Bradford City
	£000		
Planned Care	1,354	3,233	907
Urgent Care		546	214
Prescribing	987	3,974	1,468
New ways of working	654	685	364
Unidentified	1,535	4,259	233
Right Care Programmes	1,514	401	98
MH		33	17
Corporate		259	218
TOTAL	6,044	13,390	3,519

Planned Care: The overarching vision for planned care is to lead a system-wide approach that develops a model which is financially sustainable and that ensures maximum value at every clinical encounter. For this to work we have been working closely with our providers to ensure that any inefficiencies within the planned care system are removed. Areas that we have agreed to focus on include:

- Procedures of limited clinical value – this works looks to standardise

procedures across West Yorkshire, based on the right patient, right care, right time principle, whilst allowing for clinical exceptionality and improving consistency of care;

- Follow-up patient appointments - aims to reduce unnecessary follow-up appointments to comparator CCG levels and to offer alternatives to consultant-led appointments where it is clinical appropriate;
- Increasing patient responsibility (self-care programme) – this aims to highlight opportunities for patients to take more responsibility for their care throughout their journey of care and empowering them to do so; and
- Improving referral efficiency – looks at improving access to e-referrals and e-consultants and developing new easy-to-use tools to allow primary care clinicians to access pathways of care.

Urgent Care: Work continues in the system Urgent Care Programme to develop schemes that assist in managing demand on Accident and Emergency services (A&E). Areas being reviewed are:

- Implementing GP streaming services within A&E to ensure that patients are treated in the right place within the department and performance against the A&E target is maintained;
- Reviewing pathways of emergency care including developing services around ambulatory care;
- Reviewing patients who visit A&E more frequently than average; and
- A number of the schemes in other QIPP areas have a direct link with the reduction on urgent care spend, including both the Enhanced Primary Care and Complex Care schemes in Airedale and the Out of Hospital Programme within Bradford.

Prescribing: For all 3 CCGs work continues on targeting inefficiency and waste within the area of medicine management spend. As previously mentioned AWCCCG is starting on the journey of reducing costs around repeat prescribing and stopping gluten free prescribing. Other areas where the CCGs are focussing in 2017/18 are:

- Commissioning services that will provide medicine optimisation by providing pharmacist led medicine reviews for house bound patients, care homes and people on multiple medicines. A key factor to this work is providing education and information of medicine safety and how to manage medicine by preventing stock piles and wastage;
- Develop medicine management strategies across primary care, community and secondary care;
- All 3 CCGs have introduced a new software package within general practice to standardise prescribing across practices and improve medicine reviews;
- Reviewing prescribing of Oral Nutritional supplements and vitamins; and
- Working with providers of secondary care services to develop new formulas to ensure consistency in prescribing for all patients.

New ways of working (new models of care): All CCGs have a vision to

develop new types of services that will deliver care in a more integrated manner and that will reduce the complexities for patients having to circumnavigate the complex health and social care system.

Both Bradford CCGs are working closely with their main stakeholders including Acute, Mental Health and Community providers alongside primary care and the local authority to develop an out of hospital programme of care. This joint work will look at developing efficiencies within the system by doing things once and together, whilst reducing unnecessary admissions into the hospital. They are tackling this by:

- Developing an intermediate care hub and virtual ward that provides people over 65, with a team of nurses, social workers and therapists that will be provide an extra level of care to allow them to stay in their own home and preventing unnecessary hospital stays;
- Developing a complex care team (CCT) that has a range of community teams that can provide both reactive and proactive care and support when most needed;
- Expanding the home from hospital service; and
- Developing an extended primary care (EPC) function that provides evening clinics in Bradford. Services will include elements of support around self-care on both health and social issues.

Within AWCCCG they have been investing in a number of services to change the way services are delivered including:

- Complex Care – this works with the patients who have complex health and social needs that have led to a dependency on both health and social care services. Care is provided by a range of health and social care specialists; and
- Enhanced Primary Care – an addition to the historical primary care model that allows practices to develop a proactive and personalised care to patients that need a little bit more support who have a history or requiring a high level of support within both a primary and secondary settings.

The Right Care Programme: From a national perspective all CCGs have been involved in a programme that identifies areas when compared to other CCGs who have similar demographics, where we spend much more than they do and our outcomes are not as good. For all 3 CCGs the areas where we have been identified as outliers include: Diabetes; Coronary Vascular Disease; Musculoskeletal (MSK); Respiratory disease; and Gastroenterology. Work has started that will look at developing more appropriate pathways, removing waste and inefficient processes across all these areas.

Initiatives that have already started to improve these pathways are already in place across both our local systems. Bradford has implemented a number of services including Bradford Healthy Hearts and Bradford Breathing Better. Airedale has reviewed its MSK referral pathway and has developed an MSK pathway that keeps patients from being referred for unnecessary appointments within a hospital setting.

QIPP unidentified: For all 3 CCGs, when original QIPP plans were developed there was a shortfall in the QIPP schemes value against the total target required. Work is ongoing to close these gaps and all 3 CCGs are looking at areas were additional savings can be identified.

CCG IMPROVEMENT & ASSESSMENT FRAMEWORK 2016/17

NHS AIREDALE, WHARFEDALE & CRAVEN CCG

Appendix 1

Quality of leadership ranked 31st place

Working relationships effective

Probity and corporate governance

Financial plan

★★★ Better ★★★ Similar ★★★ Worse

LOCAL CONTEXT

This CCG spends an estimated £1,564 per head of population and is ranked as the 121st most deprived CCG (out of 209). The percentage population who are 65 years or over in this CCG is just 20.6%, higher than the England average 17.1%

RISK FACTORS

Smoking in pregnancy

★★★

Percentage of women smoking at the time of delivery is 9.9%, which is similar to the England average of 10.6%

Childhood obesity

★★★

Percentage of children aged 10/11 years who are overweight or obese is 30.2%, lower than the England average of 33.4%. The best achieving CCG result is 23%

Inequalities

★★★

The difference in the rate of unplanned hospitalisation for deprived people with chronic ambulatory care sensitive conditions is 1,147 which is higher than the England average of 904 and ranked 161 out of 209 CCGs

DIAGNOSIS AND SERVICES

Care quality ratings

★★★

Ratings for primary care, hospitals and community services are satisfactory and are similar to England, however adult social care is a concern ranked 174 out of 209

Experience of Primary Care

★★★

Experience of making an appointment at a GP practice in this CCG was 84.6%, which is similar to the England average of 85.2%

Dementia diagnosis

★★★

Diagnosis rate for those expected to have dementia is 73.7%, which is higher than the England average of 67.6% and ranked 58 out of 209 CCGs

Cancer diagnosis

★★★

Early stage diagnosis is 50.2%, which is similar to the England average of 52.4% and ranked 147 out of 209 CCGs

Mental Health

★★★

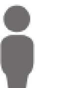
Early intervention psychosis within 2 weeks of referral is 61.8%, which is lower than the England average of 74.4%, however is above the national standard of **50%**

Feeling supported

★★★

People with long-term conditions who feel supported by health and social care services is 69.5%, which is higher than the England average of 64.3% and ranked 19 out of 209 CCGs

OUTCOMES



Cancer Survival

★★★

One year cancer survival in this CCG is 71.7%, which is higher than the England average of 70.4% and ranked 32 out of 209 CCGs

Mental Health

★★★

Recovering following access to psychological therapies for is 56.5% which is above the national standard of **50%** and ranked 20 out of 209 CCGs

Emergency Admissions

★★★

Emergency admissions for people with an chronic ambulatory care sensitive conditions is 902 which is similar to the England average of 895 and ranked 107 out of 209 CCGs

CCG IMPROVEMENT & ASSESSMENT FRAMEWORK 2016/17

NHS BRADFORD CITY CCG

LOCAL CONTEXT

This CCG spends an estimated £1,331 per head of population and is ranked as the 1st most deprived CCG (out of 209). The percentage population who are 65 years or over in this CCG is just 5.7% and lower than the England average 17.1%

Quality of leadership ranked 1st place

Working relationships effective

In-year financial performance

Staff engagement index

★★★ Better ★★★ Similar ★★★ Worse

RISK FACTORS

Smoking in pregnancy

★★★

Percentage of women smoking at the time of delivery is 9%, which is lower than the England average of 10.6%

Childhood obesity

★★★

Percentage of children aged 10/11 years who are overweight or obese is 40.2%, which is higher than the England average of 33.4%. The best achieving CCG result is 23%

Inequalities

★★★

The difference in the rate of unplanned hospitalisation for deprived people with chronic ambulatory care sensitive conditions is 1,845, which is double the England average of 904 and ranked 207 out of 209 CCGs

DIAGNOSIS AND SERVICES

Care quality ratings

★★★

Ratings for primary care, hospitals and community services are satisfactory and are similar to England, however adult social care is a concern ranked 209 out of 209 CCGs

Experience of Primary Care

★★★

Experience of making an appointment at a GP practice in this CCG has improved to 70.2%, however is still lower than the England average of 85.2% and ranked 209 out of 209 CCGs

Dementia diagnosis

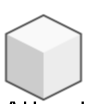
★★★

Diagnosis rate for those expected to have dementia is 97.5%, which is higher than the England average of 67.6% and ranked 4 out of 209 CCGs

Cancer diagnosis

★★★

Early stage diagnosis is 43.8%, which is significantly lower than the England average of 52.4% and ranked 204 out of 209 CCGs



Diabetes

★★★

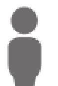
Attendance at a structured education programme by people within a year of diagnosis is 3%, which is also low compared to the England average of 7.4%. The best achieving CCG result is 38.8%

Feeling supported

★★★

People with long-term conditions who feel supported by health and social care services is 53.0%, which is lower than the England average of 64.3% and ranked 209 out of 209 CCGs

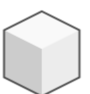
OUTCOMES



Cancer Survival

★★★

One year cancer survival in this CCG is 67.9%, which is lower than the England average of 70.4% and ranked 178 out of 209 CCGs



Diabetes

★★★

The 3 NICE recommended treatment levels (for HbA1c, BP and cholesterol), within range is 34.3%, which is below the England average of 39% and ranked 197 out of 209 CCGs

Emergency Admissions

★★★

Emergency admissions for people with an chronic ambulatory care sensitive conditions is 1,500, which is above the England average of 895 and ranked 206 out of 209 CCGs

CCG IMPROVEMENT & ASSESSMENT FRAMEWORK 2016/17

NHS BRADFORD DISTRICTS CCG

Quality of leadership ranked 1st place

Working relationships effective

In-year financial performance

Staff engagement index

*** Better *** Similar *** Worse

LOCAL CONTEXT

This CCG spends an estimated £1,486 per head of population and is ranked as the 26th most deprived CCG (out of 209). The percentage population who are 65 years or over in this CCG is just 14.9% and lower than the England average 17.1%

RISK FACTORS

Smoking in pregnancy

Percentage of women smoking at the time of delivery is 17.7%, which is higher than the England average of 10.6%

Childhood obesity

***

Percentage of children aged 10/11 years who are overweight or obese is 35.9%, which is similar to the England average of 33.4%. The best achieving CCG result is 23%

Inequalities

The difference in the rate of unplanned hospital admissions for deprived people with urgent care sensitive conditions is 2,449 which is higher than the England average of 1,758 and ranked 169 out of 209 CCGs

DIAGNOSIS AND SERVICES

Care quality ratings

***

Ratings for primary care, hospitals and community services are satisfactory and are similar to England, however adult social care is a concern ranked 192 out of 209

Experience of Primary Care

Experience of making an appointment at a GP practice in this CCG has improved to 80.3%, however this is still lower than the England average of 85.2% and ranked 186 out of 209 CCGs

Dementia diagnosis

***

Diagnosis rate for those expected to have dementia is 83.2% , which is higher than the England average of 67.6% and ranked 22 out of 209 CCGs

Maternity experience

***

Experience of maternity services reported in 2015 score is 79.2, which is similar to the England average score of 78.7

Mental Health

***

Early intervention psychosis within 2 weeks of referral is 72.4%, which is similar to the England average of 74.4% and above the national standard of **50%**

Feeling supported

***

People with long-term conditions who feel supported by health and social care services was 61.1%, which is lower than the England average of 64.3% and ranked 167 out of 209 CCGs

OUTCOMES

Neonatal mortality and stillbirths

***

The rate of neonatal mortality and stillbirths improved in 2015 with a rate of 10.7 per 1,000 births ranked 202 out of 209 CCGs. The best CCG result is 2.3 per 1,000 births

Mental Health

***

Recovering following access to psychological therapies is 50.7%, which is higher than the national standard of **50%**

Emergency Admissions

***

Emergency admissions for people with an urgent care sensitive conditions is 2,865, which is higher than the England average of 2,405 and ranked 161 out of 209 CCGs

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APPENDIX 2: CCG SCORECARD

NHS Airedale, Wharfedale And Craven CCG

Commissioner data with CCG plans in grey. CCGs are ranked out of 23 Yorkshire & Humber CCGs

RTT	Threshold		Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	<87%		92.0%	91.1%	90.9%	91.7%	91.9%	92.1%	91.7%	92.0%	91.6%	91.9%	91.7%	92.0%	92.3%
	87% to 92%		93.3%	93.5%	93.6%	93.6%	93.0%	92.8%	92.5%	92.8%	92.2%	92.7%	#N/A	#N/A	#N/A
	>=92%	Rank	14/23	14/23	13/23	12/23	9/23	9/23	9/23	9/23	8/23	8/23	7/23	7/23	7/23
Number of patients waiting more that 52 weeks on incomplete pathways	>10		0	0	0	0	0	0	0	0	0	0	0	0	1
	1 to 10														
	0	Rank	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	15/23

Diagnostic	Threshold		Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Percentage of patients waiting 6 weeks or more for a diagnostic test (15 key tests)	<6%		0.2%	0.2%	0.5%	0.3%	0.2%	0.2%	0.3%	0.5%	0.3%	1.0%	2.0%	2.9%	3.9%
	1% to 6%		0.1%	0.1%	0.0%	0.1%	0.2%	0.3%	0.2%	0.3%	0.3%	0.2%	0.0%	0.2%	#N/A
	>=1%	Rank	3/23	1/23	4/23	5/23	5/23	5/23	5/23	6/23	4/23	10/23	10/23	16/23	19/23

Cancer Monthly	Threshold		Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	<88%		96.2%	95.7%	97.1%	97.2%	97.9%	96.4%	98.0%	96.7%	97.8%	97.7%	97.1%	95.2%	95.0%
	88% to 93%		96.3%	95.0%	96.2%	96.1%	96.5%	97.0%	97.7%	96.7%	97.8%	96.9%	#N/A	#N/A	#N/A
	>=93%	Rank	8/23	10/23	6/23	6/23	4/23	9/23	4/23	4/23	6/23	3/23	3/23	13/23	9/23
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	<88%		98.6%	100.0%	100.0%	100.0%	100.0%	93.2%	100.0%	100.0%	98.1%	93.5%	100.0%	100.0%	100.0%
	88% to 93%		97.5%	98.8%	93.2%	94.7%	100.0%	98.0%	97.8%	95.1%	98.3%	98.8%	#N/A	#N/A	#N/A
	>=93%	Rank	#N/A	#N/A	1/23	1/23	1/23	#N/A	#N/A	#N/A	9/23	18/23	#N/A	#N/A	1/23
Maximum 31-day wait from diagnosis to first definitive treatment for all cancers	<91%		98.8%	97.5%	100.0%	95.9%	98.7%	98.9%	100.0%	98.8%	100.0%	98.9%	98.4%	100.0%	98.8%
	91% to 96%		100.0%	98.9%	100.0%	100.0%	100.0%	100.0%	100.0%	97.6%	100.0%	100.0%	#N/A	#N/A	#N/A
	>=96%	Rank	10/23	20/23	1/23	21/23	9/23	7/23	1/23	6/23	1/23	7/23	9/23	1/23	9/23
Maximum 31-day wait for subsequent treatment where that treatment is surgery	<89%		100.0%	95.0%	100.0%	100.0%	100.0%	88.0%	100.0%	100.0%	100.0%	94.3%	100.0%	100.0%	93.8%
	89% to 94%		95.2%	100.0%	100.0%	96.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.9%	#N/A	#N/A	#N/A
	>=94%	Rank	1/23	20/23	1/23	1/23	1/23	20/23	1/23	1/23	1/23	15/23	1/23	1/23	18/23
Maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen	<93%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	93% to 98%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#N/A	#N/A	#N/A
	>=98%	Rank	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	<89%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	89% to 94%		100.0%	100.0%	96.4%	100.0%	100.0%	96.0%	100.0%	100.0%	100.0%	100.0%	#N/A	#N/A	#N/A
	>=94%	Rank	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23
Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer	<80%		87.8%	85.4%	95.7%	84.2%	87.5%	91.8%	93.9%	80.9%	83.3%	89.7%	90.9%	83.3%	88.5%
	80% to 85%		87.8%	89.6%	90.7%	90.2%	89.1%	93.2%	93.0%	87.8%	89.2%	92.3%	#N/A	#N/A	#N/A
	>=85%	Rank	8/23	8/23	2/23	11/23	4/23	3/23	1/23	12/23	9/23	4/23	2/23	9/23	3/23
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	<85%		100.0%		100.0%	60.0%	100.0%	90.0%	92.3%	100.0%	0.0%	75.0%		100.0%	100.0%
	85% to 90%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#N/A	#N/A	#N/A
	>=90%	Rank	#N/A		#N/A	#N/A	1/23	19/23	#N/A	1/23	#N/A	19/23		1/23	1/23
Maximum 62-day wait for first definitive treatment following a consultants decision to upgrade the priority of the patients (all cancers)	NA		100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%
			66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	#N/A	#N/A	#N/A
		Rank	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A

Mixed Sex Accommodation	Threshold		Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Breaches of Mixed-Sex Accommodation	>10		0	0	0	0	0	0	0	0	0	0	0	0	0
	1 to 10														
	0	Rank	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	

Mental Health	Threshold		14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4	16-17 Q1	16-17 Q2	16-17 Q3	16-17 Q4	17-18 Q1
Care Programme Approach (CPA): Percentage of people under adult mental illness specialities on CPA who were followed up within 7 days of discharge from psychiatric inpatient care during the period	<90%		100.0%	98.2%	98.2%	96.1%	96.8%	96.4%	98.0%	98.1%	100.0%	97.9%	100.0%	100.0%	100.0%
	90% to 95%														
	>=95%	Rank	1/23	8/23	11/23	23/23	19/23	12/23	7/23	8/23	1/23	10/23	1/23	1/23	1/23

Dementia	Threshold		Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Dementia diagnosis rate	<62%		75.2%	75.7%	75.4%	75.0%	75.2%	74.5%	73.4%	73.5%	73.7%	78.7%	78.5%	78.2%	78.2%
	62% to 67%		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	#N/A	#N/A	#N/A	
	>=67%	Rank	8/23	8/23	8/23	11/23	11/23	11/23	11/23	11/23	11/23	7/23	7/23	7/23	

IAPT Monthly			May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
IAPT 6 Weeks First Treatment	<70%		96.2%	97.6%	100.0%	96.9%	97.1%	97.1%	100.0%	100.0%	96.8%	96.4%	96.7%	95.5%	100.0%
	70% to 75%														
	>=75%	Rank	6/23	6/23	1/23	6/23	7/23	9/23	1/23	1/23	7/23	7/23	5/22	8/23	
IAPT 18 Weeks First Treatment	<90%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.4%	100.0%	100.0%	100.0%
	90% to 95%														
	>=95%	Rank	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	20/23	1/22	1/23	

IAPT (*Rolling 3 month*)			May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
IAPT Access (rolling 3 months)	<3.75%		3.6%	3.6%	3.6%	4.0%	4.0%	4.3%	4.4%	4.7%	4.8%	4.4%	4.2%	4.0%	4.6%
			3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	4.2%	4.2%
	>=4.20%	Rank	14/23	13/23	11/23	8/23	9/23	6/23	6/23	4/23	3/23	2/23	8/23	11/23	
IAPT Recovery rate (rolling 3 months)	<45%		50.5%	51.5%	55.4%	56.1%	57.6%	55.6%	54.6%	55.1%	56.5%	61.4%	61.2%	60.0%	58.7%
	45% to 50%														
	>=50%	Rank	7/23	7/23	2/23	3/23	2/23	2/23	3/23	3/23	2/23	1/23	1/23	2/23	

Early Intervention Psychosis - 2 Week Waits (*rolling quarter*)			Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Early intervention in psychosis - 2 week wait (Rolling quarter)	<45%		70.0%	58.3%	56.3%	53.8%	56.3%	66.7%	61.1%	71.4%	57.9%	75.0%	63.2%	70.6%	66.7%
	45% to 50%														
	>=50%	Rank	14/23	20/23	22/23	21/23	21/23	18/23	20/23	17/23	21/23	13/23	18/23	15/23	

Safe Environment and Protection from Avoidable Harm			Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Incidence of healthcare associated infection (HCAI) i) MRSA - Cases which have been assigned to the CCG following a Post Infection Review	>0		0	0	0	1	0	0	0	0	0	0	0	0	0
		Rank	1/23	1/23	1/23	23/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23
Incidence of healthcare associated infection (HCAI) ii) C.difficile	>Ceiling		3	2	3	1	3	2	5	4	3	1	7	2	1
	<=Ceiling	Rank	8/23	3/23	5/23	2/23	6/23	2/23	13/23	11/23	5/23	1/23	15/23	6/23	1/23
	Ceiling		3	3	3	3	3	3	3	3	3	3	3	3	3

Ambulance Calls (Pilot Phase 2.2) **			Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Category 1 - Response within 8mins	<70%					59.2%	59.4%	56.7%	66.4%	61.2%	67.6%	59.8%	60.0%	70.3%	67.7%
	70% to 75%														
	>=75%														
Category 2R - Response within 19mins by a resource.	NA					61.9%	62.7%	69.6%	77.6%	66.0%	83.9%	78.6%	81.1%	78.0%	80.7%
			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Category 2T - Response within 19mins by DCA unless RRV arrives and DCA is not required	NA					55.3%	65.8%	61.4%	65.1%	64.9%	69.0%	70.3%	68.5%	70.8%	68.3%
			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

*** YAS have been participating in a pilot which has involved new call categories. The initial pilot ran from 21st April 2016 until 19th October 2016 and the second phase began on 20th October 2016. Due to the changes in categories direct comparison between the different phases cannot be done because they don't necessarily represent the same activity. Currently no performance target has been set for the 2R and 2T categories.*

APPENDIX 2: CCG SCORECARD

NHS Bradford Districts CCG

Commissioner data with CCG plans in grey. CCGs are ranked out of 23 Yorkshire & Humber CCGs

RTT			Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	<87%		92.1%	91.1%	90.6%	90.3%	90.5%	90.9%	90.0%	89.4%	89.7%	90.0%	89.3%	90.2%	89.7%
	87% to 92%		94.8%	94.0%	93.8%	93.8%	93.7%	93.8%	94.1%	94.1%	94.1%	94.1%	#N/A	#N/A	#N/A
	>=92%	Rank	13/23	15/23	15/23	16/23	16/23	16/23	16/23	16/23	15/23	15/23	16/23	15/23	15/23
Number of patients waiting more that 52 weeks on incomplete pathways	>10		0	0	0	0	0	0	0	0	0	0	1	0	0
	1 to 10														
	0	Rank	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	13/23	1/23	1/23

Diagnostic			Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Percentage of patients waiting 6 weeks or more for a diagnostic test (15 key tests)	<6%		1.2%	1.4%	2.6%	0.7%	0.4%	0.8%	0.5%	1.2%	0.6%	1.4%	2.4%	3.1%	3.5%
	1% to 6%		0.4%	0.2%	0.4%	0.5%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	#N/A
	>=1%	Rank	16/23	15/23	20/23	14/23	8/23	16/23	9/23	12/23	9/23	13/23	13/23	18/23	17/23

Cancer Monthly			Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	<88%		95.3%	96.3%	96.5%	98.2%	97.8%	96.5%	97.4%	96.8%	96.8%	96.4%	93.8%	94.8%	94.2%
	88% to 93%		94.8%	94.7%	94.6%	96.1%	96.3%	95.7%	95.6%	95.6%	95.6%	95.6%	#N/A	#N/A	#N/A
	>=93%	Rank	11/23	6/23	7/23	1/23	5/23	8/23	8/23	2/23	11/23	12/23	12/23	14/23	14/23
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	<88%		95.2%	93.3%	100.0%	100.0%	92.3%	100.0%	100.0%	94.7%	100.0%	100.0%	100.0%	100.0%	100.0%
	88% to 93%		100.0%	96.4%	93.9%	94.4%	100.0%	96.6%	96.6%	96.6%	96.6%	96.6%	#N/A	#N/A	#N/A
	>=93%	Rank	#N/A	#N/A	1/23	1/23	22/23	#N/A	#N/A	#N/A	1/23	1/23	#N/A	#N/A	1/23
Maximum 31-day wait from diagnosis to first definitive treatment for all cancers	<91%		99.1%	100.0%	100.0%	99.0%	98.2%	97.6%	99.0%	99.1%	96.6%	98.4%	99.1%	99.3%	99.2%
	91% to 96%		99.3%	97.8%	97.2%	99.2%	97.0%	100.0%	98.4%	98.5%	98.5%	98.5%	#N/A	#N/A	#N/A
	>=96%	Rank	8/23	1/23	1/23	2/23	12/23	14/23	9/23	4/23	19/23	9/23	5/23	5/23	3/23
Maximum 31-day wait for subsequent treatment where that treatment is surgery	<89%		96.6%	100.0%	100.0%	97.4%	97.4%	97.1%	91.2%	91.7%	94.9%	93.5%	96.4%	97.0%	100.0%
	89% to 94%		95.0%	97.3%	100.0%	96.9%	100.0%	97.6%	100.0%	100.0%	100.0%	100.0%	#N/A	#N/A	#N/A
	>=94%	Rank	13/23	1/23	1/23	12/23	14/23	10/23	19/23	15/23	16/23	18/23	14/23	15/23	1/23
Maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen	<93%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	93% to 98%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#N/A	#N/A	#N/A
	>=98%	Rank	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	<89%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	89% to 94%		97.7%	100.0%	97.8%	100.0%	97.8%	100.0%	100.0%	97.4%	100.0%	100.0%	#N/A	#N/A	#N/A
	>=94%	Rank	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23
Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer	<80%		79.2%	89.1%	89.7%	88.7%	85.3%	79.0%	80.6%	79.4%	78.1%	91.5%	78.9%	82.8%	77.8%
	80% to 85%		86.1%	87.0%	85.9%	85.9%	88.6%	87.3%	87.5%	86.1%	85.1%	85.1%	#N/A	#N/A	#N/A
	>=85%	Rank	19/23	5/23	4/23	3/23	7/23	15/23	13/23	16/23	16/23	2/23	14/23	11/23	19/23
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	<85%		100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	71.4%	93.8%	93.3%	100.0%	100.0%
	85% to 90%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#N/A	#N/A	#N/A
	>=90%	Rank	#N/A	#N/A	#N/A	#N/A	21/23	1/23	#N/A	1/23	#N/A	13/23	#N/A	1/23	1/23
Maximum 62-day wait for first definitive treatment following a consultants decision to upgrade the priority of the patients (all cancers)	NA		66.7%	100.0%	100.0%	100.0%	33.3%	100.0%	75.0%	#N/A	100.0%	50.0%	100.0%	100.0%	100.0%
			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#N/A	#N/A	#N/A
		Rank	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	#N/A

Mixed Sex Accommodation			Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Breaches of Mixed-Sex Accommodation	>10		0	0	0	0	0	1	0	0	0	0	0	0	0
	1 to 10														
	0	Rank	1/23	1/23	1/23	1/23	1/23	1/23	21/23	1/23	1/23	1/23	1/23	1/23	

Mental Health			14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4	16-17 Q1	16-17 Q2	16-17 Q3	16-17 Q4	17-18 Q1
Care Programme Approach (CPA): Percentage of people under adult mental illness specialities on CPA who were followed up within 7 days of discharge from psychiatric inpatient care during the period	<90%		97.8%	97.5%	98.3%	100.0%	98.0%	99.1%	98.9%	93.7%	96.0%	98.3%	97.0%	98.8%	97.1%
	90% to 95%														
	>=95%	Rank	10/23	13/23	9/23	1/23	14/23	4/23	6/23	21/23	20/23	8/23	14/23	10/23	#N/A

Dementia			Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Dementia diagnosis rate	<62%		84.2%	84.2%	84.0%	83.4%	84.2%	84.1%	83.4%	83.1%	83.2%	81.6%	82.0%	81.9%	82.0%
	62% to 67%		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	#N/A	#N/A	#N/A	
	>=67%	Rank	3/23	3/23	3/23	3/23	3/23	4/23	4/23	4/23	4/23	1/23	1/23	1/23	

IAPT Monthly			May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
IAPT 6 Weeks First Treatment	<70% 70% to 75% >=75%		90.6%	89.4%	87.5%	90.6%	94.5%	90.7%	92.9%	93.0%	91.1%	94.6%	94.4%	95.3%	95.9%
		Rank	10/23	12/23	15/23	12/23	10/23	16/23	13/23	15/23	14/23	#N/A	7/22	9/23	
IAPT 18 Weeks First Treatment	<90% 90% to 95% >=95%		98.1%	97.9%	95.0%	98.1%	98.2%	100.0%	98.2%	97.7%	98.2%	98.2%	100.0%	100.0%	100.0%
		Rank	12/23	14/23	19/23	14/23	17/23	1/23	18/23	19/23	17/23	16/23			
IAPT (Rolling 3 month)			**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**	**Apr-17**	**May-17**
IAPT Access (rolling 3 months)	<3.75%		3.4%	3.2%	2.8%	3.3%	3.4%	3.7%	3.7%	3.9%	3.8%	3.9%	3.9%	3.8%	4.1%
			3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	4.2%	4.2%
	>=4.20%	Rank	16/23	20/23	21/23	14/23	14/23	12/23	13/23	11/23	14/23	12/23	13/23	14/23	
IAPT Recovery rate (rolling 3 months)	<45% 45% to 50% >=50%		43.8%	47.2%	48.5%	45.2%	43.8%	45.9%	47.5%	49.7%	50.7%	51.7%	51.6%	52.1%	56.0%
		Rank	19/23	13/23	11/23	14/23	20/23	16/23	13/23	10/23	10/23	9/23	11/23	11/23	
Early Intervention Psychosis - 2 Week Waits (rolling quarter)			**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**
Early intervention in psychosis - 2 week wait (Rolling quarter)	<45% 45% to 50% >=50%		63.4%	67.3%	70.3%	79.4%	78.1%	75.7%	64.3%	73.8%	73.2%	82.9%	76.5%	79.5%	80.4%
		Rank	17/23	19/23	17/23	14/23	16/23	14/23	18/23	15/23	13/23	9/23	11/23	11/23	
Safe Environment and Protecting from Avoidable Harm			**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**	**Apr-17**	**May-17**	**Jun-17**
Incidence of healthcare associated infection (HCAI) i) MRSA - Cases which have been assigned to the CCG following a Post Infection Review	>0		0	0	0	0	1	1	1	0	0	1	1	1	1
		Rank	1/23	1/23	1/23	1/23	22/23	22/23	22/23	1/23	1/23	22/23	21/23	18/23	19/23
Incidence of healthcare associated infection (HCAI) ii) C.difficile	>Ceiling		5	7	10	6	16	3	6	9	6	7	4	6	8
	<=Ceiling	Rank	15/23	15/23	21/23	12/23	22/23	6/23	16/23	19/23	18/23	18/23	10/23	19/23	19/23
	Ceiling		8	10	14	9	8	8	9	9	9	11	7	14	8
Ambulance Calls (Pilot Phase 2.2) **			**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**
Category 1 - Response within 8mins	<70% 70% to 75% >=75%					62.3%	61.7%	63.9%	70.0%	71.7%	64.9%	67.6%	74.4%	70.8%	77.2%
Category 2R - Response within 19mins by a resource.	NA					58.3%	79.1%	79.9%	89.4%	82.8%	81.3%	89.7%	82.5%	86.8%	83.9%
			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Category 2T - Response within 19mins by DCA unless RRV arrives and DCA is not required	NA					67.0%	71.5%	71.1%	80.3%	77.6%	78.3%	83.4%	81.8%	79.2%	73.8%
			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	

*** YAS have been participating in a pilot which has involved new call categories. The initial pilot ran from 21st April 2016 until 19th October 2016 and the second phase began on 20th October 2016. Due to the changes in categories direct comparison between the different phases cannot be done because they don't necessarily represent the same activity. Currently no performance target has been set for the 2R and 2T categories.*

APPENDIX 2: CCG SCORECARD

NHS Bradford City CCG

Commissioner data with CCG plans in grey. CCGs are ranked out of 23 Yorkshire & Humber CCGs

RTT			Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	<87%		90.7%	89.6%	89.4%	90.1%	89.6%	91.4%	90.1%	89.7%	89.4%	89.7%	88.4%	89.0%	88.7%
	87% to 92%		93.7%	92.3%	92.1%	93.5%	93.3%	94.0%	93.4%	93.4%	93.4%	93.4%	#N/A	#N/A	#N/A
	>=92%	Rank	17/23	17/23	17/23	17/23	17/23	13/23	15/23	15/23	16/23	17/23	17/23	17/23	17/23
Number of patients waiting more that 52 weeks on incomplete pathways	>10		0	0	0	0	0	0	0	0	0	0	0	0	0
	1 to 10														
	0	Rank	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23

Diagnostic			Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Percentage of patients waiting 6 weeks or more for a diagnostic test (15 key tests)	<6%		1.7%	1.8%	3.0%	0.4%	0.1%	0.6%	0.3%	1.1%	0.7%	1.3%	2.3%	3.1%	4.1%
	1% to 6%		0.4%	0.3%	0.3%	0.6%	0.4%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	#N/A
	>=1%	Rank	18/23	19/23	23/23	6/23	1/23	12/23	6/23	11/23	13/23	12/23	11/23	17/23	21/23

Cancer Monthly			Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	<88%		94.7%	95.8%	97.2%	96.9%	97.2%	96.7%	94.3%	94.9%	96.2%	97.8%	92.9%	94.7%	96.6%
	88% to 93%		97.7%	94.0%	96.8%	93.3%	96.1%	97.2%	96.4%	96.4%	96.4%	96.4%	#N/A	#N/A	#N/A
	>=93%	Rank	13/23	9/23	5/23	7/23	6/23	4/23	20/23	14/23	16/23	2/23	16/23	15/23	5/23
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	<88%				100.0%	100.0%	100.0%				100.0%	100.0%			100.0%
	88% to 93%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#N/A	#N/A	#N/A
	>=93%	Rank			1/23	1/23	1/23				1/23	1/23			1/23
Maximum 31-day wait from diagnosis to first definitive treatment for all cancers	<91%		91.7%	100.0%	92.9%	100.0%	94.7%	100.0%	91.7%	82.4%	100.0%	93.8%	96.2%	100.0%	100.0%
	91% to 96%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#N/A	#N/A	#N/A
	>=96%	Rank	22/23	1/23	23/23	1/23	23/23	1/23	23/23	23/23	1/23	23/23	17/23	1/23	1/23
Maximum 31-day wait for subsequent treatment where that treatment is surgery	<89%		100.0%	100.0%	83.3%	100.0%	100.0%	100.0%	100.0%	60.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	89% to 94%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#N/A	#N/A	#N/A
	>=94%	Rank	1/23	1/23	21/23	1/23	1/23	1/23	1/23	23/23	1/23	1/23	1/23	1/23	1/23
Maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen	<93%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	93% to 98%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#N/A	#N/A	#N/A
	>=98%	Rank	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	<89%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	89% to 94%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#N/A	#N/A	#N/A
	>=94%	Rank	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23
Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer	<80%		83.3%	80.0%	100.0%	70.0%	77.8%	91.7%	85.7%	66.7%	63.6%	62.5%	76.9%	68.8%	90.0%
	80% to 85%		100.0%	90.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#N/A	#N/A	#N/A
	>=85%	Rank	14/23	20/23	1/23	23/23	17/23	4/23	8/23	21/23	23/23	22/23	18/23	23/23	1/23
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	<85%			100.0%		100.0%	100.0%	100.0%	100.0%	66.7%		100.0%	100.0%	100.0%	100.0%
	85% to 90%		#N/A	#N/A	#N/A	#N/A	100.0%	100.0%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
	>=90%	Rank		#N/A		#N/A	1/23	1/23	#N/A	22/23		1/23	#N/A	1/23	1/23
Maximum 62-day wait for first definitive treatment following a consultants decision to upgrade the priority of the patients (all cancers)								100.0%							
			#N/A	#N/A	100.0%	100.0%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
		Rank						#N/A							

Mixed Sex Accommodation			Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Breaches of Mixed-Sex Accommodation	>10		0	0	1	0	0	0	0	0	0	0	0	0	0
	1 to 10														
	0	Rank	NA	NA	1/23	NA	NA	NA	NA	NA	NA	NA	NA	NA	

Mental Health			14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4	16-17 Q1	16-17 Q2	16-17 Q3	16-17 Q4	17-18 Q1
Care Programme Approach (CPA): Percentage of people under adult mental illness specialities on CPA who were followed up within 7 days of discharge from psychiatric inpatient care during the period	<90%		100.0%	97.7%	97.4%	98.0%	97.1%	95.2%	89.7%	94.6%	97.5%	92.7%	100.0%	100.0%	96.5%
	90% to 95%														
	>=95%	Rank	1/23	12/23	13/23	14/23	17/23	17/23	23/23	19/23	12/23	21/23	1/23	1/23	#N/A

Dementia			Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Dementia diagnosis rate	<62%		89.7%	91.2%	94.0%	95.5%	95.0%	95.0%	94.2%	97.3%	97.5%	81.0%	80.3%	81.4%	81.8%
	62% to 67%		75.1%	75.1%	75.1%	75.1%	75.1%	75.1%	75.1%	75.1%	75.1%	#N/A	#N/A	#N/A	
	>=67%	Rank	2/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	2/23	2/23	2/23	

IAPT Monthly			May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
IAPT 6 Weeks First Treatment	<70%														
	70% to 75%		88.9%	88.2%	94.1%	94.1%	93.3%	100.0%	94.4%	100.0%	100.0%	100.0%	91.7%	100.0%	90.9%
	>=75%	Rank	12/23	13/23	11/23	11/23	13/23	1/23	11/23	1/23	1/23	1/23			
IAPT 18 Weeks First Treatment	<90%														
	90% to 95%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	>=95%	Rank	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23			

IAPT (Rolling 3 month)			May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
IAPT Access (rolling 3 months)	<3.75%		3.4%	3.4%	2.9%	3.2%	3.1%	3.3%	3.3%	3.8%	4.0%	4.3%	4.4%	5.0%	5.4%
			3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	4.2%	4.2%
	>=4.20%	Rank	17/23	16/23	19/23	15/23	19/23	17/23	19/23	13/23	8/23	6/23			
IAPT Recovery rate (rolling 3 months)	<45%														
	45% to 50%		39.6%	40.0%	42.3%	47.1%	49.0%	48.9%	43.5%	46.5%	47.5%	50.0%	47.2%	45.5%	44.1%
	>=50%	Rank	21/23	22/23	17/23	10/23	10/23	13/23	20/23	16/23	15/23	13/23			

Early Intervention Psychosis - 2 Week Waits (rolling quarter)			Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Early intervention in psychosis - 2 week wait (Rolling quarter)	<45%														
	45% to 50%		56.5%	57.1%	62.5%	80.8%	85.7%	78.9%	70.4%	74.1%	71.0%	78.3%	73.9%	83.3%	75.0%
	>=50%	Rank	19/23	21/23	20/23	13/23	10/23	12/23	16/23	13/23	16/23	12/23	12/23	10/23	

Safe Environment and Protecting from Avoidable Harm			Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Incidence of healthcare associated infection (HCAI) i) MRSA - Cases which have been assigned to the CCG following a Post Infection Review	>0		0	0	0	0	0	0	0	0	0	0	0	0	0
		Rank	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23	1/23
Incidence of healthcare associated infection (HCAI) ii) C.difficile	>Ceiling		2	1	3	0	1	1	1	1	2	1	1	1	1
	<=Ceiling	Rank	3/23	1/23	5/23	1/23	2/23	1/23	1/23	1/23	1/23	1/23	3/23	2/23	1/23
	Ceiling		0	0	1	2	2	1	2	2	2	9	1	1	0

Ambulance Calls (Pilot Phase 2.2) **			Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Category 1 - Response within 8mins	<70%														
	70% to 75%					64.0%	78.5%	68.0%	73.6%	77.3%	74.3%	81.8%	79.1%	79.5%	80.5%
	>=75%														
Category 2R - Response within 19mins by a resource.	NA					66.7%	84.2%	80.7%	83.6%	80.5%	92.7%	91.2%	90.2%	84.5%	84.3%
			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Category 2T - Response within 19mins by DCA unless RRV arrives and DCA is not required	NA					72.6%	77.1%	75.9%	82.9%	82.0%	81.4%	86.5%	84.2%	83.3%	78.5%
			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

*** YAS have been participating in a pilot which has involved new call categories. The initial pilot ran from 21st April 2016 until 19th October 2016 and the second phase began on 20th October 2016. Due to the changes in categories direct comparison between the different phases cannot be done because they don't necessarily represent the same activity. Currently no performance target has been set for the 2R and 2T categories.*

APPENDIX 2: CCG SCORECARD

PROVIDER LEVEL PERFORMANCE

Airedale NHS Foundation Hospital Trust

A&E			Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
A&E waits -Percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge	<95%		90.3%	88.8%	91.3%	90.2%	90.8%	87.0%	88.4%	94.5%	93.1%	93.3%	93.7%	95.2%	95.6%
	95% to 95%														
	>=95%	STF										91.7%	91.7%	91.7%	91.7%
A&E Trolley Waits over 12 hours	>0		0	0	0	0	0	0	1	0	0	0	0	0	0
	0														

RTT			Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	<87%		91.2%	91.0%	91.8%	91.8%	92.5%	92.4%	92.8%	92.3%	92.9%	92.5%	93.0%	93.2%	93.2%
	87% to 92%														
	>=92%	STF										92.0%	92.0%	92.0%	92.0%

Diagnostic			Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Percentage of patients waiting 6 weeks or more for a diagnostic test (15 key tests)	<6%		0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	2.0%	3.0%	3.3%
	1% to 6%														
	>=1%	STF											6.0%	6.0%	6.0%

Cancer Monthly			Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Maximum 62-day wait from urgent GP referral to first definitive treatment for cance	<80%		91.2%	89.7%	95.4%	87.1%	95.0%	93.0%	95.7%	85.5%	91.3%	93.8%	92.9%	90.1%	91.5%
	80% to 85%														
	>=85%	STF											85.0%	85.0%	85.0%

Cancelled Elective Operations			14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4	16-17 Q1	16-17 Q2	16-17 Q3	16-17 Q4	17-18 Q1
Cancelled Operations - For non clinical reasons rebooked > 28 days	>10		0	0	1	0	0	0	1	0	1	3	0	1	0
	1 to 10														
	0	Rank	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A

Safe Environment and Protecting from Avoidable Harm			Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Venous Thromboembolism (VTE) Assessment Percentage	90%		96.2%	95.0%	95.0%	95.0%	94.3%	95.3%	95.8%	94.7%	93.9%	93.8%	93.3%	96.2%	97.4%
	90% to 95%														
	>=95%	Rank	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A

Delayed Transfers			Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Bed Day Delays per Occupied Bed			2.49%	4.09%	4.51%	4.79%	4.34%	3.36%	2.01%	2.14%	1.58%	1.54%	1.28%	2.43%	1.40%

Bradford NHS Teaching Hospital Foundation Trust

A&E			Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
A&E waits -Percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge	<95%		89.8%	90.1%	88.2%	85.0%	85.1%	82.1%	86.8%	90.1%	92.4%	87.4%	81.9%	86.3%	88.1%
	95% to 95%														
	>=95%	STF										92.1%	89.6%	88.4%	90.3%
A&E Trolley Waits over 12 hours	>0		0	0	0	0	0	0	0	0	0	0	0	0	0
	0														

RTT			Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	<87%		90.6%	90.1%	89.7%	89.8%	90.5%	89.7%	89.1%	89.1%	89.3%	88.3%	89.0%	88.7%	88.0%
	87% to 92%														
	>=92%	STF										89.1%	89.2%	89.7%	90.3%

Diagnostic			Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Percentage of patients waiting 6 weeks or more for a diagnostic test (15 key tests)	<6%		1.6%	2.7%	0.5%	0.3%	0.8%	0.6%	1.3%	1.0%	3.1%	4.1%	4.7%	6.2%	6.1%
	1% to 6%														
	>=1%	STF											2.4%	2.4%	1.9%

Cancer Monthly			Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Maximum 62-day wait from urgent GP referral to first definitive treatment for cance	<80%		82.7%	89.0%	89.5%	87.6%	83.6%	83.1%	84.2%	77.6%	75.9%	90.2%	80.3%	79.7%	76.8%
	80% to 85%														
	>=85%	STF											80.0%	82.1%	83.1%

Cancelled Elective Operations			14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4	16-17 Q1	16-17 Q2	16-17 Q3	16-17 Q4	17-18 Q1
Cancelled Operations - For non clinical reasons rebooked > 28 days	>10		4	2	1	0	1	2	1	5	1	1	2	11	2
	1 to 10														
	0	Rank	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A

Safe Environment and Protecting from Avoidable Harm			Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Venous Thromboembolism (VTE) Assessment Percentage	90%		96.8%	85.1%	82.8%	83.5%	82.2%	83.8%	78.3%	78.0%	77.3%	83.8%	87.0%	89.4%	90.9%
	90% to 95%														
	>=95%	Rank	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A

Delayed Transfers			Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Bed Day Delays per Occupied Bed			1.96%	1.26%	1.97%	1.73%	2.52%	2.50%	2.19%	2.17%	2.85%	2.52%	2.62%	1.16%	1.31%

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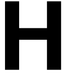
Report of the Strategic Director Health and Wellbeing to the meeting of the Health and Social Care Overview and Scrutiny Committee to be held on the 5 October 2017.



Subject: Adult and Community Services Annual Performance Report 2016/17

Summary statement: The following report sets out a summary of the Adult and Community Services Department for the financial year 2016/17 across a range of national performance indicators.

Bev Maybury Strategic Director Health and Wellbeing	**Portfolio Holder** **Health and Wellbeing**
Report Contact: Phone: (01274) 431730 email: imran.rathore@bradford.gov.uk	Overview & Scrutiny Area: Health and Social Care

1.0 SUMMARY

1.1 The report provides an overview of the Department of Health and Wellbeing's performance across the Adult Social Care Outcomes Framework (Public Health Outcome Framework) in 2016/17.

1.2 The report also builds on the Home First Vision and Operating Model presentation at the Feb O&S Committee meeting and sets the improvement activity we are putting in place to strengthen performance management arrangements to measure the implementation process and the impact on the people who we support.

2.0 BACKGROUND

2.1 The Adult Social Care Outcomes Framework (ASCOF) is used both locally and nationally to set priorities for care and support, measure progress and strengthen transparency and accountability.

2.2 The key roles of the ASCOF are:

- It provides councils with robust information that enables us to monitor the success of local interventions in improving outcomes, and to identify our priorities for making improvements.
- We can also use ASCOF to inform outcome-based commissioning models
- It is a useful resource for our Health and Wellbeing board who can use the information to inform their strategic planning and leadership role for local commissioning
- It strengthens accountability to local people. By fostering greater transparency on the outcomes delivered by care and support services, it enables local people to hold councils to account for the quality of the services that they provide, commission or arrange. We also use the ASCOF to develop and publish our local account to communicate directly with local communities on the outcomes that are being achieved, and their priorities for developing local services
- Regionally, the data supports sector led improvement; bringing councils together to understand and benchmark their performance. This, in turn, stimulates discussions between councils on priorities for improvement, and promotes the sharing of learning and best practice. In Bradford we are fully engaged in the Y&H Sector Led Improvement Programme and the ASCOF measures are monitored on a quarterly basis together with Risk Awareness via the Regional Performance and Standards Network.
- At the national level, the ASCOF demonstrates the performance of the adult social care system as a whole, and its success in delivering high-quality, personalised care and support. Meanwhile, the framework supports Ministers in discharging their accountability to the public and Parliament for the adult social care system, and continues to inform, and support, national policy development. The Government does not seek to performance manage councils in relation to any of the measures set out in this framework. Instead, the ASCOF will inform and support improvement led by the sector itself, underpinned by strengthened transparency and local accountability.

2.3 The ASCOF outcome measures come from a variety of data sources, mainly:

Adult Social Care Survey	Annual random survey of people receiving longer term Adult Social Care Services, in the Community and in Residential or Nursing Care	This informs 7 ASCOF Outcomes: • 1A Social Care related Quality of Life • 1B Control Over Daily Life • 1I(i) Social Contact • 3A Satisfaction with Care and Support • 3D(i) Information and Advice • 4A Feeling Safe and 4B Feeling Safe as a result of Services
Survey of Adult Carers Experience	Biennial random survey of Adult Carers of people receiving longer term Adult Social Care Services.	This survey informs **5 ASCOF Outcomes**: • 1D Carers Quality of Life • 1I(ii) Social Contact • 3B Satisfaction with Care and Support • 3C Consultation/Discussion • 3D(ii) Information and Advice
Short and Long Term Support (SALT) Data Collection	Adult Social Care activity data from the Customer Journey i.e. Initial Contact through short term support to maximise independence, assessment and support to longer term service delivery. This data collection informs 11 ASCOF Outcomes:	• 1C (pt1/pt2) Self Directed Support and Direct Payments (Cared For and Carers) • 1E/1G People with Learning Disabilities in Paid Employment / Settled Accommodation • 2A Long Term Care Needs met by Permanent Admissions to Res/Nurs Care • 2B Effectiveness of Re-ablement • 2D Outcomes from Short Term Support

3.0 REPORT ISSUES

3.1 In August 2016 we implemented SystmOne, which has made a huge step change in data quality compared to previous years and we are now in place where we have increasing confidence in data quality.

While we have included data from previous years for comparison purpose, this needs to be taken with a degree of caution.

3.2 ASCOF outcomes measures

3.2.1 The table below summarises the latest ASCOF outcomes measures, compared to previous year’s performance and showing direction of travel and an overall rating based on latest comparator data available. We will share a revised version of this table once the official regional and national data is made available.

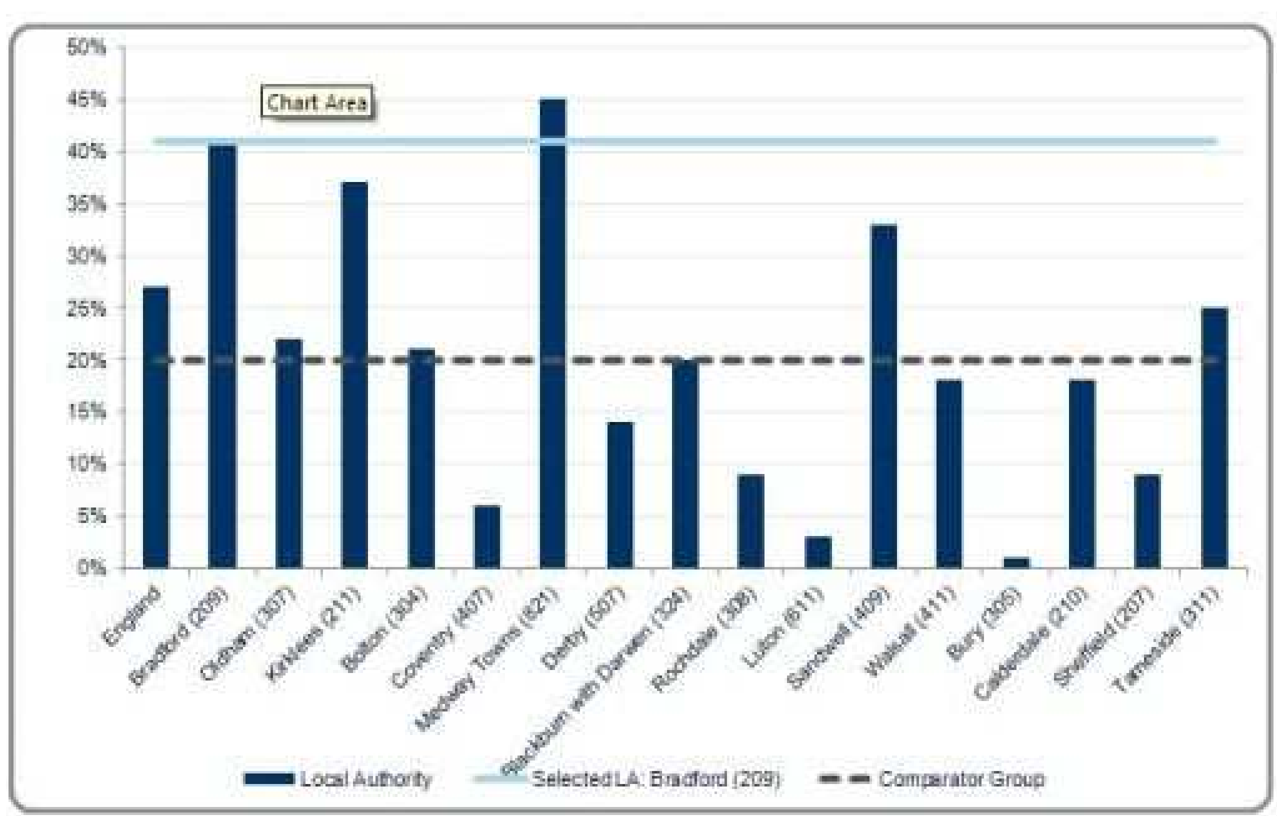
ASCOF		2016-17 Out-turns					2015-16 Final						
		Num	Denom	Outcome	*DoT*	*RAG*	Outcome	*DoT*	*RAG*	Regional Rank	National Rank	Region Ave	National Ave
1A	Social Care Quality Of Life						19.5	↑		5	28	19.1	19.1
1B	Control Over Daily Life						79.2%	↑		6	46	76.2%	76.6%
1C(1a)	Self Directed Support (Cared For)						86.8%	↑		9	99	87.9%	86.9%
1C(1b)	Self Directed Support (Carers)						82.5%	↑		10	113	70.3%	77.7%
1C(2a)	Direct Payments (Cared For)	638	2,719	23.5%	↑		17.5%	↑		13	132	25.8%	28.1%
1C(2b)	Direct Payments (Carers)						81.9%	↑		7	92	59.8%	67.4%
1D	Carers QOL	2,397	299	8.0	↓		-			-	-	8.1	7.9
1E	LD Employment						5.5%	↑		8	77	6.3%	5.8%
1F	MH Employment	210	2,615	8.0%	↑		6.1%	↓		11	78	8.2%	6.7%
1G	LD Independence						86.3%	↑		3	24	78.6%	75.4%
1H	MH Independence	1,915	2,615	73.2%	↑		69.1%	↑		7	65	64.7%	58.6%
1I(i)	Social Contact						51.4%	↓		2	17	46.0%	45.4%
1I(ii)	Social Contact Carers	125	318	39.3%	↓		-			-	-	40.8%	38.5%
2A(i)	Perm Admissions To Care 18-64	42	315,051	13	↑		14.0	↑		9	91	13.9	13.3
2A(ii)	Perm Admissions To Care 65+	392	76,088	515	↓		513	↑		1	35	699.5	628.2
2B(i)	Re-ablement (effectiveness)	197	225	87.6%	↓		88.2%	↓		7	43	82.9%	82.7%
2B(ii)	Re-ablement (offered)						2.8%	↑		4	81	3.1	2.9
2C(i)	Delayed Transfers of Care (ALL)	13.2	391,139	3.4	↑		3.4	↑		2	7	10.2	12.1
2C(ii)	Delayed Transfers of Care (social care)	5.7	391,139	1.46	↓		0.19	↑		1	4	3.4	4.7
2D	Outcomes from Short Term Support						64.8%	↑		12	120	73.1%	75.8%
3A	Satisfaction						63.1%	↑		11	90	63.8%	64.4%
3B	Carers Satisfaction	87	244	35.7%	↓		-			-	-	43.7%	41.2%
3C	Carers Discussion/Consultation	160	217	73.7%	↓		-			-	-	74.7%	72.3%
3D(i)	Information and Advice						70.8%	↓		13	113	75.3%	73.5%
3D(ii)	Carers Info & Advice	140	199	70.4%	↑		-			-	-	68.9%	65.5%
4A	Feeling Safe						73.2%	↑		5	24	69.9%	69.2%
4B	Feeling Safe As A Result of Services						84.8%	↑		12	85	85.9%	85.4%

3.2.2 Key areas for strength

- The overall **access to social care advice, information and services** in Bradford has been rated as ‘Good’ in the 2016/17 ADASS Regional Assessment with improvements in every area. It’s the first time in 5 years we’ve had no ‘Unsatisfactory’

Scenario	2012	2013	2014	2015	2016
telephone	Unsatisfactory	Fair	Good	Fair	Good
Website	Good	Good	Good	Excellent	Excellent
Face to face	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory	Good
Reception	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory	Fair
Out of hours	Good	Excellent	Excellent	Fair	Good
Safeguarding		Fair	Fair	Fair	Good

- The Adult Services Access Team receive over 56,000 calls each year and the Department's overall signposting to other 'universal' services rate in 2015-16 was double that of the national average. Latest figures from Access indicate around 64% of requests for support are dealt with at point of contact.
  A recent review of our approach has show that that the level of support provided to some individuals may not be appropriate to their needs as such we are putting in measures to address this



- **2C: Delayed Transfers of Care (2C)**

  Traditionally an area of excellent performance. 3 adults per 100,000 population in Bradford experienced a delayed transfer of care in 2016-17, compared with the Y&H Regional average of 10 and an England average of 12. In Bradford only 0.6 per 100,000 population were attributable to social care, compared to Y&H average of 3.4 and an England average of 4.7.

- **2A: Long-term support needs for older people met by admission to residential and nursing care homes**

  The best performance in Y&H and integral to the joint LA/NHS Better Care Fund In 2016-17 55 people aged 18-64 care needs were met by admission to permanent care, an increase from the 44 reported in 2015-16 and representative of 18 people per 100,000 population, compared to 14 in Y&H Region and 13 England average.

  The same measure for people aged 65+ saw 441 individuals' care and support needs met by admission to residential and nursing care, up from 385 in 2015-16. This equates to 580 people per 100,000 population in Bradford, 700 in Y&H and 628 in England.

- **4A Proportion of people who use services who feel safe**
  73% of people receiving Adult Social Care Services say that they feel safe, which is in the top 5 in the Region and 25th best from 152 councils with social services responsibilities.

- **1A Social Care Related Quality of Life**
  Our Social Care related Quality of Life score encompasses multiple ASCOF domains from questions in our Annual Adult Social Care Survey, and at 19.5 is one of the highest in the Region and 28th highest from 152 councils.

- **4B: The proportion of people who use services who say that those services have made them feel safe and secure**
  In 2016-17 86% of people receiving long term social care and support reported that the services they received helped make them feel safe and secure, improved from 84.8% in 2015-16 and to above the latest England average of 85.4%.

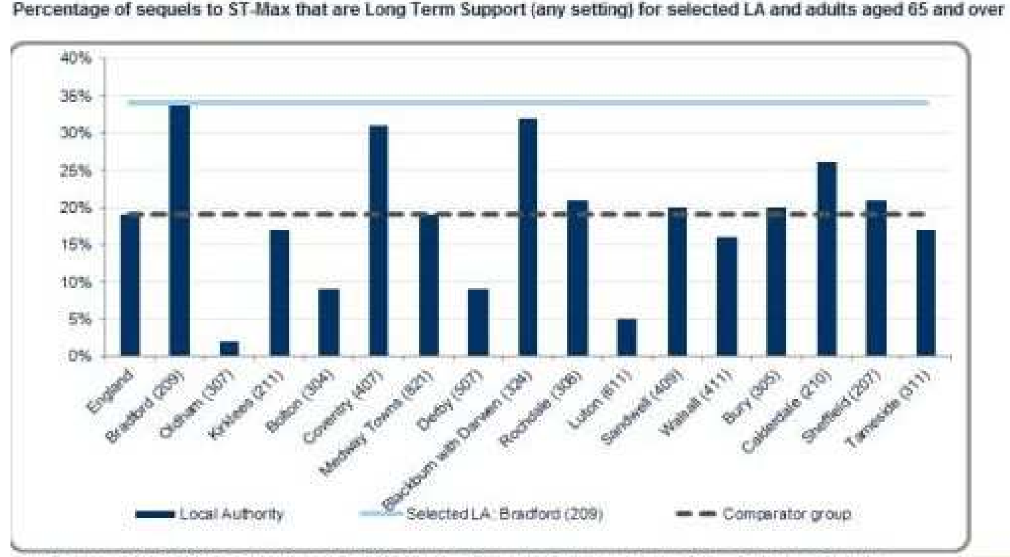
- We have strong partnerships with health and the voluntary sector and we have been implementing new integrated digital care records systems so our confidence in reporting on performance and outcomes is improving

3.2.3 Key areas for improvement

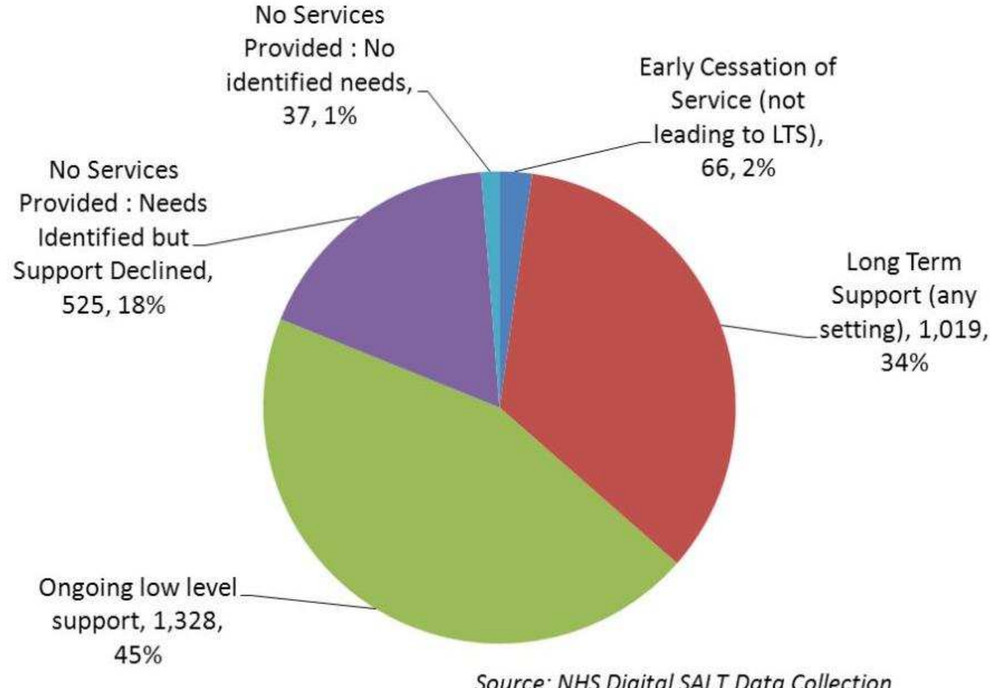
- Work is currently underway to integrate all our Adult Social Care intelligence into our new systems and to develop our reporting capabilities. This includes the roll out of Power BI performance management tool across all our front line staff. Power BI will enable us to provide bespoke performance management reports to staff on their individual and team performance.

- We are also reviewing our performance management framework to reflect Short and Long Term Support activity, in line with national SALT Data Collection and consistent with our configuration of SystmOne.

- **2D Outcome of short-term services: sequel to service -** Our model of short term support to maximise independence results in a proportionately higher number of older people going into long term care

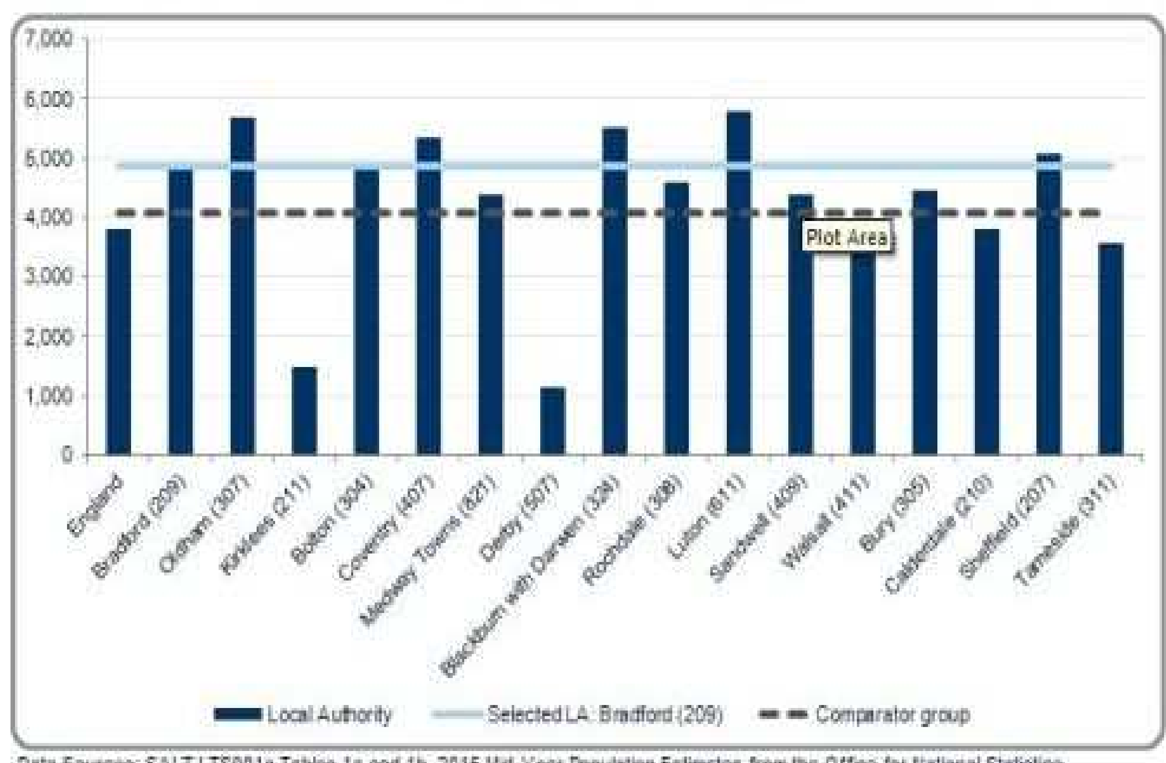


ASCOF 2D Outcomes from Short Term Services 2015-16



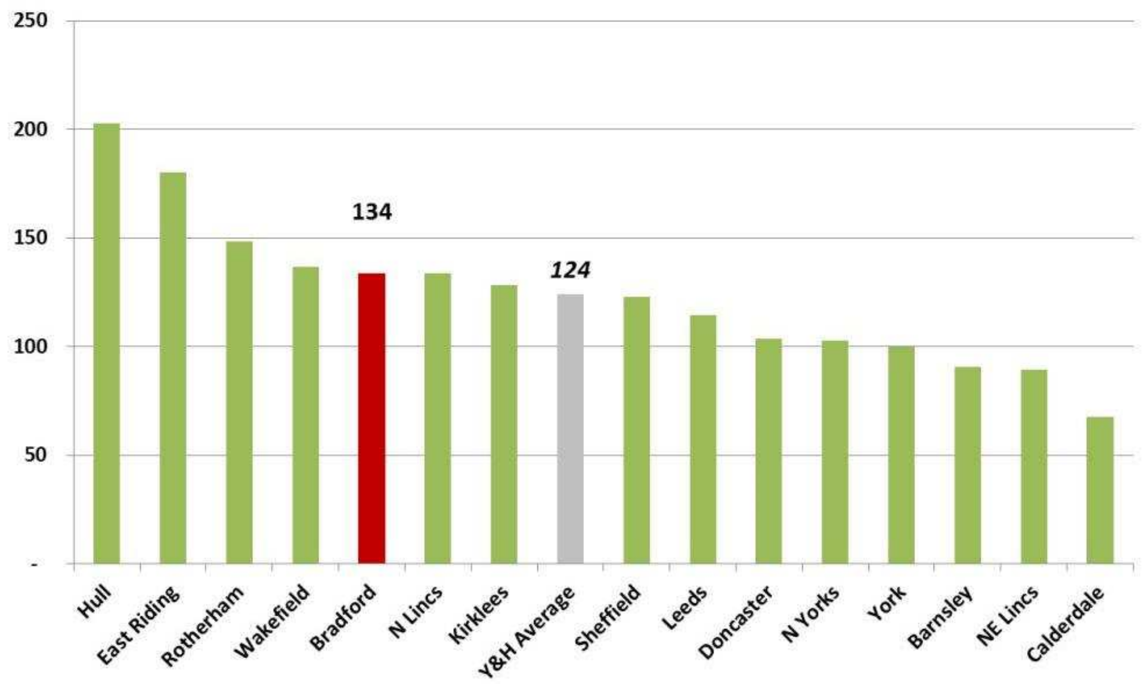
- We have above average numbers of people receiving long term care and support, particularly in Personal Care

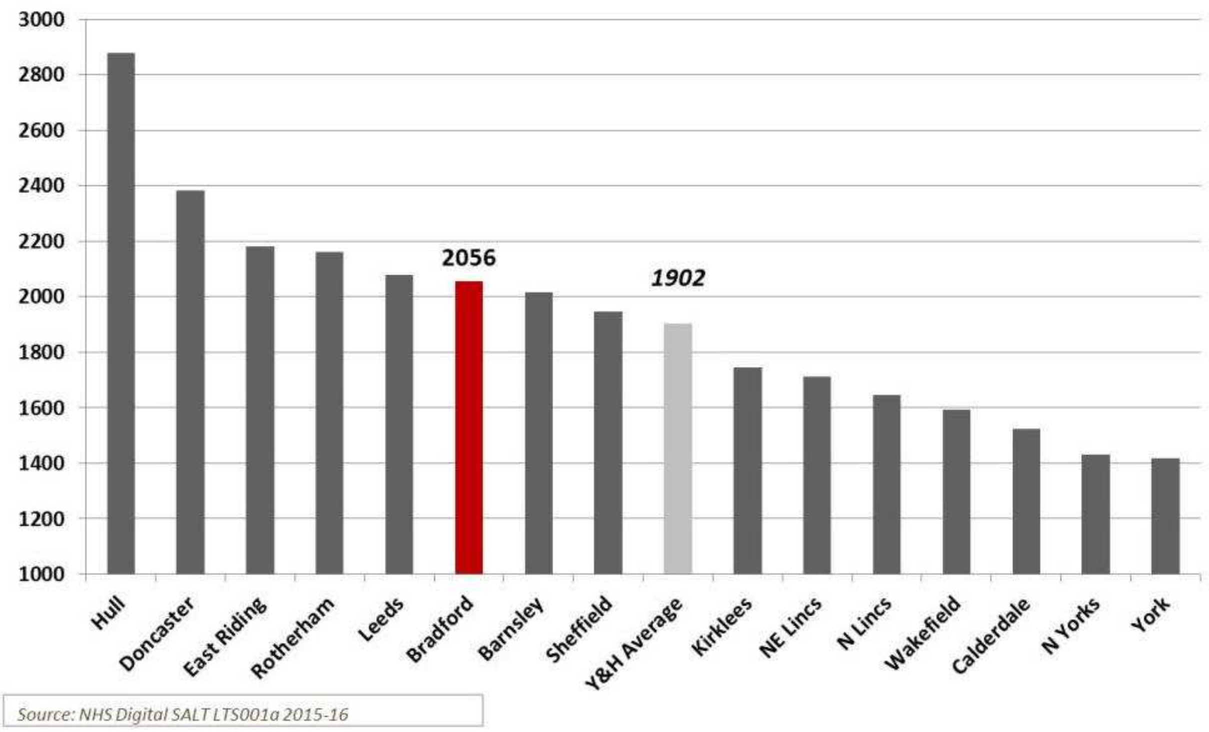
Long Term Support clients with a PSR of Physical Support: Personal care support for selected LA and adults aged 6



Data Sources: SALT LTS001a Tables 1a and 1b, 2015 Mid-Year Population Estimates from the Office for National Statistics

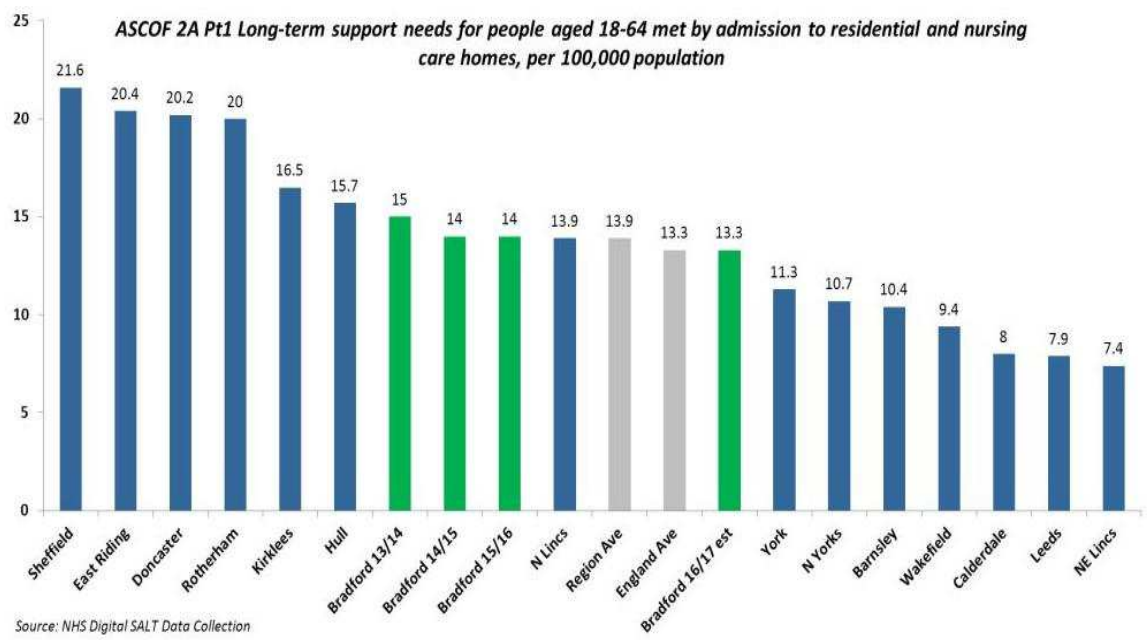
- We have a relatively high number of people who are in care homes, aged 18-64 and 65+. The tables below show our performance compared to other LAs.





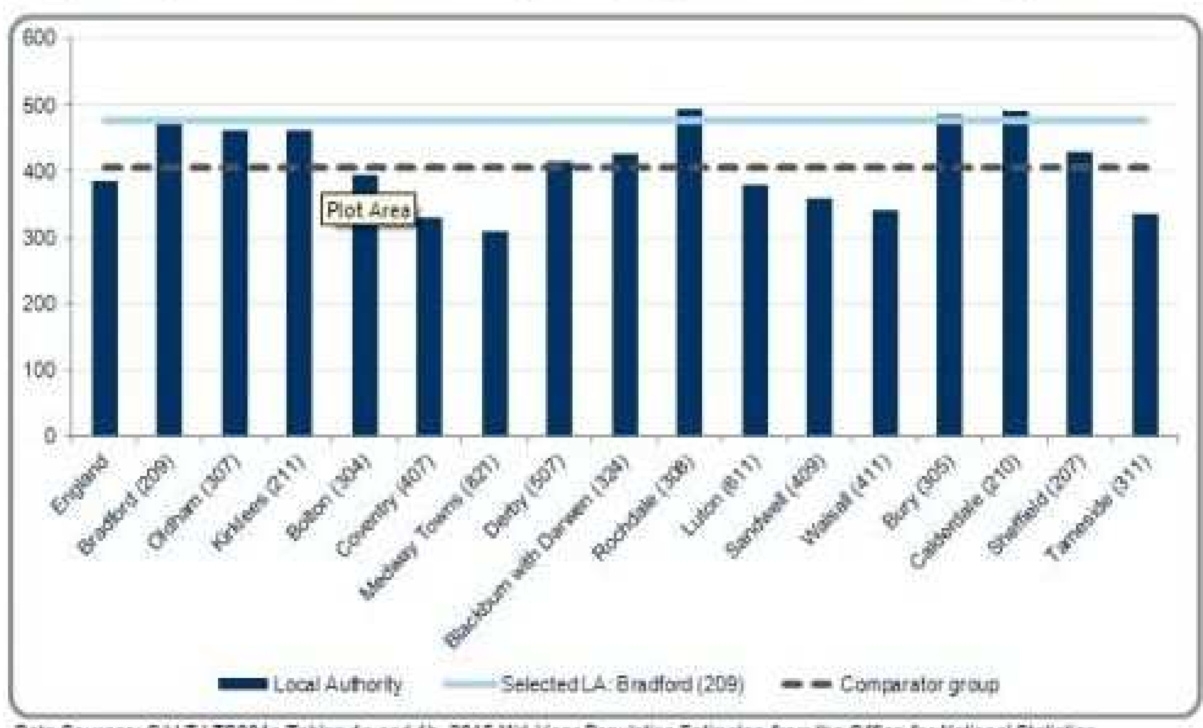
- When we review people receiving long term support we are seeing a high proportion of care packages staying the same or with increased care. Latest figures from SystmOne indicate that of the Outcomes from Reviews 86% of planned reviews result in no change or increased support, and 96% of unplanned.

- The number of younger people (aged 18-64) whose long term care needs have been met by residential care has remained roughly the same since 2013



- We have a relatively higher population of people with a learning disability receiving long term care and support and a number we have assessed as being “at risk” of a care home or hospital admission through transforming care

Long Term Support clients with a PSR of Learning Disability Support for selected LA and adults aged 18-64



Data Sources: SALT LTS001a Tables 1a and 1b, 2015 Mid-Year Population Estimates from the Office for National Statistics

- 1D, 3B, 3C, 3D(ii) : Carer Quality of Life, Satisfaction, Involvement and Information and Advice

The outcomes from the 2016-17 Survey of Adult Carers Experience were generally poor. Compared to the last time the survey was carried out in 2013-14 carers' self-reported overall quality of life was worse at 8.2 compared to 8.4 though still above the latest Regional and England averages of 8.1 and 7.9.

The sample of carers surveyed were less satisfied with their care and support, 37% compared to 40%, less involved in consultation and discussion about the person they care for, 75% compared to 78%.

The only improvement on the ASCOF measure was that carers felt that the provision of information and advice had improved, 72% in 2016-17 from 67% in 2013-14.

- Our review of ADASS Performance and Risk Dashboard shows that we currently benchmark low on:
  - Number of people in receipt of long term care whose primary health care need is met/funded by health commissioners through Continuing Health Care
  - Q3 Delayed Transfers of Care performance has deteriorated as pressures on the acute hospital sector are mounting
  - Initial Outcomes from the 2016-17 Carers Survey are poor and worse than previous survey in 2014-15 (where we were one of the poorer performing LAs)

- We are putting in further measures to strengthen the performance management approach within the department which includes:
  - buddying up with Rotherham through the regional Sector Led Improvement Programme
  - developing our performance reporting and look to incorporate into our Dashboard the Y&H Performance and Risk data, allowing quarterly benchmarking on Leadership and Governance, Safeguarding, DoLS, Resource and Workforce, Commissioning and Quality, Complaints.
  - Implementing of PowerBI to support team and individual performance reporting, to identify and address variations within practice and approach

3.3 SALT Activity

3.3.1 It has been a transitional year for systems and reporting relating to Adult Social Care in Bradford. Our implementation of Integrated Digital Care Records in August 2016 has seen us move from AIS to Systm One, Commcare to ContrOcc, wholesale changes in business and recording processes as well as performance and business intelligence tools.

This has impacted on reported SALT activity in 2016-17, some positive and some negative and so in some cases year on year comparisons are not advised. However, transparency of data has never been greater and a post SALT review of activity will help inform a gap analysis already underway, taking in Care Act and statutory reporting requirements, to improve the recording and reporting of an accurate Adult Social Care customer journey in Bradford.

Information not previously available from legacy systems has been reported for the first time, from Systm One, for example Route of Access, Primary Support Reason, Reported Health Condition, Reason for Unplanned Review. Many of these new data items are subject to on-going data quality monitoring. Our 2016-17 SALT Data Collection is now subject to further validation from NHS Digital ahead of publication later in the year.

3.3.2 The table below summarises some of the key SALT activity, compared to previous year's performance.

SALT Ref	Short and Long Term Support Statistics	16-17*	15-16
STS001	Total requests for support from new clients aged 18-64	3,258	6,805
STS001	Total requests for support from new clients aged 65+	8,439	24,700
STS002a	Total sequels to STS Max for new clients	3,127	3,005
STS002b	Total sequels to STS Max for existing clients	232	480
STS004	Hospital Discharges in period to Rehab/Reablement	337	370
STS004	Of which person was still at home 91 days later	296	330
LTS001a	No. of people aged 18-64 receiving LTS during year	2,518	2,550
LTS001a	No. of people aged 65+ receiving LTS during year	4,918	5,075
LTS001b	No. of people aged 18-64 in LTS at year end	2,263	2,365
LTS001b	No. of people aged 65+ in LTS at year end	3,377	3,375
LTS001b	No. of people aged 18-64 in Long Term Res/Nurs Care at year end	393	430
LTS001b	No. of people aged 65+ in Long Term Res/Nurs Care at year end	1,297	1,547
LTS001b	No. of people aged 18-64 in Long Term Comm Care at year end	1,872	1,934
LTS001b	No. of people aged 65+ in Long Term Comm Care at year end	2,080	1,827
LTS001c	No. of people aged 18-64 receiving LTS for >12months	1,609	2,220
LTS001c	No. of people aged 65+ receiving LTS for >12months	1,900	2,800
LTS002	No. of unplanned reviews for those in LTS001a 18-64	139	200
LTS002	No. of unplanned reviews for those in LTS001a 65+	643	1,025

SALT Ref	Short and Long Term Support Statistics	16-17*	15-16
LTS002	Planned reviews leading to Permanent Care	103	140
LTS003	No. of Carers Supported	1,402	3,580
LTS004	No. of people with LD in settled accommodation	1,203	1,285
LTS004	No. of people with LD in unsettled accommodation	151	205
LTS004	No. of people with LD in paid employment	44	82
LTS004	No. of people with LD not in employment	1,310	1,409
SSDA902	No. of blind/severely sighted on Vi Register	1,295	1,445**
SSDA902	No. of partially sighted on Vi Register	1,482	1,625**

3.4. Accessible Information

3.4.1 Work on accessible information within the Health and Wellbeing department has recently undergone a review to ensure that the Accessible Information Standards are embedded in the implementation plans to deliver our new Home First vision (approved by the Council Executive on 4 April 2017).

As part of this review we have identified dedicated resources to support the implementation of this work stream going forward – we believe this resource will help to improve the speed of implementation and provide a better coordination of activity.

3.4.2 Other key developments over the last few months include:

- Home First Vision main document and the easy read version has been sent to services users.

- A review of all Adult Services Literature (leaflets, policy documents etc.) is underway with the aim to update content, reflect the Home First Vision and also identify areas which need addressing from an accessible information point of view

  As part of this review we are also currently updating content of the Adult Services web pages on the Council's website – this work is being supported by the Strategic Disability Partnership (SDP) who are reviewing content and providing feedback on issues which need addressing

- Staff at all points of contact have been trained in the standard. There are systems in place to flag an Accessible Information need on SystmOne and to record what the need is and how to meet it. The services trained are Adult Services Access Point, Sensory Needs Services and the two hospital sites

The table below provides an update against the information provided in March:

Area	March 17	Sept 17
(Xabsc) Requires contact by short message service text message	1	2
(Xabsd) Requires contact by letter	9	10
(XacJU) Reqs written information in at least 20 point sans serif font	4	3
(XacJV) Reqs written information in at least 24 point sans serif font	56	84
(XacJW) Reqs written information in at least 28 point sans serif font	2	3
(Xad6e) Requires contact via carer	6	13
(XaJPI) Using Makaton sign language	4	4
(XaLTC) Interpreter needed - British Sign Language	9	15
(XaPSq) Requires information verbally	3	4
(XaR7B) Preferred method of communication: written	7	7
(XaYA0) Requires contact by telephone	3	8
(XaYAB) Requires information on audio cassette tape	2	2
(XaILE) Using British sign language	165	159
Grand Total	**271**	**314**

- We are undertaking further work to roll out capturing accessible information standards to all staff. This will allow the information to be updated at each point along the Customer Journey, providing a more accurate/real time picture of people's requirements and ensuring that communication is tailored to their needs

- We are in the process of reviewing and updating all forward facing communications (e.g. letters) that go out from the service via SystmOne, with a view to developing accessible information versions. At the moment the work is being updated on a priority basis, however we are considering whether to commission an external partner to speed this up

- We have worked with Bradford Talking Media (BTM) to deliver training to all providers of residential, domiciliary and nursing care across the district that are contracted by the council. BTM delivered training to 180 people face to face

  BTM created an ELearning platform to enhance knowledge base – this allows for close monitoring of those who had engaged with the training and those who had started, completed, identifying providers in the process.

We also arranged for BTM to attend a Home Care Provider Forum meeting to explain and discuss the duties for health and social care providers under the Accessible Information Standard

Following these sessions it was highlighted that our own in house providers had not received any training - This is under discussion at present as extra funding needs identifying

- Healthwatch have agreed to monitor how the standard is being applied when they complete their Enter and View visits. All their Enter and View staff have been trained

- As part of the wider roll out of Connect to Support Portal, we have consulted with the SDP and the Access to Care and Support group to identify issues and areas that need addressing from an accessibility point of view. The Virtual Village is now in place and improvement work from an accessibility point of view will take place over the next few months

- The NHS and Social Care Leads group are reviewing a document management system - 'Synertic' as a way of improving the way we might meet our Accessible Information obligations.

3.4.3 The implementation Plan, will undergo a further review in Oct 2017, to incorporate feedback from the national review undertaken by NHS England. The implementation plan will also include additional activity required to meet the Council's Equality Objectives - aspirations of all customer facing services to meet the NHS Information Standard.

4.0 FINANCIAL & RESOURCE APPRAISAL

There are no financial issues arising from this report.

5.0 RISK MANAGEMENT AND GOVERNANCE ISSUES

N/A

6.0 LEGAL APPRAISAL

There are no legal implications at this time.

7.0 RECOMMENDATIONS

Members are invited to comment on the report.

8.0 APPENDICES

None

9.0 BACKGROUND DOCUMENTS

None

Report of the Deputy to the Director of Public Health to the meeting of Health and Social Care Overview and Scrutiny Committee to be held on 5 October 2017

I

Subject:

The Healthy Bradford Plan: Shaping the System, Improving Lifestyles.

Summary statement:

The Healthy Bradford Plan sets out four core activities to be undertaken to tackle the lifestyle behaviours which lead to poor health outcomes and premature mortality for people in the District.

This plan requires multiple partners to work together to take coordinated action at scale to transform the District to a place which supports making living healthier lifestyles easier for everyone.

The Healthy Bradford plan aligns and coordinates with the existing work of the Self Care and Prevention Programme, together delivering the priority actions of the 2017 Health and Wellbeing Board Strategy.

Sarah Muckle
Deputy to the Director of Public Health
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Portfolio: Health and Wellbeing

Overview & Scrutiny Area: Health and Social Care

1. SUMMARY

As Summary Statement

2. BACKGROUND

Context

On the 26th July 2016 the Health and Wellbeing Board received a discussion paper to outline the challenges to health outcomes that are posed by high rates of excess weight in both the adult and child population. The paper was broad-ranging, aiming to facilitate discussion of the scale of the issue through local and national data, and exploring the evidence of effective approaches to achieving healthy weight for the population of the District.

Discussions recognised that there is no single approach or single organisation that can address a population level issue with such complex causes. It described the best current evidence which points towards a system wide approach encompassing: the built environment and healthy eating and physical activity, requiring the commitment and input of a wide range of sectors and organisations.

A system-wide or 'whole systems' approach seeks to work at scale to link together the large number of factors that influence individuals' lifestyles. The approach resolves to do this through acknowledging that the system in which we live too often impedes, instead of supports, individuals' and whole communities' efforts to improving their lifestyles.

The Health and Wellbeing Board resolved:

1. That the Health and Wellbeing Board leads a system-wide approach to healthy weight for the population of the District.
2. That a Programme Delivery Board be established to develop an action plan for an integrated system wide approach to healthy weight; the Programme Delivery Board to comprise of representatives from the Local Authority, Clinical Commissioning Groups, Health Providers, and the Voluntary and Community Sector and led by the Portfolio Holder for Health and Wellbeing and the Director of Health and Wellbeing
3. That the Terms of Reference for the Programme Delivery Board be submitted to the Health and Wellbeing Board in 2016.

Progress to date

The Healthy Weight Board was set up in August 2016 and is chaired by Councillor Val Slater. The Board incorporates a wide range of partners; these include senior representatives from: the Directorate of Health and Wellbeing and Directorate of Places in the Local Authority; Bradford City and District and Airedale CCGs; Active Bradford; the Voluntary Sector and Bradford Teaching Hospitals Foundation Trust.

The Healthy Weight Board has met six times in the past 12 months and examined the root causes of people becoming overweight and obese. In understanding the parallels and associations between the wider range of lifestyle issues which lead to obesity, long term conditions and diseases resulting in premature mortality, the Healthy Weight Board resolved that it would wish to extend its remit to include excessive alcohol consumption and smoking and has rename itself the Healthy Bradford Board, subject to approval from the Health and Wellbeing Board. This is to be considered by the Health and Wellbeing Board on 26th September 2017.

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Over the past 12 months the Healthy Bradford Board has explored different areas contributing to why people find it so challenging to lead a healthy lifestyle. In the process of our meetings, the Healthy Bradford Board have discussed opportunities and examples of existing good practice locally as well as looking at the latest evidence base, research and thinking on the issues at hand.

The core themes which emerged during this process included; the need for us to all **work together** and take **coordinated action at scale** to match the extent of the embedded lifestyle issues in our population; the need to **change behaviours** and how the latest research and evidence can help us develop tools and techniques for doing this on a **population level** using a **system wide approach to tackle the drivers of poor lifestyles.**

3. OTHER CONSIDERATIONS

The Healthy Bradford Plan: an overview

The Healthy Bradford Plan incorporates five key areas of lifestyle behaviours in its scope:
- eating unhealthy food,
- over eating,
- physical inactivity,
- smoking
- excess alcohol consumption

The "Healthy Bradford Plan: Shaping the System, Improving Lifestyles" to be presented at the Health and Wellbeing Board on the 26th September 2017 sets out a four core activities to be undertaken to ensure that Bradford is at the forefront of the national challenge to help people improve their lifestyles through delivering a system wide approach addressing poor lifestyle behaviours at their roots.

The four core areas are:

1) **The Healthy Bradford Partnership**: Establishing a delivery group of key stakeholders to identify and map drivers of unhealthy lifestyles. The partnership, overseen by the Healthy Bradford Board, will identify and prioritise multiple system-wide actions to be undertaken to address the drivers and make healthy lifestyles easier for everyone every day.

2) **The Healthy Bradford Charter**: Enacting the Healthy Bradford Charter framework developed to support and enable the implementation of changes, at scale, in organisations, schools, offices and services to help make living healthy lifestyles easier for everyone every day

3) **The Healthy Bradford Movement**: Delivering a sustained series of health education and health promotion activities to be launched to educate and raise awareness of opportunities for healthy living in the District

4) **The Healthy Bradford Service:** Commissioning an integrated lifestyle and wellbeing service to be launched to support people struggling to change their lifestyles through 1:1 guidance and peer to peer support focussed on targeting

those most in need

The four activities to be undertaken are embedded in the latest research, evidence and innovative concepts identified to change lifestyle behaviours at scale and simultaneously work to ensure inequalities in the levels of preventable ill health are reduced.

Outcomes

The Healthy Bradford Plan assures that processes and milestones for assessing both the implementation of the plan itself, as well as the actions it takes, are embedded into the work as it is undertaken.

The overarching outcome of the plan is improve the five key lifestyle behaviours that subsequently lead to the longer term outcome of reducing preventable ill health across the District, but particularly in the areas most in need.

Links to other programmes

Once implemented, the Healthy Bradford Plan will complete a coordinated continuum to reducing preventable ill health in Bradford District. The continuum of activity will run from system wide actions addressing the drivers of poor lifestyle behaviours, through to targeted prevention, early intervention and then self-care.

4. FINANCIAL & RESOURCE APPRAISAL

There are no financial issues arising; all work will be undertaken within existing budgets.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

Governance and risk management operates through the established governance structure of the Health and Wellbeing Board and its working-groups. Dependent on the decision of the Board as to future action further governance arrangements will be developed as needed.

6. LEGAL APPRAISAL

No legal implications.

7. OTHER IMPLICATIONS

None

7.1 EQUALITY & DIVERSITY

The suggested approach to healthy lifestyles would contribute to more of the population enjoying better health and seeing a reduced rate of preventable illness. Tackling the impacts of unhealthy lifestyles, in particular through the provision of a guidance and support service on lifestyles and wellbeing, will help to reduce health inequalities. This most commonly mirrors the social inequalities found between some protected characteristics groups and the general population.

7.2 SUSTAINABILITY IMPLICATIONS

The suggested approach will represent a shift towards prevention at the scale discussed in the national Five Year Forward View for the NHS, with the aim of improving health outcomes and reducing preventable illness in order to bring the health and wellbeing eco

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

Adopting wide approach to healthy lifestyles should increase the rate of active travel. Success in this area would contribute to reductions in greenhouse gas emissions.

7.4 COMMUNITY SAFETY IMPLICATIONS

Safety and perceptions of safety in respect of neighbourhoods and communities impact on willingness to use urban neighbourhoods and local green space for physical activity.

7.5 HUMAN RIGHTS ACT

None

7.6 TRADE UNION

None

7.7 WARD IMPLICATIONS

Ward level action may be needed to engage more people in becoming physically active and to eat healthily and to ensure that local green space and urban space is safe and accessible particularly in wards with higher levels of preventable illness.

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

1) Adopt the Healthy Bradford Plan as a comprehensive system-wide approach to encouraging healthy lifestyle behaviours in the district, i.e. for this plan to continue to include overweight/ obesity, smoking and excess alcohol consumption in its scope
2) Request this plan is revised to a narrower remit as a Healthy Weight Plan only focus entirely on tackling overweight/ obesity

10. RECOMMENDATIONS

It is recommended that the Health and Social Care Overview and Scrutiny Committee:

1) Accept the broader lifestyle behaviours approach set out in the Healthy Bradford Plan.
2) Support the development of the system wide Partnership and the implementation of the actions it identifies as priority areas for improving lifestyles.
3) Encourage and support officers, other public sector organisations, business owners

and community groups to use the Healthy Bradford Charter within their own organisations to identify and achieve the potential to make healthy lifestyles easier for everyone.

11. APPENDICES

Appendix 1 - The Healthy Bradford Plan

12. BACKGROUND DOCUMENTS

None

The Healthy Bradford Plan

Shaping the system, improving lifestyles

September 2017

1. The Issue

Bradford District has some of the highest rates of preventable diseases in the country these include; obesity; Type 2 Diabetes; and some kinds of cardiovascular, respiratory and liver diseases and muscular skeletal disorders.

These preventable diseases, often called 'lifestyle diseases', are linked to five key behaviours:

eating too much **eating unhealthy food** **being physically inactive** **drinking excessive alcohol** **smoking**

It has been recognised both nationally and locally that current efforts to support people to address these behaviours themselves are not making enough impact on the scale that we need them too. For example, over 67% of people in the District have a Body Mass Index over 30 and are classified as being overweight or obese.

Interventions to directly tackle these behaviours (e.g. diet and exercise classes) have had a relatively low impact. While the changes made by people participating in such activities are normally very positive, there are often low numbers of people when looking at the District as a whole and the changes being made are very challenging to sustain.

This lack of sustainability when we make lifestyle changes is evidenced to be a result of the culture and environments in which we now live making *un*healthy lifestyles behaviours much easier to maintain than healthy ones. For example, compared to even 20 years ago, we now find ourselves with cheaper and high calorie foods readily available to eat and snack on, convenient motorised transport to travel just short distances, spending long hours sat at computer/tv screens with less opportunity to exercise or having family time to cook from scratch… the list of changes to our lives and lifestyles is long. Furthermore, many of these 'drivers' of unhealthy behaviours are interrelated; working together to make living a consistent healthy lifestyle a challenge. We call these interconnected drivers working together the 'system'. There is now overwhelming research showing that, in order for us address the root causes of peoples unhealthy behaviours, we must find ways to understand this system and work together to shape it for a better and healthier future for our District.

2. The Plan

The Healthy Bradford Plan aims to bring a collaboration of partners together to shape the system with coordinated actions towards a shared ambition: **To make it easier for everyone, everywhere in the District, to live healthy and active lifestyles every day**. The plan consists for four core activities shown in Figure 1. Each activity will build on the previous and each will develop numerous actions with multiple partners to identify and tackle the drivers of unhealthy lifestyles across the population.

Figure 1: The four core activities to be undertaken to deliver the Healthy Bradford Plan

The Healthy Bradford Partnership: The key stakeholder group identifying and taking bold and coordinated system wide actions to make healthy lifestyles easier for everyone every day

The Healthy Bradford Charter: The framework, developed to support and enable the implementation of changes at scale in schools, offices and services to make healthy lifestyles easier for everyone every day.

The Healthy Bradford Movement: The sustained health education and health promotion activities to be launched to educate and raise awareness of opportunities for healthy living in the District

The Healthy Bradford Service: The integrated lifestyle and wellbeing service to be launched to support people struggling to change their lifestyles through 1:1 guidance and peer to peer support

2.1 The Healthy Bradford Partnership

The Healthy Bradford Partnership will be established in October 2017 as a working group to include a wide range of partners from across the District. The group will be tasked to map the local drivers of poor lifestyles using the latest tools and techniques developed by Leeds Beckett University on behalf of Public Health England. The system map developed will identify and prioritise areas where we can work together to positively shape and change our existing system at pace, and at scale. This may include both scaling up existing good practice or entirely new areas of activity. Examples of the kinds of drivers and actions that could be used are shown in Figure 2. There are known to be multiple drivers to lifestyle behaviours and addressing each will result in multiple potential actions; the Partnership will work together to identify key themes of activity from these and prioritise the actions for delivery.

Figure 2: A sample of the type of drivers of poor lifestyles and examples of the kind of actions that may be undertaken to address them

Learned activity pattern in early childhood	Identify, facilitate and raise aware of opportunities for families based physical activity in the District
	All Children's centres to provide a programme of physical activity for early years
Level of recreational activity	Healthy Charter Movement to highlight simple daily changes to be more active e.g. keeping the remote control away from your sofa area , ways to discourage children from excess screen time
	Provide and develop safe spaces where children can enjoy active play across the District
	Support communities to develop with easy low /no cost opportunities for physical activity – both sporting (e.g. park runs) and non-sporting (e.g. walking meetings, active travel)
Parental role modelling of activity	Identify, facilitate and raise aware of opportunities for families based physical activity in the District
	Promote walking and cycling for journeys under two miles using a mixture of methods (e.g. awareness campaigns, car parking restrictions)
	Continue delivery of HENRY programme at scale
Level of occupational activity	Work with employers and use Healthy Bradford Charter to promote physical activity in general and where possible encourage occupational physical activity
	Work with employers to encourage voluntary take up of Business Travel Plans
Dominance of	Provide innovative and evidence based ideas and suggestions to increase physical activity in schools, workplaces and care homes through the Healthy Bradford Charter

2.2 The Healthy Bradford Charter

The Healthy Bradford Charter (Figure 3) is a framework that has been developed specifically to support implementation of a large scale approach to making living healthy lifestyles easier in the Bradford District and facilitate the ability to make positive changes at scale.

The framework is designed to support everyone in the District to examine their own environments, workplaces and whole organisations to identify ways in which they can contribute to making it easier for people to live healthier lifestyles.

In its design the Charter applies some of the basic approaches of behavioural change science and population wide working through its core principle: **Being healthy is made easier for everyone, every day, everywhere**

Toolkits will be developed to provide different sectors such as schools, factories, restaurants or offices with tailored resources to help them utilise the framework and share simple innovative ideas for activity they can undertake within each of three areas. Examples of the kinds of actions and opportunities we might expect organisations to identify are shown in Figure 4. Incentives and promotional activities will be developed to inspire and encourage uptake of the Charter, including a self-scoring system and the opportunity to receive awards.

Figure 3: The Healthy Bradford Charter

Figure 4: Examples of the kinds of actions and opportunities we might expect organisations to identify through using the Healthy Bradford Charter and the sector specific toolkits to be developed

EXAMPLE ACTIONS: PEOPLE		
All our staff and pupils will be automatically registered to use a free health and wellbeing app and online tool (*School/ employer*)	We will run a monthly competition between staff with who have walked the most steps per person that month – the winner will get a paid early finish and first pick of shifts for the following month (*Factory)*	We will encourage staff to start to grow vegetables in our waste ground area at the rear of the building and allow staff and customers to pick and take them home for free (*Café*)
EXAMPLE ACTIONS: POLICY		
We will develop a policy that all the offers and special deals we put on in our staff canteen will be on healthy meal choices only (*Factory*)	We will create a school policy to request parents not to bring birthday cakes or sweets into the classroom and provide them with a list of ideas for other great fun ways they can help their child celebrate with their class at school. (*Primary School*)	We will develop a policy to ensure that sub-contractors we use in future are caring for their own staff's health and wellbeing too (*Local medium size business*)
EXAMPLE ACTIONS: PLACE		
We will install an exercise bike and table tennis into our staff room to make it easier for staff to be active in their breaks (*Retail shop*)	We will encourage our staff and customers to join Stoptober and to stop smoking by banning tobacco in our grounds but continue to allow vaping. (*Museum*)	We will clear and mark out a mile long route around the our grounds for pupils and encourage teachers to run/ walk a daily mile with ease (*School*)

2.3 The Healthy Bradford Movement

A sustained health promotion campaign will be developed by the partnership with the following aims:

- To educate the public on easy steps they can take to live a healthier lifestyle
- To raise awareness of local activities and ways to become involved in healthy activities in the community
- To raise awareness and uptake of the Healthy Bradford Charter

The campaign will feature a single recognisable brand/ slogan that will be available for use by any group, business or organisation wishing to raise awareness of a health improving activity. It will also include unusual high profile activities to inspire the inactive public to challenge themselves for example a District wide digitally tracked walking game such as Beat the Street..

At its core, the Healthy Bradford Movement will be responsible for providing consistent key messages on healthy living and improving the understanding of health related information in the population (health literacy). Where relevant, all activity will be coordinated with those of national campaigns where appropriate (e.g. Change 4 Life and One You) to maximise the impact and audiences. The unique and high profile challenges and activities being developed will provide continued momentum and new audiences for these health education messages.

2.4 The Healthy Bradford Service

A community based Integrated Healthy Lifestyles and Wellbeing Service will be commissioned. The service will be specified to provide:

- Individual 1:1 personalised behavioural change support targeted to people who face additional challenges to improving their health and physical and mental wellbeing

- To establish Health Champions in communities across the district working to understand and support people in their community using a peer to peer training and support model.

The aim of the service will be to ensure that, while all the other elements of the plan are being delivered to across the population, people in the most disadvantaged areas who often experience worse health outcomes are given the necessary additional support, guidance and motivation they need to improve their own wellbeing. The service will be focussed towards helping those with the greatest changes to make and who also often face the greatest challenges to overcome to make those changes. This service will also be the interface of the Healthy Bradford Plan with those services and activities being delivered under the Self Care and Prevention Programme; working together delivering the priority actions set out in the 2017 Health and Wellbeing Board Strategy.

3. Measuring our activity and impact

The actions developed through this Healthy Bradford Plan will be subject to thorough evaluation with clear metrics set out to identify the changes in behaviour we will need to see. In turn, these changes in behaviour will go on to achieve the longer term high level outcome of reducing the numbers of people living with, and dying of, preventable diseases.

We will also seek to evaluate not only the actions developed but also the implementation of each of the four key elements of the plan itself, setting out clear milestones and ensuring we continually reflect on and refine our ways of working.

HEALTHY LIFESTYLES PLAN IS FULLY IMPLEMENTED (2017-2019)

LIFESTYLE BEHAVIOURS CHANGE (2018/19 onwards)

All of the five identified lifestyle behaviours are evidenced to be reducing across the District: eating too much, eating unhealthy food, being physically inactive, drinking excessive alcohol and smoking

- Rate of hospital admissions for alcohol reduces
- Smoking prevalence at age15 & adults reduces
- Proportion of the population meeting the recommended "5-a-day" age 15 & adults increases
- Proportion of the population physically inactive reduces
- Adults classed as overweight or obese reduces
- Children classed as overweight or obese in Reception and Year 6 reduces

HEALTH OUTCOMES CHANGE

The number of people living with preventable diseases is reducing

- % population with recorded Diabetes reduces
- Under 75 mortality rate from specified diseases considered preventable including respiratory, cardiovascular diseases, liver disease, cancer reduces

Report of the City Solicitor to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 5 October 2017

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Subject: Health and Social Care Overview and Scrutiny Committee Work Programme 2017/18

Summary statement:
This report presents the work programme 2017/18

Parveen Akhtar
City Solicitor

Portfolio:

Health and Wellbeing

Report Contact: Caroline Coombes
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1. **Summary**

1.1 This report presents the work programme 2017/18.

2. **Background**

2.1 The Committee adopted its 2017/18 work programme at its meeting of 7 September 2017.

3. **Report issues**

3.1 **Appendix 1** of this report presents the work programme 2017/18. It lists issues and topics that have been identified for inclusion in the work programme and have been scheduled for consideration over the coming year**. Appendix 2** lists items for inclusion in the work programme that have not yet been scheduled.

4. **Options**

4.1 Members may wish to amend and / or comment on the work programme at **Appendix 1** and **2**.

5. **Contribution to corporate priorities**

5.1 The Health and Social Care Overview and Scrutiny Committee Work Programme 2017/18 reflects the ambition of the District Plan for ‘all of our population to be healthy, well and able to live independently for a long as possible’ (District Plan: Better health, better lives).

6. **Recommendations**

6.1 That the Committee notes the information in **Appendix 1** and **2**

7. **Background documents**

7.1 Constitution of the Council

8. **Not for publication documents**

None

9. **Appendices**

9.1 **Appendix 1** – Health and Social Care Overview and Scrutiny Committee work programme 2017/18

9.2 **Appendix 2** – Unscheduled items for inclusion in Committee’s work programme 2017/18

Democratic Services - Overview and Scrutiny

Health and Social Care O&S Committee

Scrutiny Lead: Caroline Coombes tel - 43 2313

Work Programme

Agenda	Description	Report	Comments
Thursday, 26th October 2017 at City Hall, Bradford			
Chair's briefing 11/10/2017. Report deadline 13/10/2017			
1) Annual Complaints Report	Annual Report	Irina Arcas	
2) Draft 'Daytime Strategy'	Details TBC	Bev Maybury	resolution of 27 October 2016 (joint meeting with Children's Services OSC)
4) Dementia	Post diagnosis pathway and update on Dementia Friendly Communities programme	Mary Surr / Bev Fletcher (Alzheimer's Society Bradford Area)	resolution of 26 January 2017
5) Care Quality Commission (CQC) Inspection at Airedale NHS Foundation Trust	Report and Trust response	Bridget Fletcher	
Thursday, 16th November 2017 at City Hall, Bradford			
Chair's briefing 31/10/2017. Report deadline 03/11/2017			
1) Obesity in Bradford	Update from the Healthy Weight Board setting out its identified priorities and information on what is currently known to be working effectively	Alison Moore	resolution of 17 November 2016
2) Domiciliary Care	Look back at issues raised by the Committee as part of its Scrutiny investigation (Jan 2015) and the report of Healthwatch Bradford and District (July 2015)	Bev Maybury	resolution of 21 January 2016
3) Diabetes	Report to cover all areas of the District and involve patients and voluntary sector	CCGs	
4) Integrated Transitions Service for Young People with Disabilities in Bradford	Update to include benchmarking information and appropriate indicators to demonstrate progress	Bev Maybury	resolution of 27 October 2016 (joint meeting with Children's Services OSC)
5) Health and Wellbeing Board Annual Report 2017-18 and draft MoU with HSCOSC	Update to include information on progress towards delivery of a whole systems approach to health, social care and wellbeing	Contact: Angela Hutton	resolution of 28 July 2017

Health and Social Care O&S Committee

Scrutiny Lead: Caroline Coombes tel - 43 2313

Work Programme

Agenda	Description	Report	Comments
Tuesday, 28th November 2017 at City Hall, Bradford			
Chair's briefing 13/11/2017. Report deadline 16/11/2017			
1) Children's Mental Health	Update	Sasha Bhatt	Resolution of Joint meeting with Children's Services OSC 27 Oct 16
2) Autism	TBC	TBC	
Thursday, 7th December 2017 at City Hall, Bradford			
Chair's briefing 21/11/2017. Report deadline 24/11/2017			
1) NHS Screening and Immunisation Programmes	24 month update	West Yorkshire Screening and Immunisation Team	resolution of 10 December 2015
2) Workforce issues	Committee to consider a report on workforce issues across the health and care sector	Council / NHS	ref Committee minutes 9 June 2016
3) Update on the progress made by Airedale and partners enhanced health in care homes Vanguard	Update	Helen Bourner	resolution of 23 March 2016
Thursday, 25th January 2018 at City Hall, Bradford			
Chair's briefing 10/01/2018. Report deadline 12/01/2018			
1) Department of Health and Wellbeing Budget and financial outlook	Annual report	Bev Maybury	
2) Smoking cessation	Report on smoking cessation activity in the District (to include update on lung cancer)	Public Health / NHS	resolution of 6 April 2017
Thursday, 8th February 2018 at City Hall, Bradford.			
Chair's briefing 24/01/2018. Report deadline 26/01/2018			
1) Access to primary medical (GP) services in Bradford	Update	Vicki Wallace	resolution of 9 February 2017
2) Access to primary medical (GP) services in Airedale Wharfedale and Craven	Update	Lynne Scrutton	resolution of 9 February 2017

Health and Social Care O&S Committee

Scrutiny Lead: Caroline Coombes tel - 43 2313

Work Programme

Agenda	Description	Report	Comments
Thursday, 8th February 2018 at City Hall, Bradford			
Chair's briefing 24/01/2018. Report deadline 26/01/2018			
3) Enhanced primary care	To include details of the consultation undertaken with service users	Vicki Wallace	resolution of 9 February 2017
Thursday, 1st March 2018 at City Hall, Bradford			
Chair's briefing 14/02/2018. Report deadline 16/02/2018			
1) Mental health services in Bradford District	Item to include people with a lived experience of mental health services and voluntary sector representatives	CCGs / BDCFT / Council	resolution of 2 March 2017
Thursday, 22nd March 2018 at City Hall, Bradford			
Chair's briefing 07/03/2018. Report deadline 09/03/2018			
1) Care Quality Commission	Annual update on inspection activity in Bradford District	Sarah Drew	resolution of 23 March 2017
Thursday, 12th April 2018 at City Hall, Bradford			
Chair's briefing 26/03/2018. Report deadline 30/03/2018			
1) Respiratory health in Bradford District	Update - clinical lead and services users to be invited	Toni Williams	resolution of 5 April 2017
2) Infant mortality	Update on progress report	Shirley Brierley	last considered by Committee April 2016

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Democratic Services - Overview and Scrutiny
Scrutiny Committees Forward Plan
Unscheduled Items

Health and Social Care O&S Committee

	Agenda item	Item description	Author	Management comments
0	Outcome of Consultation on the Proposed Change to Bradford Council's Contributions Policy for nonresidential Services	resolution of 8 September 2016 - update report	Bev Maybury	
0	Update on CQC inspections Hospitals in Bradford District	ref meeting of the Committee 23 March 2017	NHS Hospital Trusts in Bradford District	
0	Primary Care Services in Keighley		Lynne Scrutton	
0	Stroke Services update		CCGs / BTHFT	
0	Consideration of ways to improve consultation with vulnerable groups	resolution of 8 September 2016 - update report	TBC	
0	Safeguarding Adults Board	Annual Report	Yvonne Bultler	
0	Multi-agency Safeguarding Hub (MASH)	Report on the establishment and operation of the MASH	TBC	

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