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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Agenda for a meeting of the Bradford and Airedale Health and Wellbeing Board to be held on Tuesday, 4 September 2018 at 10.00 am in Committee Room 1 - City Hall, Bradford

Dear Member

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

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

Yours sincerely

P Akhtar

City Solicitor

Notes:

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

From:
Parveen Akhtar
City Solicitor
Agenda Contact: Fatima Butt
Phone: 01274 432227
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To:

MEMBER	REPRESENTING
Councillor Susan Hinchcliffe	Leader of Bradford Metropolitan District Council (Chair)
Councillor Jackie Whiteley	Bradford Metropolitan District Council
Councillor Sarah Ferriby	Healthy People and Places Portfolio
Kersten England	Chief Executive of Bradford Metropolitan District Council
Helen Hirst	Bradford City, Bradford Districts and Airedale, Wharfedale and Craven Clinical Commissioning Groups
Sarah Muckle	Director of Public Health
Bev Maybury	Strategic Director Health and Wellbeing
Michael Jameson	Strategic Director of Children's Services
Steve Hartley	Strategic Director, Place
Sarah Hutchinson	HealthWatch
Sam Keighley	Bradford Assembly Representing the Voluntary, Community and Faith Sector
Clive Kay	Chief Executive of Bradford Teaching Hospitals NHS Foundation Trust
Brendan Brown	Chief Executive of Airedale NHS Foundation Trust
Nicola Lees	Chief Executive of Bradford District Care NHS Foundation Trust
Dr Richard Haddad	Member from the GP Community
Martin Speed	District Commander West Yorkshire Fire and Rescue Service
Scott Bisset	Chief Superintendent Bradford District, West Yorkshire Police
Geraldine Howley	Group Chief Executive, InCommunities Group Ltd
Dr Andy Withers	Bradford Districts Clinical Commissioning Group
Dr James Thomas	Airedale, Wharfedale and Craven Clinical Commissioning Group
Dr Akram Khan	Bradford City Clinical Commissioning Group (Deputy Chair)
Lou Auger	Head of Operations and Delivery for West Yorkshire (NHS England)

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 24 July 2018 be signed as a correct record (previously circulated).

(Fatima Butt – 01274 432227)

4. INSPECTION OF REPORTS AND BACKGROUND PAPERS

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

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

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

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

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

(Fatima Butt - 01274 432227)

B. BUSINESS ITEMS

5. MEMORANDUM OF UNDERSTANDING (MOU) FOR THE WEST YORKSHIRE AND HARROGATE HEALTH AND CARE PARTNERSHIP 1 - 46

The Strategic Director, Health and Wellbeing will submit **Document "C"** which seeks the Board's approval for the Memorandum of Understanding (MoU) for the West Yorkshire and Harrogate Health and Care Partnership.

Individual partner organisations in Bradford District and Craven, and across West Yorkshire and Harrogate as a whole, are also being asked to approve the MoU. Other local partner organisations that are anticipated to sign the MoU are;

- Airedale Wharfedale and Craven NHS CCG
- Bradford City NHS CCG
- Bradford Districts NHS CCG
- Airedale NHS Foundation Trust
- Bradford District Care NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Craven District Council
- North Yorkshire County Council

Recommended-

That the draft Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership be approved.

(James Drury – 01274 431057)

6. HEALTH AND SOCIAL CARE ECONOMIC PARTNERSHIP

The Strategic Director, Children's Services will provide a verbal update on the current development, priorities and work of the Health and Social Care Economic Partnership and the "One Workforce" expression of interest for funding to the Leeds City Region Business Rates Pool.

(Michael Jameson – 01274 434335)

7. CONNECTING PEOPLE AND PLACE: A JOINT HEALTH AND WELLBEING STRATEGY FOR BRADFORD AND AIREDALE 47 - 88

'Connecting People and Place' , the new Joint Health and Wellbeing Strategy for Bradford and Airedale 2018-23 was published on the Health and Wellbeing Board website in June 2018 (Appendix 1).

The Strategic Director, Health and Wellbeing will submit **Document "D"** which provides updates for the four outcome areas under the strategy, and a proposal for tracking progress against the strategy forms an appendix to the report.

Recommended-

That the Board receives the update and provides feedback for further action.

(Sarah Muckle – 01274 432805)

8. CHAIR'S HIGHLIGHT REPORT - SUB GROUP UPDATES (ICB AND ECB)/DOMESTIC ABUSE AND SEXUAL VIOLENCE SPECIALIST SERVICES RE-COMMISSIONING UPDATE 89 - 110

The Health and Wellbeing Board Chair's highlight report **(Document "E")** summarises business conducted between Board meetings. September's report brings the updates from the Board's sub-groups and Domestic Abuse and Sexual Violence Specialist services re-commissioning.

Recommended-

(1) That the progress of the sub groups be noted.

(2) That the Board recognises the breadth, importance and complexity of the work undertaken by providers in relation to the Domestic Violence Sexual Abuse services re-commissioning and notes the continuation of these via the new commissioning programme.

(Pam Bhupal – 01274 431057)

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Strategic Director of Health and Wellbeing to the meeting of Bradford and Airedale Health and Wellbeing Board to be held on Tuesday 4th September 2018

C

Subject:

A Memorandum of Understanding (MOU) for the

West Yorkshire and Harrogate Health and Care Partnership

Summary statement:

The purpose of this paper is to seek the Health and Wellbeing Board's approval for the Memorandum of Understanding (MoU) for the West Yorkshire and Harrogate Health and Care Partnership.

Strategic Director for Health and Wellbeing – Bev Maybury

Report Contact: James Drury
E-mail: james.drury2@bradford.gov.uk

Portfolio:

Healthy people and places

Overview & Scrutiny Area:

Health and Social care

1. SUMMARY

The purpose of this paper is to seek the Health and Wellbeing Board's approval for the Memorandum of Understanding (MoU) for the West Yorkshire and Harrogate Health and Care Partnership.

Individual partner organisations in Bradford District and Craven, and across West Yorkshire and Harrogate as a whole, are also being asked to approve the MoU. Other local partner organisations that are anticipated to sign the MoU are;

- Airedale Wharfedale and Craven NHS CCG
- Bradford City NHS CCG
- Bradford Districts NHS CCG
- Airedale NHS Foundation Trust
- Bradford District Care NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Craven District Council
- North Yorkshire County Council

2. BACKGROUND

West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the NHS Five Year Forward View. It brings together all health and care organisations in our six places: Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

In November 2016 the STP published high level proposals to improve health, reduce care variation and manage our finances. Since then the partnership has made significant progress to build capacity and infrastructure and establish the governance arrangements and ways of working that will enable us to achieve our collective aims.

The partnership has already begun to make an impact in other important areas. Our Cancer Alliance Board has attracted £12.6m in funding to transform cancer diagnostics. In Bradford the Cancer Alliance has invested in additional support to tackle smoking and to enable more people to be screened and receive earlier diagnostic testing to improve lung cancer outcomes. We have developed a strategic case for change for stroke from prevention to after care. We have streamlined management of CCGs and established a Joint Committee of CCGs; Committee in Common for acute trusts and Mental Health Collaborative; these will strengthen working and facilitate joint decision making. We have secured £31m in transformation funding for A&E, cancer, mental health, learning disabilities and diabetes, and £38m capital from the Autumn 2017 budget for CAMHS, pathology, telemedicine, and digital imaging.

In October 2017 the System Leadership Executive Group agreed that a new MoU should be developed to formalise working arrangements and support the next stage of development of the WY&H HCP. The MoU builds on the existing partnership arrangements to establish more robust mutual accountability.

3. OTHER CONSIDERATIONS

3.1 Purpose of the MoU

3.1.1 The MoU is an agreement between the WY&H health and care partners. It sets out the details of our commitment to work together in partnership to realise our shared ambitions to improve the health of the 2.6 million people who live in our area, and to improve the quality of their health and care services.

3.1.2 The MoU does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework to underpin collective ownership of delivery. It also provides the basis for a refreshed relationship between local NHS organisations and national oversight bodies.

3.1.3 The MoU is not a legal contract, but is a formal agreement between all of the partners. It is based on an ethos that the partnership is a servant of the people in WY&H and of its member organisations. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Councils. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.

3.1.4 The draft MoU should be read in conjunction with the STP Plan, published in November 2016, the Next Steps (February 2018) and the local plans for Bradford and Airedale, Wharfedale and Craven. – 'Happy Healthy at Home', which was refreshed and approved by the Health and Wellbeing Board in December 2017.

3.1.5 The MoU provides a platform for:

a. a refresh of the governance arrangements for the partnership, including across WY&H, and the relationship with individual Places and (e.g. Bradford District and Craven) statutory bodies;

b. the delivery of a mutual accountability framework that ensures we have collective ownership of delivery, rather than a hierarchical approach

c. a new approach to the NHS commissioning, and maturing provider networks that collaborate to deliver services in place and at WY&H level;

d. clinical and managerial leadership of change in major transformation programmes;

e. a transparent and inclusive approach to citizen engagement in development, delivery and assurance;

f. better political ownership of, and engagement in the agenda, underpinned by regular opportunities for challenge and scrutiny; and

g. a new assurance and accountability relationship with the NHS regulatory and oversight bodies that provides new flexibilities for WY&H to assert greater control over health and care system performance and delivery and the use of transformation and capital funds; and (e.g. from NHS England)

h. the agreement an effective system of risk management and reward for NHS

bodies.

3.1.6 The text of the MoU sets out details of:

- The context for our partnership;
- The partner organisations;
- How we work together in WY&H, including our principles, values and behaviours;
- The objectives of the partnership, and how our joint priority programmes and enabling workstreams will improve service delivery and outcomes across WY&H;
- Our mutual accountability and governance arrangements, including how we will move towards a new approach to assurance, regulation and accountability with the NHS national bodies;
- Our joint financial framework;
- The support that will be provided to the Partnership by the national and regional teams of NHSE and NHSI;
- Which aspects of the agreement apply to particular types of organisation. (see Annex 1 of the MoU). In relation to the local organisations in Bradford District the following elements of the MoU apply;
    - CCGs – all elements apply
    - NHS providers – all elements apply
    - Local authorities – all elements apply except shared financial risk management
    - Healthwatch and other partners – the following elements apply
        - vision, principles, values and behaviour
        - partnership objectives
        - governance
        - decision making and dispute resolution

3.2 Becoming and Integrated Care System

3.2.1 In May 2018 NHS England and NHS Improvement announced that WY&H HCP would be one of four health and care systems to join the Integrated Care System (ICS) Development Programme. This demonstrated national recognition for the way our WY&H partnership works and for the progress we have made. It means we can join the leading edge of health and care systems, gaining more influence and more control over the way we deliver services and support for the 2.6 million people living in our area.

3.2.2 The importance of joining up services for people at a local level in Bradford District and Craven; Calderdale; Harrogate and Rural District; Kirklees; Leeds; and Wakefield is at the heart of our local plans and our WY&H programmes. All decisions on services are made as locally and as close to people as possible. Our move to becoming an ICS is predicated on this continuing to be the case.

3.2.3 This integrated approach to health and care will continue to support much closer

working between our organisations. The MoU will provide a firm foundation for this. It reflects and builds on the current ways of working and agreed principles for the partnership and maintains an ethos of the primacy of local Place.

3.2.4 It is important to note that our name won't change as a result. We are proud to remain the West Yorkshire and Harrogate Health and Care Partnership.

3.3 Progress to date

3.3.1 Over recent months drafts of the MoU have been discussed in development sessions by members of the Boards and Governing Bodies of partner organisations and by members of Health and Wellbeing Boards and the WY&H Joint Overview and Scrutiny Committee.

3.3.2 Feedback from these discussions has directly influenced the development of the final draft, which has now been agreed by the WY&H HCP System Leadership Executive Group.

3.3.3 This item has been discussed at the Health and Wellbeing Board development session and is due to seek approval at the Bradford and Airedale Health and Wellbeing Board on Tuesday 4th September.

3.4 What it means for Bradford District and Craven

3.4.1 By signing the MoU partner organisations in Bradford District and Craven will commit to play their full roles as a members of WY&H HCP and to work within the frameworks described. Accepting our share of collective responsibility will give us and our partners the opportunity to achieve greater autonomy and control over how we develop and transform our health and care services.

3.4.2 The partnership will be an overall collaborative framework for local Health and Care Partnerships in each place, including those in Bradford and in Airedale, Wharfedale in Craven. As such the WY&H HCP arrangements described in the MoU are compatible with the local development of neighbourhood level collaborations such as the Primary Care Home model, and with our local Health and Care Partnership Boards.

3.4.3 Active participation in the ICS will enable City of Bradford MDC to shape the delivery of health and care at a strategic level across West Yorkshire and Harrogate. By ensuring that the voice of local political leadership is heard the Council can enhance democratic accountability of decision making and help ensure that decision making recognises the needs of local people and places. For example supporting a focus on prevention and on reducing health inequalities.

3.5 Next steps

3.5.1 Each partner organisation is being asked to approve and sign the MoU. It is expected that this process will be completed by October 2018.

4. FINANCIAL & RESOURCE APPRAISAL

The MoU does not introduce any additional financial risk or commitments.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

The MoU describes how member organisations will participate in the partnership governance arrangements (see section 4 of the MOU document).

6. LEGAL APPRAISAL

External Legal appraisal: The WY&H HCP core team has sought a legal opinion on the text of the MoU, on behalf of all partner organisations. The lawyers were able to provide helpful suggestions to improve clarity and remove elements of ambiguity. They also confirmed that the MoU was sound, and was not inconsistent with statutory or regulatory frameworks, or with the powers and duties of individual partners.

Internal Legal Appraisal: The WY&H HCP core team has sought legal advice on the text of the MoU from Hill Dickinson, solicitors. The Legal Department has not been involved in drafting or negotiating the MOU.

The external lawyer's advice was that the MOU was sound, and was not inconsistent with statutory or regulatory frameworks, or with the powers and duties of the individual partners.

The critical legal criteria for the Council in relation to this MOU are whether:

i. It has the legal power to enter into these arrangements.
ii. The proposed partnership arrangements are consistent with the Council's constitution.
iii. The Council's decision-making arrangements have been complied with in relation to entering into the MOU.

The document itself states that it has no legal power, is not intended to create legal obligations or rights, will not change existing legal and regulatory frameworks and is intended to sit alongside rather than change existing arrangements. On that basis we consider that the legal criteria are satisfied.

The overall practical effect of these arrangements for the Council will currently be limited to the availability of transformational or HCP funding for priority programmes, the prioritisation of national capital investment in services and response to system stress. We understand that there is no current proposal for the MOU structure to be used for decision-making in relation to the Council's statutory functions. The MOU will also become the regional medium for certain NHS assurance and accountability activities. The legal roles of the Council or the HWB will not be affected by these measures.

There will be financial governance implications in relation to the receipt of transformation funds. The presence of the Council's own Chief Executive and

Leader on the Partnership Board and the Director of Finance on the System Assurance and Oversight Group should ensure that these implications are kept under appropriate review.

The adoption of the MOU structure will not have future legal consequences for the Council so long as the new structure and the decisions made within it are:

i. compatible with the Council's constitutional arrangements and

ii. consistent with its democratic direction through its elected members.

If the WYHHCP sought to impose its will on the Council, this would be unlawful, and the Council would be compelled to act in order to remedy the illegality. If the illegality was only prospective, then such action could include using the dispute resolution procedure in the MOU. If the MOU has no legal status, then it is difficult to see how it could effectively remedy an illegality. This illustrates the difficulties involved in seeking to regulate entities with legal obligations using mechanisms that have no legal status, and raises the possibility that any dissent may either end the entire arrangement, or lead to the expulsion of the dissenting party. It is evident that the key to the future success of these arrangements lies in managing the partner's relationships in order to avoid dispute.

Should disputes arise between the partners then there is a clear possibility for conflicts of interest, and the Council will need to keep this under careful review.

Should the proposed arrangements involve operational and financial decisions that require authorisation by Council officers and members, and are subject to scrutiny, then it is critical that such requirements are complied with before decisions are authorised at the level of the PB, SLE or SAOG.

We would also recommend that careful thought is given to the delegated powers that Council's officers may be required to exercise in the course of the new arrangements. An officer who possesses ostensible but not actual authority may bind the Council to act in a manner that has not been authorised. A scheme of delegation should be established to avoid this possibility.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

N/A

7.2 SUSTAINABILITY IMPLICATIONS

N/A

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

N/A

7.4 COMMUNITY SAFETY IMPLICATIONS

N/A

7.5 HUMAN RIGHTS ACT

N/A

7.6 TRADE UNION

N/A

7.7 WARD IMPLICATIONS

N/A

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

N/A

7.9 IMPLICATIONS FOR CORPORATE PARENTING

N/A

7.10 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

N/A

8. NOT FOR PUBLICATION DOCUMENTS

N/A

9. OPTIONS

N/A

10. RECOMMENDATIONS

The draft MoU for the West Yorkshire and Harrogate Health and Care Partnership to be approved

11. APPENDICES

Annex 1 – Draft Memorandum of Understanding

West Yorkshire and Harrogate
Health and Care Partnership

Memorandum of Understanding

D R A F T

August 2018

Contents

Foreword

Since the creation of West Yorkshire and Harrogate Health and Care Partnership in March 2016, the way we work has been further strengthened by a shared commitment to deliver the best care and outcomes possible for the 2.6 million people living in our area.

Our commitment remains the same and our goal is simple: we want everyone in West Yorkshire and Harrogate to have a great start in life, and the support they need to stay healthy and live longer. We are committed to tackling health inequalities and to improving the lives of the poorest fastest. Our commitment to an NHS free at the point of delivery remains steadfast, and our response to the challenges we face is to strengthen our partnerships.

The proposals set out in our plan are firming up into specific actions, backed by investments. This is being done with the help of our staff and communities, alongside their representatives, including voluntary, community organisations and local councillors. Our bottom-up approach means that this is happening at both a local and WY&H level which puts people, not organisations, at the heart of everything we do.

We have agreed to develop this Memorandum of Understanding to strengthen our joint working arrangements and to support the next stage of development of our Partnership. It builds on our existing collaborative work to establish more robust mutual accountability and break down barriers between our separate organisations.

Our partnership is already making a difference. We have attracted additional funding for people with a learning disability, and for cancer diagnostics, diabetes and a new child and adolescent mental health unit.

However, we know there is a lot more to do. The health and care system is under significant pressure, and we also need to address some significant health challenges. For example we have higher than average obesity levels, and over 200,000 people are at risk of diabetes. There are 3,600 stroke incidents across our area and we have developed a strategic case for change for stroke from prevention to after care and are identifying and treating people at high risk of having a stroke.

We all agree that working more closely together is the only way we can tackle these challenges and achieve our ambitions. This Memorandum demonstrates our clear commitment to do this.

Rob Webster
West Yorkshire and Harrogate Health and Care Partnership Lead
CEO South West Yorkshire Partnership NHS FT

1. Parties to the Memorandum

1.1. The members of the West Yorkshire and Harrogate Health and Care Partnership (the **Partnership**) , and parties to this Memorandum, are:

Local Authorities

- City of Bradford Metropolitan District Council
- Calderdale Council
- Craven District Council
- Harrogate Borough Council
- Kirklees Council
- Leeds City Council
- North Yorkshire County Council[1]
- Wakefield Council

NHS Commissioners

- NHS Airedale, Wharfedale and Craven CCG
- NHS Bradford City CCG
- NHS Bradford Districts CCG
- NHS Calderdale CCG
- NHS Greater Huddersfield CCG
- NHS Harrogate and Rural District CCG
- NHS Leeds CCG
- NHS North Kirklees CCG
- NHS Wakefield CCG
- NHS England

NHS Service Providers

- Airedale NHS Foundation Trust
- Bradford District Care NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- The Leeds Teaching Hospitals NHS Trust
- The Mid Yorkshire Hospitals NHS Trust

- South West Yorkshire Partnership NHS Foundation Trust[1]
- Tees, Esk, and Wear Valleys NHS Foundation Trust[1]
- Yorkshire Ambulance Service NHS Trust[1]

Heath Regulator and Oversight Bodies

- NHS England
- NHS Improvement

Other National Bodies

- Health Education England
- Public Health England
- Care Quality Commission [TBC]

Other Partners

- Locala Community Partnerships CIC
- Healthwatch Bradford and District
- Healthwatch Calderdale
- Healthwatch Kirklees
- Healthwatch Leeds
- Healthwatch North Yorkshire
- Healthwatch Wakefield
- Yorkshire and Humber Academic Health Science Network[1.]

1.2. As members of the Partnership all of these organisations subscribe to the vision, principles, values and behaviours stated below, and agree to participate in the governance and accountability arrangements set out in this Memorandum.

1.3. Certain aspects of the Memorandum are not relevant to particular types of organisation within the partnership. These are indicated in the table at **Annex 1**.

Definitions and Interpretation

1.4. This Memorandum is to be interpreted in accordance with the Definitions and Interpretation set out in Schedule 1, unless the context requires otherwise.

Term

1.5. This Memorandum shall commence on the date of signature of the Partners, and shall continue for an initial period of three (3) years and thereafter subject to an annual review of the arrangements by the [Partnership Board].

[1] These organisations are also part of neighbouring STPs.

Local Government role within the partnership

1.6. The West Yorkshire and Harrogate Health and Care Partnership includes eight local government partners. The five Metropolitan Councils in West Yorkshire and North Yorkshire County Council lead on public health, adult social care and children's services, as well as statutory Health Overview and Scrutiny and the local Health and Wellbeing Boards. The Metropolitan Councils, Harrogate Borough Council and Craven District Council lead on housing. Together, they work with the NHS as commissioning and service delivery partners, as well as exercising formal powers to scrutinise NHS policy decisions.

1.7. Within the WY&H partnership the NHS organisations and Councils will work as equal partners, each bringing different contributions, powers and responsibilities to the table.

1.8. Local government's regulatory and statutory arrangements are separate from those of the NHS. Councils are subject to the mutual accountability arrangements for the partnership. However, because of the separate regulatory regime certain aspects of these arrangements will not apply. Most significantly, Councils would not be subject a single NHS financial control total and its associated arrangements for managing financial risk. However, through this Memorandum, Councils agree to align planning, investment and performance improvement with NHS partners where it makes sense to do so. In addition, democratically elected councillors will continue to hold the partner organisations accountable through their formal Scrutiny powers.

Partners in Local Places

1.9. The NHS and the Councils within the partnership have broadly similar definitions of place. (The rural Craven district is aligned with Bradford for NHS purposes, but is seen as a distinct local government entity in its own right within North Yorkshire.)

1.10. All of the Councils, CCGs, Healthcare Providers and Healthwatch organisations are part of their respective local place-based partnership arrangements. The extent and scope of these arrangements is a matter for local determination, but they typically include elements of shared commissioning, integrated service delivery, aligned or pooled investment and joint decision-making. Other key members of these partnerships include:

- GP Federations
- Specialist community service providers
- Voluntary and community sector organisations and groups
- Housing associations.
- other primary care providers such as community pharmacy, dentists, optometrist
- independent health and care providers including care homes

2. Introduction and context

2.1. This Memorandum of Understanding (Memorandum) is an understanding between the West Yorkshire and Harrogate health and care partners. It sets out the details of our commitment to work together in partnership to realise our shared ambitions to improve the health of the 2.6 million people who live in our area, and to improve the quality of their health and care services.

2.2. West Yorkshire and Harrogate Health and Care Partnership began as one of 44 Sustainability and Transformation Partnerships (STPs) formed in 2016, in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven[2], Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

2.3. Our partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.

2.4. We published our high level proposals to close the health, care and finance gaps that we face in November 2016. Since then we have made significant progress to build our capacity and infrastructure and establish the governance arrangements and ways of working that will enable us to achieve our aims.

Purpose

2.5. The purpose of this Memorandum is to formalise and build on these partnership arrangements. It does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework, based on principles of subsidiarity, to ensure we have collective ownership of delivery. It also provides the basis for a refreshed relationship with national oversight bodies.

2.6. The Memorandum is not a legal contract and is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this Memorandum. It is a formal understanding between all of the Partners who have each entered into this Memorandum intending to honour all their obligations under it. It is based on an ethos that the partnership is a servant of the people in West Yorkshire and Harrogate and of its member organisations. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Councils. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.

2.7. Nothing in this Memorandum is intended to, or shall be deemed to, establish any partnership or joint venture between the Partners to the

[2] Whilst Craven is organisationally aligned with the NHS in Bradford, it is a distinctive place in its own right, forming part of North Yorkshire.

Memorandum, constitute a Partner as the agent of another, nor authorise any of the Partners to make or enter into any commitments for or on behalf of another Partner.

2.8. The Memorandum should be read in conjunction with the Partnership Plan, published in November 2016, the Next Steps (February 2018) and the six local Place plans across West Yorkshire and Harrogate.

Developing new collaborative relationships

2.9. Our approach to collaboration begins in each of the 50-60 neighbourhoods which make up West Yorkshire and Harrogate, in which GP practices work together, with community and social care services, to offer integrated health and care services for populations of 30-50,000 people. These integrated neighbourhood services focus on preventing ill health, supporting people to stay well, and providing them with high quality care and treatment when they need it.

2.10. Neighbourhood services sit within each of our six local places (Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield). These places are the primary units for partnerships between NHS services, local authorities, charities and community groups, which work together to agree how to improve people's health and improve the quality of their health and care services.

2.11. The focus for these partnerships is moving increasing away from simply treating ill health to preventing it, and to tackling the wider determinants of health, such as housing, employment, social inclusion and the physical environment.

2.12. These place-based partnerships, overseen by Health and Wellbeing Boards, are key to achieving the ambitious improvements we want to see. However, we have recognised that there also clear benefits in working together across a wider footprint and that local plans need to be complemented with a common vision and shared plan for West Yorkshire and Harrogate as a whole. We apply three tests to determine when to work at this level:

- to achieve a critical mass beyond local population level to achieve the best outcomes;
- to share best practice and reduce variation; and
- to achieve better outcomes for people overall by tackling 'wicked issues' (ie, complex, intractable problems).

2.13. The arrangements described in this Memorandum describe how we will organise ourselves, at West Yorkshire & Harrogate level, to provide the best health and care, ensuring that decisions are always taken in the interest of the patients and populations we serve.

Promoting Integration and Collaboration

2.14. The Partners acknowledge the statutory and regulatory requirements which apply in relation to competition, patient choice and collaboration. Within the constraints of these requirements we will aim to collaborate, and to seek greater integration of services, whenever it can be demonstrated that it is in the interests of patients and service users to do so.

2.15. The Partners are aware of their competition compliance obligations, both under competition law and, in particular (where applicable) under the NHS Improvement Provider Licence for NHS Partners and shall take all necessary steps to ensure that they do not breach any of their obligations in this regard. Further, the Partners understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and Monitor/NHS Improvement and will keep this position under review accordingly.

2.16. The Partners understand that no decision shall be made to make changes to services in West Yorkshire and Harrogate or the way in which they are delivered without prior consultation where appropriate in accordance with the partners statutory and other obligations.

3. How we work together in West Yorkshire and Harrogate

Our vision

3.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All proposals, both as Partner organisations and at a Partnership level should be supportive of the delivery of this vision:

- Places will be healthy - you will have the best start in life, so you can live and age well.
- If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.
- If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
- If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
- Local hospitals will be supported by centres of excellence for services such as cancer and~~,~~ stroke~~, and mental health.~~
- All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example community and hospital care working together.
- Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

Overarching leadership principles for our partnership

3.2. We have agreed a set of guiding principles that shape everything we do through our partnership:

- We will be ambitious for the people we serve and the staff we employ
- The West Yorkshire and Harrogate partnership belongs to its citizens and to commissioners and providers, councils and NHS so we will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
- We will undertake shared analysis of problems and issues as the basis of taking action
- We will apply subsidiarity principles in all that we do – with work taking

place at the appropriate level and as near to local as possible

Our shared values and behaviours

3.3. We commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire and Harrogate;
- We support each other and work collaboratively;
- We act with honesty and integrity, and trust each other to do the same;
- We challenge constructively when we need to;
- We assume good intentions; and
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

Partnership objectives

3.4. Our ambitions for improving health outcomes, joining up care locally, and living within our financial means were set out in our STP plan (November 2016, available at: https://wyhpartnership.co.uk/meetings-and-publications/publications). This Memorandum reaffirms our shared commitment to achieving these ambitions and to the further commitments made in *Next Steps for the West Yorkshire and Harrogate Health and Care Partnership*, published in February 2018.

3.5. In order to achieve these ambitions we have agreed the following broad objectives for our Partnership:

i. To make fast and tangible progress in:
   - enhancing urgent and emergency care,
   - strengthening general practice and community services,
   - improving mental health services,
   - improving cancer care,
   - prevention at scale of ill-health,
   - collaboration between acute service providers,
   - improving stroke services, and
   - improving elective care, including standardisation of commissioning policies.

ii. To enable these transformations by working together to:
   - Secure the right workforce, in the right place, with the right skills, to deliver services at the right time, ensuring the wellbeing of our staff ,

- Engage our communities meaningfully in co-producing services,
- Use digital technology to drive change, ensure systems are inter-operable, and create a 21st Century NHS,
- Place innovation and best practice at the heart of our collaboration, ensuring that our learning benefits the whole population,
- Develop and shape the strategic capital and estates plans across West Yorkshire and Harrogate, maximising all possible funding sources and ensuring our plans support the delivery of our clinical strategy, and
- Ensure that we have the best information, data, and intelligence to inform the decisions that we take.

iii. To manage our financial resources within a shared financial framework ~~control total~~ for health across the constituent CCGs and NHS provider organisations; and to maximise the system-wide efficiencies necessary to manage within this share of the NHS budget;

iv. To operate as an integrated health and care system, and progressively to build the capabilities to manage the health of our population, keeping people healthier for longer and reducing avoidable demand for health and care services;

v. To act as a leadership cohort, demonstrating what can be achieved with strong system leadership and increased freedoms and flexibilities.

Delivery improvement

3.6. Delivery and transformation programmes have been established to enable us to achieve the key objectives set out above. Programme Mandates have been developed for each programme and enabling workstream. These confirm:

- The vision for a transformed service
- The specific ambitions for improvement and transformation
- The component projects and workstreams
- The leadership arrangements.

3.7. Each programme has undergone a peer review 'check and confirm' process to confirm that it has appropriate rigour and delivery focus.

3.8. As programme arrangements and deliverables evolve over time the mandates will be revised and updated as necessary.

4. Partnership Governance

4.1. The Partnership does not replace or override the authority of the Partners' Boards and governing bodies. Each of them remains sovereign and Councils remain directly accountable to their electorates.

4.2. The Partnership provides a mechanism for collaborative action and common decision-making for those issues which are best tackled on a wider scale.

4.3. A schematic of our governance and accountability relationships is provided at **Annex 2** and terms of reference of the Partnership Board, System Leadership Executive and System Oversight and Assurance Group are provided at **Annex 3**.

Partnership Board

4.4. A Partnership Board will be established to provide the formal leadership for the Partnership. The Partnership Board will be responsible for setting strategic direction. It will provide oversight for all Partnership business, and a forum to make decisions together as Partners on the range of matters highlighted in section 7 of this Memorandum, which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum.

4.5. The Partnership Board is to be made up of the chairs and chief executives from all NHS organisations, elected member Chairs of Health and Wellbeing Boards, one other elected member, and chief executives from Councils~~chairs of Health and Wellbeing Boards and chief executives from councils~~ and senior representatives of other relevant Partner organisations. The Partnership Board will have an independent chair and will meet at least four times each year in public.

4.6. The Partnership Board has no formal delegated powers from the organisations in the Partnership. However, over time our expectation is that regulatory functions of the national bodies will increasingly be enacted through collaboration with our leadership. It will work by building agreement with leaders across Partner organisations to drive action around a shared direction of travel.

System Leadership Executive

4.7. The System Leadership Executive (SLE) Group includes each statutory organisation and representation from other Partner organisations. The group is responsible for overseeing delivery of the strategy of the Partnership, building leadership and collective responsibility for our shared objectives.

4.8. Each organisation will be represented by its chief executive or accountable officer. Members of the SLE will be responsible for nominating an empowered deputy to attend meetings of the group if they are unable to do so personally. Members of the SLE will be expected to recommend that their organisations support agreements and decisions made by SLE (always subject to each Partner's compliance with internal governance and approval procedures).

System Oversight and Assurance Group

4.9. A new system oversight and assurance group (SOAG) will be established in 2018/19 to provide a mechanism for Partner organisations to take ownership of system performance and delivery and hold one another to account. It will:

- be chaired by the Partnership Lead;
- include representation covering each sector / type of organisation;
- regularly review a dashboard of key performance and transformation metrics; and
- receive updates from WY&H programme boards.

4.10. The SOAG will be supported by the partnership core team.

West Yorkshire and Harrogate programme governance

4.11. Strong governance and programme management arrangements are built into each of our West Yorkshire and Harrogate priority and enabling programmes (the **Programmes**). Each programme has a Senior Responsible Owner, typically a Chief Executive, accountable officer or other senior leader, and has a structure that builds in clinical and other stakeholder input, representation from each of our six places and each relevant service sector.

4.12. Programmes will provide regular updates to the System Leadership Executive and System Oversight and Assurance Group. These updates will be published on the partnership website.

Other governance arrangements between Partners

4.13. The Partnership is also underpinned by a series of governance arrangements specific to particular sectors (eg commissioners, acute providers, mental health providers, Councils) that support the way it works. These are described in paragraphs 4.14 to 4.29 below.

The West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups

4.14. The nine CCGs in West Yorkshire and Harrogate are continuing to develop closer working arrangements within each of the six Places that make up our Partnership.

4.15. The CCGs have established a Joint Committee, which has delegated authority to take decisions collectively. The Joint Committee is made up of representatives from each CCG. To make sure that decision making is open and transparent, the Committee has an independent lay chair and two lay members drawn from the CCGs, and meets in public every second month. The Joint Committee is underpinned by a memorandum of understanding and a work plan, which have been agreed by each CCG.

4.16. The Joint Committee is a sub-committee of the CCGs, and each CCG retains its statutory powers and accountability. The Joint Committee's work plan reflects those partnership priorities for which the CCGs believe collective decision making is essential. It only has decision-making responsibilities for the West Yorkshire and Harrogate programmes of work that have been expressly delegated to it by the CCGs.

West Yorkshire Association of Acute Trusts Committee in Common

4.17. The six acute hospital trusts in West Yorkshire and Harrogate have come together as the West Yorkshire Association of Acute Trusts (WYAAT). WYAAT believes that the health and care challenges and opportunities facing West Yorkshire and Harrogate cannot be solved through each hospital working alone; they require the hospitals to work together to achieve solutions for the whole of West Yorkshire and Harrogate that improve the quality of care, increase the health of people and deliver more efficient services.

4.18. WYAAT is governed by a memorandum of understanding which defines the objectives and principles for collaboration, together with governance, decision making and dispute resolution processes. The memorandum of understanding establishes the WYAAT Committee in Common, which is made up of the Chairs and Chief Executives of the six trusts, and provides the forum for working together and making decisions in a common forum. Decisions taken by the Committee in Common are then formally approved by each Trust Board individually in accordance with their own internal procedures.

West Yorkshire Mental Health Services Collaborative

4.19. The four trusts providing mental health services in West Yorkshire (Bradford District Care Foundation Trust, Leeds Community Healthcare NHS Trust, Leeds and York Partnership Foundation Trust and South West Yorkshire Partnership Foundation Trust) have come together to form the West Yorkshire Mental Health Services Collaborative (WYMHSC). The trusts will work together to share best practice and develop standard operating models and pathways to achieve better outcomes for people in West Yorkshire and ensure sustainable services into the future.

4.20. The WYMHSC is underpinned by a memorandum of understanding and shared governance in the form of 'committees in common'.

4.21. Tees, Esk and Wear Valleys NHS Foundation Trust provides mental health services to the Harrogate area.

Local council leadership

4.22. Relationships between local councils and NHS organisations are well established in each of the six places and continue to be strengthened. Complementary arrangements for the whole of West Yorkshire and Harrogate have also been established:

- Local authority chief executives meet and mandate one of them to lead on

health and care partnership;

- Health and Wellbeing Board chairs meet;
- A Joint Health Overview and Scrutiny Committee
- West Yorkshire Combined Authority
- North Yorkshire and York Leaders and Chief Executives

Clinical Forum

4.23. Clinical leadership is central to all of the work we do. Clinical leadership is built into each of our work programmes, and our Clinical Forum provides formal clinical advice to all of our programmes.

4.24. The purpose of the Clinical Forum is to be the primary forum for clinical leadership, advice and challenge for the work of the partnership in meeting the Triple Aim: improving health and wellbeing; improving care and the quality of services; and ensuring that services are financially sustainable.

4.25. The Clinical Forum ensures that the voice of clinicians, from across the range of clinical professions and partner organisations, drives the development of new clinical models and proposals for the transformation of services. It also takes an overview of system performance on quality.

4.26. The Clinical Forum has agreed Terms of Reference which describe its scope, function and ways of working.

Local Place Based Partnerships

4.27. Local partnerships arrangements for the Places bring together the Councils, voluntary and community groups, and NHS commissioners and providers in each Place, including GPs and other primary care providers, to take responsibility for the cost and quality of care for the whole population. Each of the six Places in West Yorkshire and Harrogate has developed its own arrangements to deliver the ambitions set out in its own Place Plan.

4.28. These new ways of working reflect local priorities and relationships, but all provide a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings.

4.29. There are seven local health and care partnerships (two in Bradford District and Craven and one in each other place) which will develop horizontally integrated networks to support seamless care for patients.

5. Mutual accountability framework

5.1. A single consistent approach for assurance and accountability between Partners on West Yorkshire and Harrogate system wide matters will be applied through the governance structures and processes outlined in Paragraphs 4.1 to 4.12 above.

Current statutory requirements

5.2. NHS England has a duty under the NHS Act 2006 (as amended by the 2012 Act) to assess the performance of each CCG each year. The assessment must consider, in particular, the duties of CCGs to: improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. The 2012 Act provides powers for NHS England to intervene where it is not assured that the CCG is meeting its statutory duties.

5.3. NHS Improvement is the operational name for an organisation that brings together Monitor and the NHS Trust Development Authority (NHS TDA). NHS Improvement must ensure the continuing operation of a licensing regime. The NHS provider licence forms the legal basis for Monitor's oversight of NHS foundation trusts. While NHS trusts are exempt from the requirement to apply for and hold the licence, directions from the Secretary of State require NHS TDA to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS trust where necessary to ensure compliance.

A new model of mutual accountability

5.4. Through this Memorandum the Partners agree to take a collaborative approach to, and collective responsibility for, managing collective performance, resources and the totality of population health. The partners will:

- Agree ambitious outcomes, common datasets and dashboards for system improvement and transformation management;
- work through our formal collaborative groups for decision making, engaging people and communities across WY&H; and
- identify good practice and innovation in individual places and organisations and ensure it is spread and adopted through the Programmes.

5.5. The Partnership approach to system oversight will be geared towards performance improvement and development rather than traditional performance management. It will be data-driven, evidence-based and rigorous. The focus will be on improvement, supporting the spread and adoption of innovation and best practice between Partners.

5.6. Peer review will be a core component of the improvement methodology. This will provide valuable insight for all Partners and support the identification and adoption of good practice across the Partnership.

5.7. System oversight will be undertaken through the application of a continuous improvement cycle, including the following elements:

- Monitoring performance against key standards and plans in each place;
- Ongoing dialogue on delivery and progress;
- Identifying the need for support through a clinically and publically-led process of peer review;
- Agreeing the need for more formal action or intervention on behalf of the partnership; and
- Application of regulatory powers or functions.

5.8. The Programmes will, where appropriate, take on increasing responsibility for managing this process. The extent of this responsibility will be agreed between each Programme and the SLE.

5.9. A number of Partners have their own improvement capacity and expertise. Subject to the agreement of the relevant Partners this resource will be managed by the Partner in a co-ordinated approach for the benefit of the overall Partnership, and used together with the improvement expertise provided by national bodies and programmes.

Taking action

5.10. The SOAG will prioritise the deployment of improvement support across the Partnership, and agree recommendations for more formal action and interventions. Actions allocated to the SOAG are to make recommendations on:

- agreement of improvement or recovery plans;
- more detailed peer-review of specific plans;
- commissioning expert external review;
- the appointment of a turnaround Director / team; and
- restrictions on access to discretionary funding and financial incentives.

5.11. For Places where financial performance is not consistent with plan, the Partnership Directors of Finance Group will make recommendations to the SOAG on a range of interventions, including any requirement for:

- financial recovery plans;
- more detailed peer-review of financial recovery plans;
- external review of financial governance and financial management;
- organisational improvement plans;
- the appointment of a turnaround Director / team;

- enhanced controls around deployment of transformation funding held at place; and
- reduced priority for place-based capital bids.

The role of Places in accountability

5.12. This Memorandum has no direct impact on the roles and respective responsibilities of the Partners (including the Councils, Trust Boards and CCG governing bodies) which all retain their full statutory duties and powers.

5.13. Health and Wellbeing Boards (HWB) have a statutory role in each upper tier local authority area as the vehicle for joint local system leadership for health and care and this is not revised by the Partnership. HWB bring together key leaders from the local Place health and care system to improve the health and wellbeing of their population and reduce health inequalities through:

- developing a shared understanding of the health and wellbeing needs of their communities;
- providing system leadership to secure collaboration to meet these needs more effectively;
- having a strategic influence over commissioning decisions across health, public health and social care;
- involving councillors and patient representatives in commissioning decisions.

5.14. In each Place the statutory bodies come together in local health and care partnerships to agree and implement plans across the Place to:

- Integrate mental health, physical health and care services around the individual
- Manage population health
- Develop increasingly integrated approaches to joint planning and budgeting

Implementation of agreed strategic actions

5.15. Mutual accountability arrangements will include a focus on delivery of key actions that have been agreed across the Partnership and agreement on areas where Places require support from the wider Partnership to ensure the effective management of financial and delivery risk.

National NHS Bodies oversight and escalation

5.16. As part of the development of the Partnership and the collaborative working between the Partners under the terms of this Memorandum, NHS England and NHS Improvement will look to adopt a new relationship with the Partners (which are NHS Bodies) in West Yorkshire and Harrogate in the form of enacting streamlined oversight arrangements under which:

- Partners will take the collective lead on oversight of trusts and CCGs and Places in accordance with the terms of this Memorandum;
- NHS England and NHS Improvement will in turn focus on holding the NHS bodies in the Partnership to account as a whole system for delivery of the NHS Constitution and Mandate, financial and operational control, and quality (to the extent permitted at Law);
- NHS England and NHS Improvement intend that they will intervene in the individual trust and CCG Partners only where it is necessary or required for the delivery of their statutory functions and will (where it is reasonable to do so, having regard to the nature of the issue) in the first instance look to notify the SLE and work through the Partnership to seek a resolution prior to making an intervention with the Partner.

6. Decision-Making and Resolving Disagreements

6.1. Our approach to making Partnership decisions and resolving any disagreements will follow the principle of subsidiarity and will be in line with our shared Values and Behaviours. We will take all reasonable steps to reach a mutually acceptable resolution to any dispute.

Collective Decisions

6.2. There will be three levels of decision making:

- **Decisions made by individual organisations** - this Memorandum does not affect the individual sovereignty of Partners or their statutory decision-making responsibilities.
- **Decisions delegated to collaborative forums** - some partners have delegated specific decisions to a collaborative forum, for example the CCGs have delegated certain commissioning decisions to the Joint Committee of CCGs. Arrangements for resolving disputes in such cases are set out in the Memorandum of the respective Joint Committee and not this Memorandum. There are also a specific dispute resolution mechanisms for WYATT and the WYMHC.
- **Whole Partnership decisions** - the Partners will make decisions on a range of matters in the Partnership which will neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum, as set out in Paragraphs 6.3 below.

6.3. Collaborative decisions on Partnership matters will be considered by the Partnership Board. The Partnership Board has no formal powers delegated by any Partner. However, it will increasingly take on responsibility for co-ordinating decisions relating to regulatory and oversight functions currently exercised from outside the WY&H system and will look to reach recommendations and any decisions on a Best for WY&H basis. The terms of reference for the Partnership Board will set out clearly the types of decision which it will have responsibility to discuss and how conflicts of interest will be managed. The Partnership Board will initially have responsibility for decisions relating to:

- The objectives of priority HCP work programmes and workstreams
- The apportionment of transformation monies from national bodies
- Priorities for capital investment across the Partnership.
- Operation of the single NHS financial control total (for NHS Bodies)
- Agreeing common actions when Places or Partners become distressed

6.4. SLE will make recommendations to the Partnership Board on these matters. Where appropriate, the Partnership Board will make decisions of the Partners by consensus of those eligible Partnership Board members present at a quorate meeting. If a consensus decision cannot be reached, then (save for decisions on allocation of capital investment and transformation funding) it may

be referred to the dispute resolution procedure under Paragraph 6.6 below by any of the affected Partners for resolution.

6.5. In respect of referring priorities for capital investment or apportionment of transformation funding from the Partnership, if a consensus cannot be reached at the SLE meeting to agree this then the Partnership Board may make a decision provided that it is supported by not less than 75% of the eligible Partnership Board members. Partnership Board members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1.

Dispute resolution

6.6. Partners will attempt to resolve in good faith any dispute between them in respect of Partnership Board (or other Partnership-related) decisions, in line with the Principles, Values and Behaviours set out in this Memorandum.

6.7. Where necessary, Place or sector-based arrangements (the Joint Committee of CCGs, WYAAT, and WYMHSC as appropriate) will be used to resolve any disputes which cannot be dealt with directly between individual Partners, or which relate to existing schemes of delegation.

6.8. The Partnership will apply a dispute resolution framework to resolve any issues which cannot otherwise be agreed through these arrangements.

6.9. As decisions made by the Partnership do not impact on the statutory responsibilities of individual organisations, Partners will be expected to apply shared Values and Behaviours and come to a mutual agreement through the dispute resolution process.

6.10. The key stages of the dispute resolution process are

i. The SOAG will seek to resolve the dispute to the mutual satisfaction of each of the affected parties. If SOAG cannot resolve the dispute within 30 days, the dispute should be referred to SLE.

ii. SLE will come to a majority decision (i.e. a majority of eligible Partners participating in the meeting who are not affected by the matter in dispute determined by the scope of applicable issues set out in Annex 1) on how best to resolve the dispute based, applying the Principles, Values and Behaviours of this Memorandum, taking account of the Objectives of the Partnership. SLE will advise the Partners of its decision in writing.

iii. If the parties do not accept the SLE decision, or SLE cannot come to a decision which resolves the dispute, it will be referred to an independent facilitator selected by SLE. The facilitator will work with the Partners to resolve the dispute in accordance with the terms of this Memorandum.

iv. In the unlikely event that the independent facilitator cannot resolve the dispute, it will be referred to the Partnership Board. The Partnership Board will come to a majority decision on how best to resolve the dispute in accordance with the terms of this Memorandum and advise the parties of its decision.

7. Financial Framework

7.1. All NHS body Partners, in West Yorkshire and Harrogate are ready to work together, manage risk together, and support each other when required. The Partners are committed to working individually and in collaboration with others to deliver the changes required to achieve financial sustainability and live within our resources.

7.2. A set of financial principles have been agreed, within the context of the broader guiding Principles for our Partnership. They confirm that we will:

- aim to live within our means, i.e. the resources that we have available to provide services;
- develop a West Yorkshire and Harrogate system response to the financial challenges we face; and
- develop payment and risk share models that support a system response rather than work against it.

7.3. We will collectively manage our NHS resources so that all Partner organisations will work individually and in collaboration with others to deliver the changes required to deliver financial sustainability.

Living within our means and management of risk

7.4. Through this Memorandum the collective NHS Partner leaders in each Place commit to demonstrate robust financial risk management. This will include agreeing action plans that will be mobilised across the Place in the event of the emergence of financial risk outside plans. This might include establishing a Place risk reserve where this is appropriate and in line with the legal obligations of the respective NHS body Partners involved.

7.5. Subject to compliance with confidentiality and legal requirements around competition sensitive information and information security the Partners agree to adopt an open-book approach to financial plans and risks in each Place leading to the agreement of fully aligned operational plans. Aligned plans will be underpinned by common financial planning assumptions on income and expenditure between providers and commissioners, and on issues that have a material impact on the availability of system financial incentives

NHS Contracting principles

7.6. The NHS Partners are committed to considering the adoption of payment models which are better suited to whole system collaborative working (such as Aligned Incentive Contracting). The Partners will look to adopt models which reduce financial volatility and provide greater certainty for all Partners at the beginning of each year of the planned income and costs.

Allocation of Transformation Funds

7.7. The Partners intend that any transformation funds made available to the Partnership will all be used within the Places. Funds will be allocated through collective decision-making by the Partnership in line with agreed priorities. The method of allocation may vary according to agreed priorities. However, funds will not be allocated through expensive and protracted bidding and prioritisation processes and will be deployed in those areas where the Partners have agreed that they will deliver the maximum leverage for change and address financial risk.

7.8. The funding provided to Places (based on weighted population) will directly support Place-based transformation programmes. This will be managed by each Place with clear and transparent governance arrangements that provide assurance to all Partners that the resource has been deployed to deliver maximum transformational impact, to address financial risk, and to meet the efficiency requirements. Funding will be provided subject to agreement of clear deliverables and outcomes by the relevant Partners in the Place through the mutual accountability arrangements of the SLE and SOAG and be subject to on-going monitoring and assurance from the Partnership.

7.9. Funding provided to the Programmes (all of which will also be deployed in Place) will be determined in agreement with Partners through the SLE, subject to documenting the agreed deliverables and outcomes with the relevant Partners.

Allocation of ICS capital

7.10. The Partnership will play an increasingly important role in prioritising capital spending by the national bodies over and above that which is generated from organisations' internal resources. In doing this, the Partnership will ensure that:

- the capital prioritisation process is fair and transparent;
- there is a sufficient balance across capital priorities specific to Place as well as those which cross Places;
- there is sufficient focus on backlog maintenance and equipment replacement in the overall approach to capital;
- the prioritisation of major capital schemes must have a clear and demonstrable link to affordability and improvement of the financial position;
- access to discretionary capital is linked to the mutual accountability framework as described in this Memorandum.

Allocation of Provider and Commissioner Incentive Funding

7.11. The approach to managing performance-related incentive funds set by NHS planning guidance and business rules (e.g. the 2018/19 Provider Sustainability Fund and Commissioner Sustainability Fund) is not part of this Memorandum. A common approach to this will be agreed by the Partnership as part of annual financial planning.

8. National and regional support

8.1. To support Partnership development as an Integrated Care System there will be a process of aligning resources from ALBs to support delivery and establish an integrated single assurance and regulation approach.

8.2. National capability and capacity will be available to support WY&H from central teams including governance, finance and efficiency, regulation and competition, systems and national programme teams, primary care, urgent care, cancer, mental health, including external support.

9. Variations

9.1. This Memorandum, including the Schedules, may only be varied by written agreement of all the Partners.

10. Charges and liabilities

10.1. Except as otherwise provided, the Partners shall each bear their own costs and expenses incurred in complying with their obligations under this Memorandum.

10.2. By separate agreement, the Parties may agree to share specific costs and expenses (or equivalent) arising in respect of the Partnership between them in accordance with a “Contributions Schedule” to be developed by the Partnership and approved by the Partnership Board.

10.3. Partners shall remain liable for any losses or liabilities incurred due to their own or their employee's actions.

11. Information Sharing

11.1. The Partners will provide to each other all information that is reasonably required in order to achieve the Objectives and take decisions on a Best for WY&H basis.

11.2. The Partners have obligations to comply with competition law. The Partners will therefore make sure that they share information, and in particular competition sensitive information, in such a way that is compliant with competition and data protection law.

12. Confidential Information

12.1. Each Partner shall keep in strict confidence all Confidential Information it receives from another Partner except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised

disclosure by a Partner. Each Partner shall use any Confidential Information received from another Partner solely for the purpose of complying with its obligations under this Memorandum in accordance with the Principles and Objectives and for no other purpose. No Partner shall use any Confidential Information received under this Memorandum for any other purpose including use for their own commercial gain in services outside of the Partnership or to inform any competitive bid without the express written permission of the disclosing Partner.

12.2. To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

12.3. The Parties agree to procure, as far as is reasonably practicable, that the terms of this Paragraph (Confidential Information) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this Memorandum.

12.4. Nothing in this Paragraph will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law.

13. Additional Partners

13.1. If appropriate to achieve the Objectives, the Partners may agree to include additional partner(s) to the Partnership. If they agree on such a course the Partners will cooperate to enter into the necessary documentation and revisions to this Memorandum if required.

13.2. The Partners intend that any organisation who is to be a partner to this Memorandum (including themselves) shall commit to the Principles and the Objectives and ownership of the system success/failure as set out in this Memorandum.

14. Signatures

14.1. This Memorandum may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Memorandum, but all the counterparts shall together constitute the same document.

14.2. The expression "counterpart" shall include any executed copy of this Memorandum transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

14.3. No counterpart shall be effective until each Partner has executed at least one counterpart.

[INSERT SIGNATURE PAGES AFTER THIS]

Schedule 1 - Definitions and Interpretation

1. The headings in this Memorandum will not affect its interpretation.

2. Reference to any statute or statutory provision, to Law, or to Guidance, includes a reference to that statute or statutory provision, Law or Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to Annexes and Schedules are to the Annexes and Schedules of this Memorandum, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

Glossary of terms and acronyms

6. The following words and phrases have the following meanings in this Memorandum:

ALB	Arm's Length Body A Non-Departmental Public Body or Executive Agency of the Department of Health and Social Care, eg NHSE, NHSI, HEE, PHE
Aligned Incentive Contract	A contracting and payment method which can be used as an alternative to the Payment by Results system in the NHS
Best for WY&H	A focus in each case on making a decision based on the best interests and outcomes for service users and the population of West Yorkshire and Harrogate
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
Committee in Common	
Confidential Information	All information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Memorandum
CQC	Care Quality Commission, the independent regulator of all health and social care services in England

GP	General Practice (or practitioner)
HCP	Health and Care Partnership
Healthcare Providers	The Partners identified as Healthcare Providers under Paragraph 1.1
HEE	Health Education England
Healthwatch	Independent organisations in each local authority area who listen to public and patient views and share them with those with the power to make local services better.
HWB	Health and Wellbeing Board
ICP	Integrated Care Partnership The health and care partnerships formed in each of the
ICS	Integrated Care System
JCCCG	Joint Committee of Clinical Commissioning Groups - a formal committee where two or more CCGs come together to form a joint decision making forum. It has delegated commissioning functions.
Law	any applicable statute or proclamation or any delegated or subordinate legislation or regulation; any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; any applicable judgment of a relevant court of law which is a binding precedent in England; National Standards (as defined in the NHS Standard Contract); and any applicable code and "Laws" shall be construed accordingly
LWAB	Local Workforce Action Board sub regional group within Health Education England
Memorandum	This Memorandum of Understanding
Neighbourhood	One of c.50 geographical areas which make up West Yorkshire and Harrogate, in which GP practices work together, with community and social care services, to offer integrated health and care services for populations of 30-50,000 people.
NHS	National Health Service
NHSE	NHS England Formally the NHS Commissioning Board
NHS FT	NHS Foundation Trust - a semi-autonomous organisational unit within the NHS

NHSI	NHS Improvement - The operational name for an organisation that brings together Monitor, the NHS Trust Development Authority and other functions
Objectives	The Objectives set out in Paragraph 3.5
Partners	The members of the Partnership under this Memorandum as set out in Paragraph 1.1 who shall not be legally in partnership with each other in accordance with Paragraph 2.7.
Partnership	The collaboration of the Partners under this Memorandum which is not intended to, or shall be deemed to, establish any legal partnership or joint venture between the Partners to the Memorandum
Partnership Board	The senior governance group for the Partnership set up in accordance with Paragraphs 4.4 to 4.6
Partnership Core Team	The team of officers, led by the Partnership Director, which manages and co-ordinates the business and functions of the Partnership
PHE	Public Health England - An executive agency of the Department of Health and Social Care which exists to protect and improve the nation's health and wellbeing, and reduce health inequalities
Places	One of the six geographical districts that make up West Yorkshire and Harrogate, being Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield, and "Place" shall be construed accordingly
Principles	The principles for the Partnership as set out in Paragraph 3.2
Programmes	The WY&H programme of work established to achieve each of the objectives set out in paras 4.2,i and 4.2,ii of this memorandum
SOAG	System Oversight and Assurance Group
STP	Sustainability and Transformation Partnership (or Plan) The NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care
System Leadership Executive or SLE	The governance group for the Partnership set out in Paragraphs 4.7 and 4.8

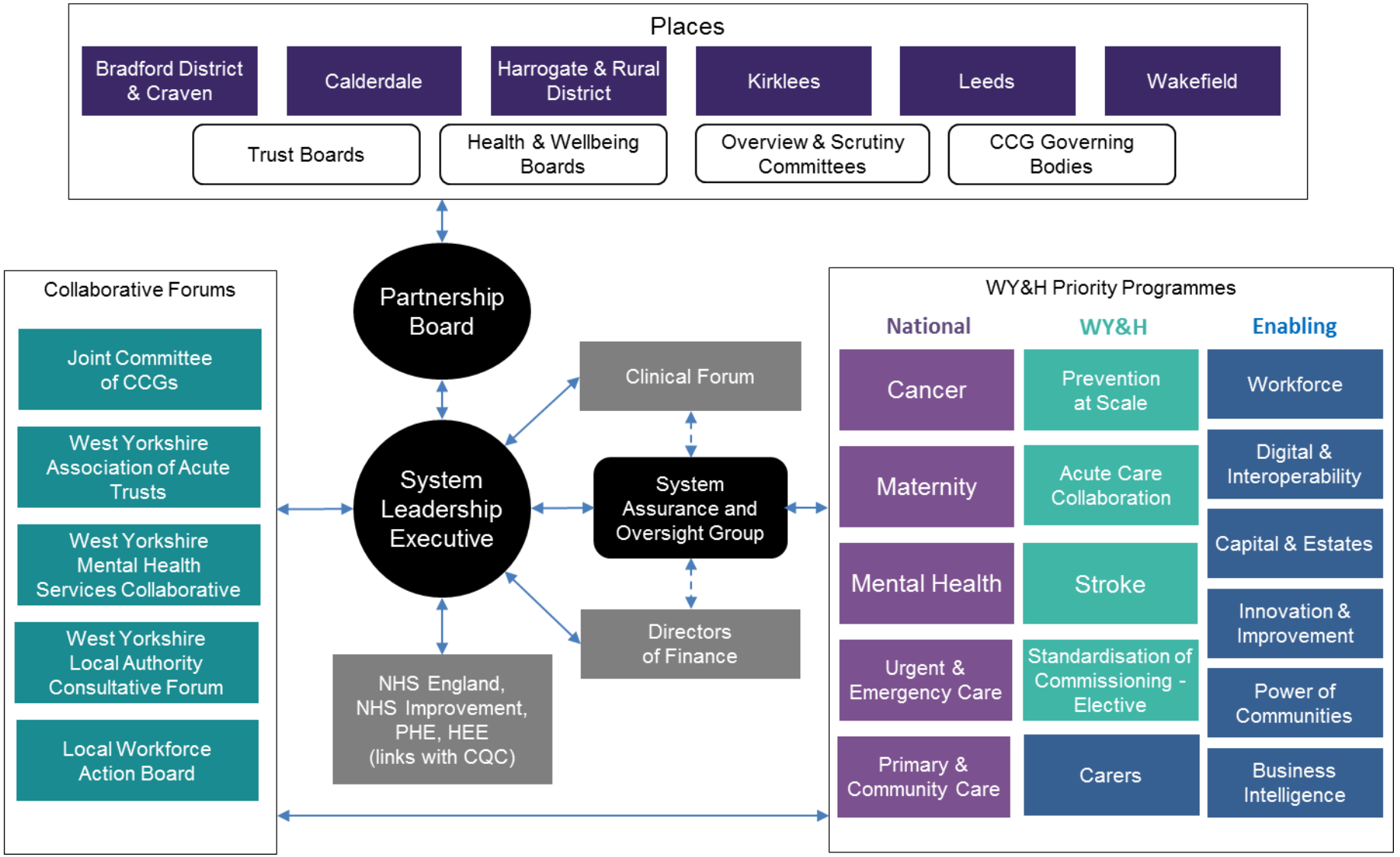
Transformation Funds	Discretionary, non-recurrent funding made available by NHSE to support the achievement of service improvement and transformation priorities
Values and Behaviours	shall have the meaning set out in Paragraph 3.3 above
WY&H	West Yorkshire and Harrogate
WYAAT	West Yorkshire Association of Acute Trusts
WYMHC	West Yorkshire Mental Health Collaborative

Annex 1 – Applicability of Memorandum Elements

	CCGs	NHS Providers[3]	Councils	NHSE and NHSI	Healthwatch	Other partners
Vision, principles, values and behaviour	✓	✓	✓	✓	✓	✓
Partnership objectives	✓	✓	✓	✓	✓	✓
Governance	✓	✓	✓	✓	✓	✓
Decision-making and dispute resolution	✓	✓	✓	✓	✓	✓
Mutual accountability	✓	✓	✓	✓		
Financial framework – financial risk management	✓	✓		✓		
Financial framework – Allocation of capital and transformation funds	✓	✓	✓	✓		
National and regional support	✓	✓	✓	✓		

[3] All elements of the financial framework for WY&H, eg the application of a single NHS control total, will not apply to all NHS provider organisations, particularly those which span a number of STPs.
Locala Community Partnerships CIC is a significant provider of NHS services. It is categorised as an 'Other Partner' because of its corporate status and the fact that it cannot be bound by elements of the financial and mutual accountability frameworks. This status will be reviewed as the partnership continues to evolve.

Annex 2 – Schematic of Governance and Accountability Arrangements



Annex 3 - Terms of Reference

Part 1: Partnership Board

Part 2: System Leadership Executive

Part 3: System Oversight and Assurance Group

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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Director of Health and Wellbeing to the meeting of Bradford and Airedale Health and Wellbeing Board to be held on 4th September 2018.

Subject: **D**

'Connecting People and Place': A Joint Health and Wellbeing Strategy for Bradford and Airedale

Summary statement:

Updates are provided for the four outcome areas under the strategy and a proposal for tracking progress against the strategy forms an appendix to the report.

Bev Maybury
Strategic Director – Health and Wellbeing

Report Contact: Sarah Muckle
Phone: (01274) 432805
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Portfolio:

Healthy People and Places

Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

Updates are provided for the four outcome areas under the strategy, and a proposal for tracking progress against the strategy forms an appendix to the report.

2. BACKGROUND

'Connecting People and Place' , the new Joint Health and Wellbeing Strategy for Bradford and Airedale 2018-23 was published on the Health and Wellbeing Board website in June 2018 (Appendix 1).

The foreword to the strategy refers to a ten year ambition to reduce health inequalities, preventable differences between different people and between different areas of the District, as well as improving health and wellbeing overall. It calls for people to work together and to be willing to do things differently in order to see a radical improvement in health and wellbeing across the District.

The Strategy has four outcomes. Each will be delivered through a strategic plan or initiative.

- Our children have a great start in life – Children, Young People and Families Plan
- People in Bradford District have good mental wellbeing – Mental Wellbeing Strategy
- People in all parts of the District are living well and ageing well – Healthy Bradford Plan
- Bradford District is a healthy place to live, learn and work – Economic Strategy, Core Strategy, Housing Strategy.

To achieve these outcomes we will create a health promoting place to live, promote wellbeing and prevent ill health, and support people to get help earlier and manage their conditions.

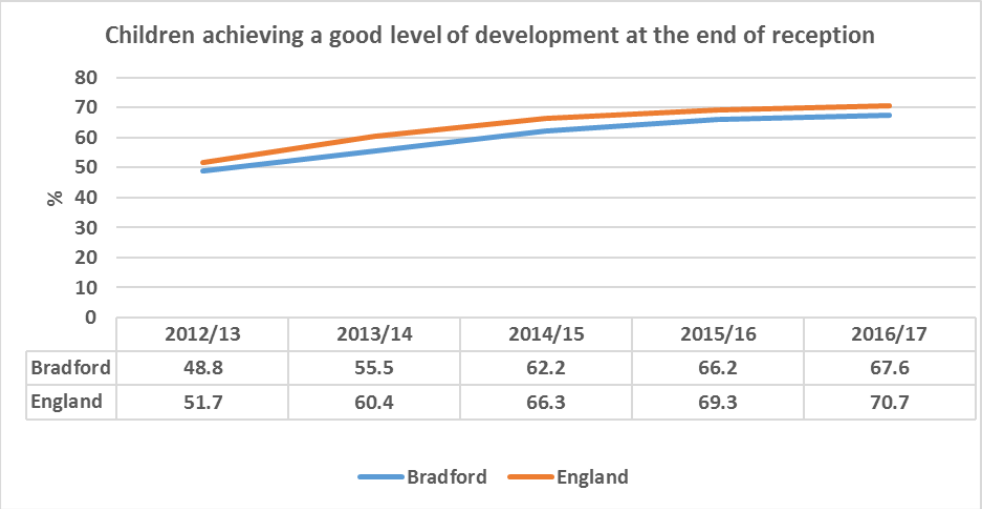
This update is organised around the four outcomes and is accompanied by a draft 'logic model' (Appendix 2). A logic model describes how each aspect of the strategy will be put into practice setting out the resources that will be used, the activities that will make a difference and how progress against the strategy's outcomes will be tracked.

The **Joint Strategic Needs Assessment** (JSNA) is being developed and is due to be published in the autumn. The JSNA provides a concise narrative of health outcomes and factors that influence health and wellbeing with chapters that are structured around the outcomes of the Strategy. This document will support commissioners to ensure services are shaped by local need.

3. OTHER CONSIDERATIONS

3.1 Outcome 1 - Our children have a great start in life

The strategy acknowledges the level of challenge to achieving good health and wellbeing for all children in the District, – reminding us that children in more deprived parts of the District have worse health and wellbeing on average, with specific challenges around infant health, dental health and healthy weight, injuries and long-term conditions such as asthma. Poor health and wellbeing impacts on children's ability to reach their potential in life.



	2012/13	2013/14	2014/15	2015/16	2016/17
Bradford	48.8	55.5	62.2	66.2	67.6
England	51.7	60.4	66.3	69.3	70.7

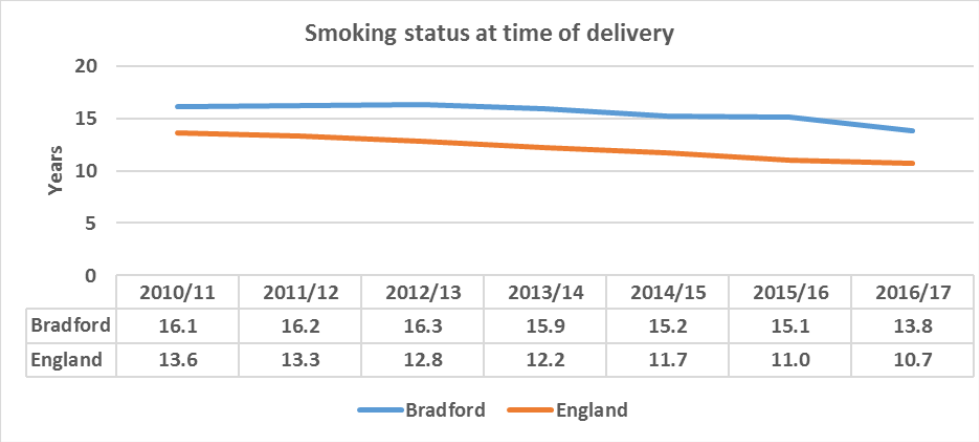
3.1.1 **School readiness.** At age five the holistic school readiness measure gives an indication of how prepared children are to succeed in school. Of the four indicators relating to school readiness the District does significantly worse than the average for England in two indicators – percentage of children achieving a good level of development at the end of reception and percentage of Year 1 pupils achieving the expected level in the phonics screening check. In recent years all four indicators show signs of improvement.

Children's Centres focus on promoting take-up of early education in some of our most disadvantaged two year olds as a means to closing the attainment gap. The Early Years Quality Support Team has introduced annual keeping-in-touch visits to early years settings alongside developing a menu of traded training and consultancy support to ensure that the quality of early years provision remains high and makes the required difference to outcomes.

3.1.2 **Reproductive health and pre-conception.** Ensuring that women and men across Bradford District achieve and maintain good health in their reproductive years is a challenge that impacts on future health for both individuals and their children. A **Bradford Preconception Health Summit** is being considered for early 2019 in recognition that preconception and reproductive health should be about improving the general health of the whole population as an underlying philosophy of all health, education, and social care. This event is being championed by the Maternity, Children and Young People's Partnership and will provide an opportunity to identify strengths, opportunities, barriers and risks across the health and social care system

across the District.

3.1.3 **Infant health.** The **Every Baby Matters** steering group continues to deliver the action plan to reduce the number of infants dying in the first year of life. This includes recommendations from the Infant Mortality Commission (2006) as well as local information from the Child Death Overview Panel, to ensure that risk factors are understood for the preventable and avoidable infant deaths which occur and action is taken. **Reducing smoking in pregnancy** remains a priority, with a comprehensive programme in place that starts with the identification and referral of pregnant smokers and their partners at the first antenatal appointment. Prevalence decreased from 15.1% in 2015/16 to13.8% in 2017/18.



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Bradford	16.1	16.2	16.3	15.9	15.2	15.1	13.8
England	13.6	13.3	12.8	12.2	11.7	11.0	10.7

Recent developments have seen the introduction of an intervention at the 12 week antenatal scan, carbon monoxide screening of all women at around 36 weeks gestation and the introduction of nicotine replacement therapy on the wards for pregnant smokers admitted antenatally.

3.1.4 **Public Health 0-19 Service.** This service (to include Health Visiting, School Nursing and Oral Health services) is in the process of being re-commissioned through a competitive tender process. The procured Public Health 0-19 Service will be integrated and co-located as part of the wider Prevention and Early Help model, across the four locality footprint. The integration and co-location of these two services will enable early and effective support for parents and children when issues arise. This will be especially important during the early years as the opportunity to reduce the impact of inequalities declines as children age. It is anticipated that the new service will be in place mid-2019.

3.1.5 **Improving Oral Health**. This remains an important commitment for Bradford District, and improvements are being made to deliver the Oral Health Improvement Action Plan. Bradford has been identified as one of thirty local authority areas in England with the highest levels of dental disease in five-year-olds. However of these areas, Bradford has been highlighted as one of only ten areas to demonstrate significant improvements in reducing the prevalence of dental decay in five-year-olds, over a nine-year period (2008–2017).

Children and young people's mental wellbeing See Outcome 2 below for an update

from the Future in Mind transformation programme under the all-age mental wellbeing strategy.

3.2 Outcome 2 - People in Bradford District have good mental wellbeing

Mental health problems are common, affecting an estimated one in ten children aged five to sixteen, and one in four adults over their lifetime. Risk factors for poor mental health include poverty, adverse life events, poor quality living and working environments, and physical ill health. The impact of poor mental health includes not only poor quality of life, but for many, a reduced life expectancy: for example, people with severe mental illness live an average of 15-20 years less than the general population. People are generally better able to take care of their physical health when they have good mental wellbeing, improving the outcomes of healthcare and increasing life expectancy.

Mental Wellbeing Partnership update. The Mental Wellbeing Partnership oversees the delivery of the Mental Wellbeing Strategy. A number of actions are being delivered under this strategy, including prevention, early diagnosis and intervention, and the transformation of acute care services.

3.2.1 **Suicide prevention** Bradford's action plan is focusing on high risk groups, providing better information and support and using national insight, in line with national areas of action. Self-harm prevention has also been identified as a local priority within this action plan.

3.2.2 **Psychological therapies**. Self-referral to MyWellbeing College is now in place**.** The reach of this service has expanded across different partners and agencies, improving inclusion. Models of delivery include telephone support, web-based support and work books.

3.2.3 **Integrated mental and physical health care** is focussing on embedding early psychological screening and interventions in physical healthcare pathways to pick up mental wellbeing issues, improve outcomes and reduce unnecessary or harmful interventions. Action learning workshops have focused on eating disorders and dementia support with GP and practice groups. Discussions are on-going about targeting more health checks on people with serious mental illness, learning disability and autism, to improve their physical health.

3.2.4 **Acute care.** Transformation of the pathway is underway, with a multiagency working group creating an adapted version of the CORE 24 approach, which includes the use of the current acute care pathway system within the safer spaces network. Partners are continuing to work together to look at the expansion of the acute care closer to home offer and the use of safer spaces. In addition, increased investment has allowed expansion of the **early intervention in psychosis** (EIP) service. All patients aged under 65 with first-onset psychosis now receive a NICE-approved care package, with over 50% of mental health service users seen within 2 weeks of referral.

3.2.5 **Community mental health.** Transformation is also underway of the community mental health team, who are moving towards a recovery and prevention model, providing improved care closer to home and making more use of community resilience approaches. A new assessment team and process is in place and workforce development in design.

Future in Mind update. Work streams within Future in Mind: the Children and Young People's Mental Wellbeing Transformation Plan include:

3.2.6 **Mental Health Champions** in schools which provides support for low level mental health needs. There are 74 schools signed up so far, and attending regular network meetings. Training has been provided for them, funded by the Anna Freud centre.

3.2.7 **Prevention and early intervention**. This is further supported by the Wellness Recovery Action Plan (WRAP) service: a 10-week course emphasising self-care, resilience building and peer support; and Primary Mental Health Workers (PMHWs), who are based in LA-led Early Help hubs and aligned to school nursing teams. PMHWs can deliver brief interventions and support for children and young people and their families, support and empower staff in schools, and act as a conduit for specialist CAMHS referrals.

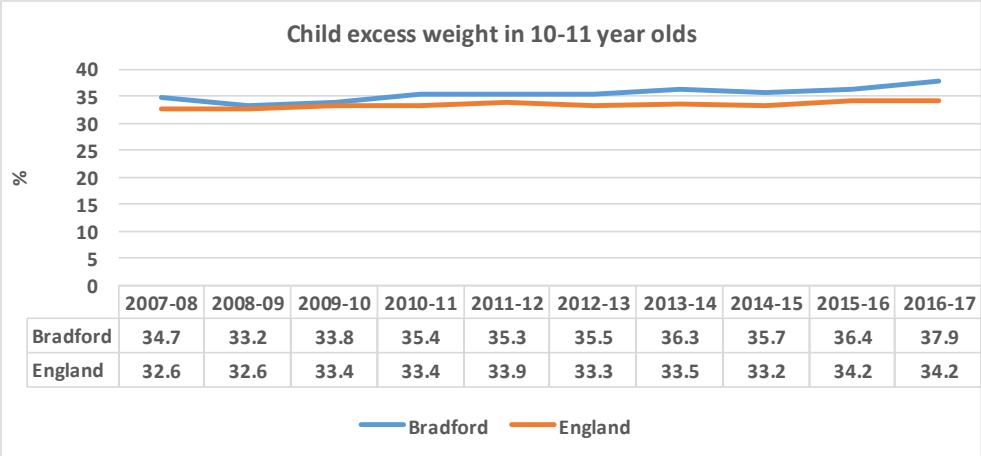
3.2.8 **CAMHS.** For children and young people requiring further assessment and intervention, the average waiting time from referral to CAMHS to treatment has significantly reduced since baseline measures in September 2017, to 108 days in quarter 1 of 2018/19, from 121 days at baseline. The First Response Service provides a single point of access 24 hours a day for referrals, including self-referrals for urgent and emergency mental health needs for children and young people. Safer Spaces provides a one-night stay in a safe, non-clinical space for children and young people aged under 18, who are at risk of a mental health crisis or emotional distress, work is underway to expand provision from 10am-10pm to 5pm-10pm provision.

3.2.9 **Youth in Mind** In order to support young people through their mental health journey, the Youth in Mind model was designed by young people, and provides them with a consistent named worker. Youth in Mind uses a range of ways to engage young people including drop-ins, one to one and peer support work through Buddies, WRAP group work led by Barnardo's, MYMUP's digital self-help tool, evidenced based peer support groups and longer term volunteer mentoring. This group has also established 'Children and Young People's Mental Health in Hospitals', which equips paediatric and adult hospital staff with the skills to support under-18s who have mental health needs in BRI and Airedale General Hospital.

3.2.10 **Vulnerable children and young people**. A number of projects are on-going to care for the most vulnerable children and young people in Bradford. An enhanced model of CAMHS service provision for looked after and adopted children has been developed and is in the process of being implemented. To address the mental health and psychological support needs of refugee and asylum seeking children in Bradford, Bevan Healthcare are delivering both one-to-one counselling sessions and a range of activities, such as fun days, football, cook and eat sessions, and

homework club, among others. A new specialist team for perinatal mental health is now operational and taking referrals.

3.3 Outcome 3 - People in all parts of the District are living well and ageing well



	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Bradford	34.7	33.2	33.8	35.4	35.3	35.5	36.3	35.7	36.4	37.9
England	32.6	32.6	33.4	33.4	33.9	33.3	33.5	33.2	34.2	34.2

A Healthy Bradford Plan has been developed through a series of engagement events, supported by Leeds Becket University, and involving many organisations from across the District. The starting point was the Health and Wellbeing Board's request to review the established approach to obesity in the District. The Board later endorsed developing a whole system approach to address a wide range of causal factors and use a range of different approaches to support people to feel more in control of their own wellbeing.

The Healthy Bradford team, working in close partnership with the Self Care and Prevention Programme is now establishing a programme of works to address the root causes of unhealthy lifestyle behaviours. The current focus has been predominantly covering unbalanced diets and physical inactivity. Thirty-seven schools across the District are now doing the **Daily Mile** with their pupils. In July a pilot of the 'Beat the Street' approach to getting people physically active took place. The evaluation will report in October but provisional figures show more than 2000 people taking part over a six week period.

The team are developing core work streams which are currently coming to fruition. These include:

3.3.1 **The Living Well Brand/Campaign and Social Movement.** The purpose of this work is to provide a single partnership brand for health messaging and identification of healthy lifestyles and activities. The voice of the brand will provide consistent key messages supporting improved health knowledge, health literacy and prompt community led motivation and inspiration to participate in healthier lifestyles. The messages will also be consistent with the voice of national campaigns including Change 4 Life and One You. The brand design has now been established and the detail of the brand feel and voice is being worked up. A joint communications officer will shortly be in post and the public aspect of the campaign and social action/

movement for health starting later this year.

3.3.2 **The Living Well Service.** This holistic lifestyle support service will be available to the district via GP and self referral from January. Working closely with Sport and Leisure the service will offer personalised advice, support and motivational interviewing across the district to support people in making a change towards living a healthier lifestyle.

3.3.3 **The Living Well Charter.** This is a framework under development to support and incentivise businesses and schools to create a healthy environment for their employees, contractors and pupils. This is intended to launch alongside the service in January 2019.

3.3.4 **Smoking reduction.** Two developing work programmes have identified reducing smoking as a priority. **Bradford Breathing Better** aims to improve respiratory health outcomes for children, young people and adults in Bradford with COPD or asthma. Public health is working in partnership with CCG colleagues to ensure smoking cessation is embedded into referral pathways. In the run up to Stoptober a Bradford Breathing Better health bus will target areas and communities across the district to engage with smokers and their families to support a quit attempt and to discuss the importance of a smokefree home.

3.3.5 A **Cancer Alliance** funded programme has identified Bradford as one of its sites to tackle lung cancer. One of the four work strands is to support smokers to quit**,** including those already receiving treatment in the NHS for smoking-related illnesses. This programme creates the opportunity to establish a local health and care partnership with the programme lead for Bradford now recruited and in post from the beginning of September.

3.4 Outcome 4 - Bradford District is a healthy place to live, learn and work

Our wellbeing is influenced by the quality, safety and condition of our built environment – our housing and other buildings, workplaces, streets, parks and other communal spaces - whether we feel safe in our local environment, in our streets and workplaces and how connected we are to people in our local neighbourhood. Cold, damp, unsafe houses increase the risk of illness and injury, new, better housing and remediation of existing stock are the main ways to address this. Poor air quality in some areas is a risk to people's lung and heart health and to children's healthy start and again needs action. We are taking action on each of these areas:

3.4.1 **Planning for the future.** A successful joint bid to the Design Council provided access to its 'Design in the Public Sector' (DiPS) programme for the Council's Health and Wellbeing and Place Departments. This four month programme provided a series of workshops and ongoing support to identify and shape joint areas of work between the two departments. To date these include: embedding a strong focus on improving health and wellbeing in the tender for the District's first Housing Design Guide and Top of Town Masterplan.

3.4.2 **Evidence review**. A comprehensive review of evidence on what makes a healthy place has been undertaken and draft principles developed, to shape discussion and planning for a healthy place. These will be tested initially at a joint learning session in October. Public Health have facilitated links between the planning team and the Born in Bradford (BiB) team. This will support the Masterplan and Housing Design Guide projects to understand what children and young people think about the area in which they live, and what a Healthy Place looks and feels like to them.

Public Health attend the Planning 'majors meeting', providing evidence-based input, at an early stage of the planning process, on how individual developments can have a positive impact on health and wellbeing.

3.4.3 **Green Space.** The Born in Bradford cohort study has added to the growing evidence base about the positive impacts of access to green space on wellbeing. Their studies that show that access to green space has a positive impact on the mental wellbeing of both pregnant women and young children, and that the quality of green space is as important as the quantity. The Better Start Bradford programme has worked with the Council's landscape architecture team to map green space in the programme area, providing a baseline for discussions with communities about where children can play, and to look for opportunities to create pockets of green space where it is lacking. The Council's Place department is preparing bids for grant funding to bring additional resource into the District to improve green infrastructure along the Canal Road corridor and in Horton Park. An update on use of open and green space for reasons of health is scheduled at the Regeneration and Environment Overview & Scrutiny Committee in early October.

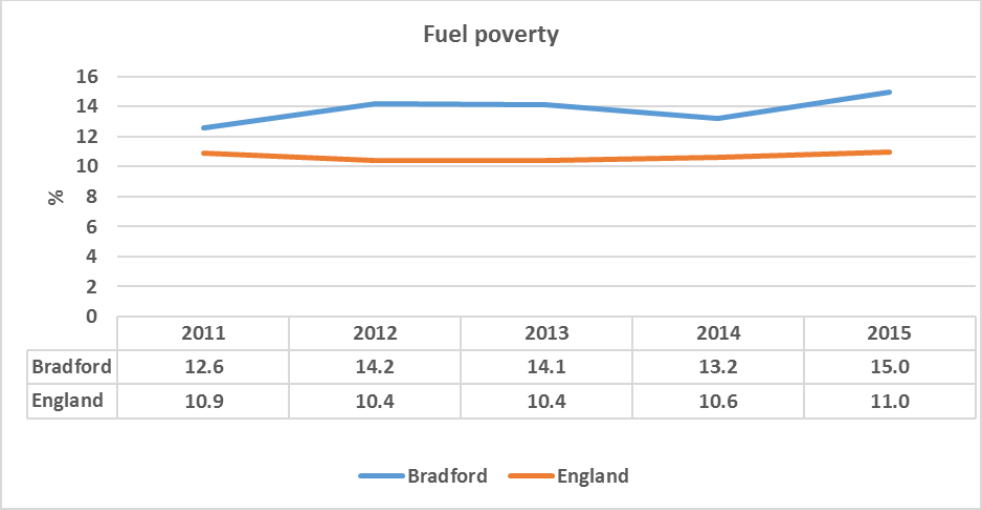
3.4.4 **Air Quality**. Work in Bradford to drive forward improvements to address air quality issues has included the adoption of the Low Emissions Strategy in 2013 when Bradford was the first city in West Yorkshire and the second in the country to adopt a Low Emission Strategy aimed at reducing air pollution and improving health in the district. Bradford has since worked collaboratively with neighbouring Councils, the Combined Authority and Public Health England to lead development of the West Yorkshire Low Emission Strategy (2016) which develops policies to improve air quality, including; planning guidance which ensures charging points, fleet standards and damage-cost equivalent air quality mitigation on all relevant schemes, bus standards, taxi licensing commitments, procurement guidance to reduce emissions and regional bids for emission reduction funding, such as bus retrofitting and Ultra-Low Emission Vehicle taxis.

The collaborative approach ensures consistent and tangible air quality improvement across the region, supported by local health professionals. Implementation has also included reviewing the road transport systems in urban areas, encouraging cost effective ways for people to make greener vehicle choices, car sharing initiatives and the promotion of cycling, walking and uses of public transport.

In May, Bradford, along with 32 other Councils, received a ministerial direction requiring investigation into whether there are any further measures that can be taken that will bring forward full compliance with legal requirements. This work has now been submitted to the Defra/DfT Joint Air Quality Unit and we expect that the

outcome will form part of the Government's amendment to the national strategy to reduce pollution from road vehicles launched last year. It is expected to be available to the public later this year.

3.4.5 **Employment and skills.** The Better Futures programme is a DWP-funded programme that aims to help more vulnerable community members into work and to continue to provide support whilst they are in work. It is being delivered by 'Reed in Partnership' across the Bradford District (as part of a larger North of England contract). Partners from the VCS and public and private sector organisations met with Reed in Partnership in July to discuss the purpose and implementation of the programme, how to align with similar programmes to avoid duplication and inappropriate referrals, and how to and access support available from existing projects to help their service users and vice versa. The group will meet again in September to continue the dialogue.



	2011	2012	2013	2014	2015
Bradford	12.6	14.2	14.1	13.2	15.0
England	10.9	10.4	10.4	10.6	11.0

3.4.6 **Anti-poverty work.** Welfare advice services, provided by four VCS partners and funded by the Council's Health and Wellbeing Department are continuing to transform services including to extend access options through development of internet and webchat services. The Council's customer contact services staff are partnering with welfare advice providers to streamline Universal Credit applications and fast-track applicants in need of formal debt counselling to welfare advice providers' co-located in Council sites during the rollout of Universal Credit. The Council's training unit/Revenues and Benefits team are providing universal credit training packages to key staff in the VCS and CCGs. An Anti-poverty strategy is now in place, with an anti-poverty board working to realise the strategic outcomes. An established winter warmth programme - Warm Homes - procured in 2017/18 for two years offers specific help to vulnerable households, which on top of a range of practical interventions, includes help with energy bills, debt and fuel poverty issues.

Comprehensive performance reporting for the strategy is in development.

4. FINANCIAL & RESOURCE APPRAISAL

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

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

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

6. LEGAL APPRAISAL

No legal issues

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

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

7.2 SUSTAINABILITY IMPLICATIONS

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

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

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

7.4 COMMUNITY SAFETY IMPLICATIONS

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

7.5 HUMAN RIGHTS ACT

No direct implications.

7.6 TRADE UNION

No direct implications.

7.7 WARD IMPLICATIONS

In areas with poorer health and wellbeing and higher levels of health inequalities different approaches may need to be developed to accelerate improvement in health and wellbeing and to reduce health inequalities.

8. NOT FOR PUBLICATION DOCUMENTS

None.

9. OPTIONS

No options are provided.

10. RECOMMENDATIONS

That the Board receives the update and provides feedback for further action.

11. APPENDICES

11.1 Connecting people and place for better health and wellbeing. A Joint Health and Wellbeing Strategy for Bradford and Airedale 2018-2023. https://bdp.bradford.gov.uk/media/1332/connecting-people-and-place-for-better-health-and-wellbeing-a-joint-health-and-wellbeing-strategy-for-bradford-and-airedale-2018-23.pdf

11.2 Logic Model - Tracking Progress for the Joint Health and Wellbeing Strategy for Bradford and Airedale 2018-2023.

12. BACKGROUND DOCUMENTS

1. Happy, Healthy and At Home - Health and Care Plan for Bradford District and Cravenhttps://bdp.bradford.gov.uk/media/1329/happy-healthy-and-at-home-our-plan-draft.pdf
2. Agenda item 8. Report on Air Quality and the fraction of mortality attributable to particulate air pollution across the Bradford District. Meeting of the Environment and Waste Management Overview & Scrutiny Committee, 26 September 2017**.**

Connecting people and place for better health and wellbeing

A Joint Health and Wellbeing Strategy for Bradford and Airedale

2018 – 2023

Contents

Leadership, development and links to other strategies and plans

Who will lead the joint Strategy?

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

How the strategy was developed

Our Joint Strategic Needs Assessment (JSNA) has helped us to understand the specific challenges for us as a population and local people helped to shape the Bradford District Plan in 2016. The District Plan's five priorities matter to local people and to our District. This Strategy implements the 'Better Health, Better Lives' priority of the Bradford District Plan.

Links to other strategies and plans

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

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

Foreword

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

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

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

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

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

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

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

The strategy sets our direction for the next five years with eight guiding principles to help us work towards the same goals and to hold each other to account for making progress.

Guiding Principles

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

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

Councillor Susan Hinchcliffe
Leader of the Council and Chair of Bradford and Airedale Health & Wellbeing Board

Dr Akram Khan
Clinical Lead, Bradford City CCG, and Deputy Chair of Bradford and Airedale Health & Wellbeing Board

Context: Our wellbeing challenge and ambition

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

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

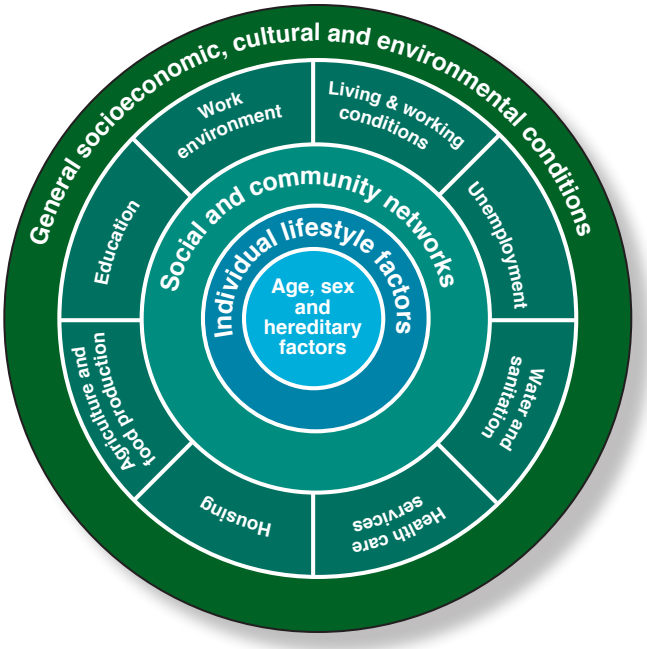
These challenges contribute to lower life expectancy at birth, almost 3 years lower than the national average for men, and 2 years lower for women. Shorter life expectancy is largely due to conditions that can be prevented: heart and lung disease, type 2 diabetes and some common types of cancer. Many people live more years of their life with a disability or a long-term illness than in other parts of the country.

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

What influences our health and wellbeing?

The diagram on this page shows that our health is determined by a wide range of factors, from our gender, how old we are and the genes we've inherited from our parents and grandparents, to how we live our day to day lives, whether we're active, able to access healthy food or have a good network of friends, family or other support. Some areas of the District will have different health and wellbeing needs simply because more of the population is older or more children live there.

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



The Determinants of Health (1992)

Dahigren and Whitehead

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

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

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

Strategy: Connecting people and place for better health and wellbeing

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

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

A shared vision and outcomes

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

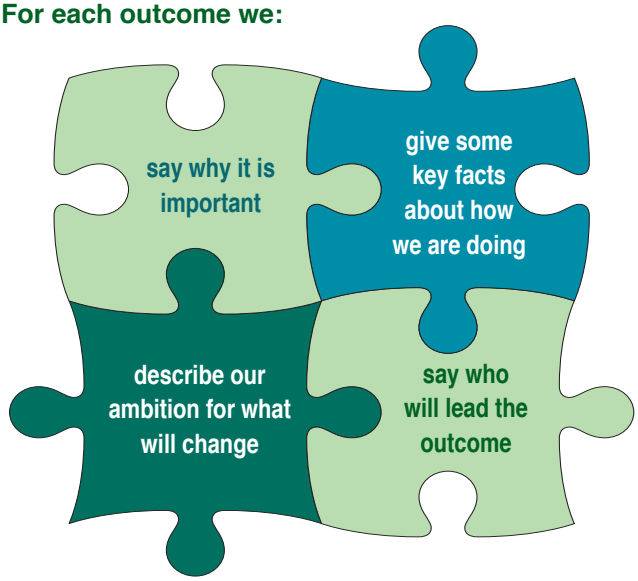
A happy, healthy Bradford District, where people have greater control over their wellbeing, living in their homes and communities for as long as they are able, with the right support when it is needed.

Four outcomes describe our aspirations for the district:

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

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

For each outcome we:



Outcome 1 Our children have a great start in life

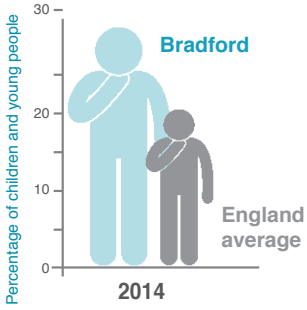
Children first and foremost need to feel loved and safe. Every child and young person needs a loving, responsive relationship with a parent or carer, enabling them to thrive. Improving the health and wellbeing of women of child-bearing age, investing in interventions for pregnant women and their partners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

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

How are we doing?

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

- Children in more deprived parts of the District have worse health and wellbeing on average. They are more likely to die in infancy, to have poorer dental health by age five and to be overweight by age 11.
- Children in more deprived areas are more likely to be injured, to have long-term conditions such as asthma and to be admitted to hospital.
- In 2014 29% of children and young people lived in households below the poverty line (England average is 20%).



Our ambitions for a great start in life are:

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

Lead responsibility

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

Outcome 2 People in Bradford District have good mental wellbeing

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

How are we doing?

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

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

Our ambitions for good mental wellbeing are:

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

Delivering outcome 2

The Health and Wellbeing Strategy will support the Mental Wellbeing partnership to deliver the District’s Mental Wellbeing Strategy and Future in Mind plan for Child Mental Wellbeing. This will ensure that mental wellbeing and physical wellbeing are recognised as having equal importance.

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

We all want to feel well throughout our lives and to stay well enough to live independently in our own homes as we age, close to family, friends and community.

This will obviously be more achievable if all our children and young people have a healthy start and we all take steps to stay healthy throughout our lives. Healthy ageing will usually follow a healthy life but we can all decide to make a change, to feel better and get healthier, with support if needed, whatever stage of life we are at.

Our ambitions for living well and ageing well are:

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

How are we doing?

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

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

Lead responsibility

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

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

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

How are we doing?

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

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

Our ambitions for a healthy place are:

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

Lead responsibility

The Bradford Economic Partnership leads the Economic Growth Strategy, the Housing Strategy and the anti-poverty work which will help to reduce inequalities and improve health and wellbeing.

6 Implementing the strategy

Three main approaches to implementing the strategy are outlined in brief here; they will be developed in further detail with the lead partnerships outlined above. The strategy should also be read alongside our local Health and Care Plan. Both documents can be found on the Bradford and Airedale Health and Wellbeing Board webpage at **https://bdp.bradford.gov.uk/about-us/health-and-wellbeing-board/**

We will make the difference by:

Creating a health-promoting place to live

Promoting wellbeing and preventing ill health

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

1. A health promoting place to live

Why is this important?

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

What can we do?

- Work with communities to identify local priorities and support local action to: build neighbourliness, reduce loneliness and isolation, and help people to feel safer, involved and included.
- Bring resources together to support community action (time pledges, donated goods, financial resources) to make streets and neighbourhoods safe, attractive and greener for children to play outside and people to walk and cycle more to school and work.
- Ensure healthy, active living is at the core of our work to bring new businesses, improved transport and better public spaces to the District.
- Build more opportunities into policies, strategies and interventions to increase the scale and pace of health and wellbeing improvement. Use new strategies for Economic Growth and Housing to ensure people can access better, well-paid jobs that an increased supply of affordable and energy efficient homes.
- Maximise opportunities to adopt a Healthy Workplace approach across the District.
- Implement the Low Emissions Strategy to improve air quality, support healthy child development and good respiratory health by securing investment in greener forms of private and public transport and encouraging people to make fewer short car journeys.
- Increase the supply of accessible and easily adapted housing stock to meet changing needs and reduce or delay the need for expensive adaptations and for residential care.

2. Promoting wellbeing, preventing ill-health

Why is this important?

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

What can we do?

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

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

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

- Co-ordinate the work through our Healthy Bradford Plan, in partnership with Active Bradford.
- Enable many more people to get involved in neighbourhood activities, particularly more vulnerable people who may need additional support to access opportunities.
- Continue to invest in interventions for pregnant women and their partners so they are well-prepared for pregnancy and parenthood. This is the best way to improve health and wellbeing for young children and to reduce health inequalities, especially for our more vulnerable young children.
- Encourage schools to walk or run a Daily Mile with their pupils, and many more people and families to increase their physical activity in a way that works for them.
- Deliver our Mental Wellbeing Strategy to improve our mental wellbeing and general health.

3. Getting help earlier and self-care

Why is this important?

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

What can we do?

- Encourage everyone to register with primary care services to access screening and earlier help. Increase uptake of screening for common cancers, focusing where uptake is low. Ensure people with mental health conditions, dementia and learning disabilities access screening.
- Increase and improve home care and community-based care to giving greater choice when it is needed, including at the end of life.
- Make greater use of technology to make it easier for people to access advice and support to stay well as well as maximising opportunities to stay independent.
- Continue successful local campaigns to identify and treat people at risk of long-term conditions and to make lifestyle changes to reduce and minimise risk.
- Support children, young people and families to access early help when difficulties arise.

Support everyone to self-care by:

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

Tracking progress

We will track the long-term impact of the strategy by measuring reduction in risks and improvement in wellbeing outcomes (Page 12). Our local health and care plan will track actions in more detail.

Putting our principles into practice

A checklist for decision-makers builds on the strategy's eight Guiding Principles to ensure that we take wellbeing into account in all that we do. See Page 13.

Measuring Progress on the Joint Health and Wellbeing Strategy

The Strategy focuses on the wider factors that shape our wellbeing (employment, housing, income, our environment) and on prevention and earlier intervention. We will track whether risks to health and wellbeing are improving, whether health inequalities are reducing and outcomes are improving. Our local health and care plan will track action plan delivery and service improvement in more detail.

	What does success look like?	We will track measures of
Outcome 1: Our children have a great start in life	All children have opportunities to play and enjoy early learning with their peers Children have good health and wellbeing and are ready to learn when they start school Children and young people eat healthily and are active every day Children, young people have good mental wellbeing and cope with life's ups and downs Issues are addressed sooner and prevented from getting worse Child health and wellbeing improves and inequalities reduce	Maternal health, smoking in pregnancy, breastfeeding, infant mortality. Children with excess weight. Child oral health, child mental health. Uptake of early learning, children ready to learn when they start school. Child poverty, family homelessness.
Outcome 2: People in Bradford District have good mental wellbeing	People including children and young people have good mental wellbeing and can cope with life's ups and downs. People have positive relationships at home at school, in communities and workplaces Fewer people are depressed or anxious People with mental health needs have good quality of life and can access employment People with mental health needs are supported at home and in their communities	Long-term mental health conditions (depression, anxiety). Social isolation. Quality of life for service users and carers. Preventable illness, health-related quality of life and early mortality for people with diagnosed mental health needs.
Outcome 3: People in all parts of the District are living well and ageing well	People have good health for longer and fewer people die early from preventable illness Inequalities in life expectancy and healthy life expectancy reduce People with long-term conditions stay as well as possible People have good health and wellbeing throughout their lives People age well - staying happy, healthy and living at home for as long as possible People have choice about end of life care and experience excellent end of life support	Physical activity and healthy eating. Rates of smoking and harmful drinking. Management and self-care of long-term conditions, health-related quality of life. Preventable mortality and early (under 75) mortality for major conditions. Permanent care home admissions. Choice over end of life plan.
Outcome 4: Bradford District is a healthy place to live, learn and work	Air quality improves, particularly in hotspots Homes, schools and workplaces are safe and energy-efficient People live in places where it is safe to walk and cycle People have access to green space and children have safe places to play outdoors People have decent jobs and financial security The District has a healthy workforce, people are supported to return to work after illness People with additional needs can access education, training and employment	Air quality. Decent homes, fuel poverty and excess winter deaths. Road safety. Access to green space. Wage levels, household income and debt levels. Employment rates, including for young people, and people with diagnosed mental illness or learning disability. Sickness absence and return to work.
Long-term outcomes	**Life expectancy and healthy life expectancy increase for both males and females** People feel in control and included in decisions about their lives	**Inequality gaps close between local and national life expectancy rates, and between different rates in different parts of the District.**

Planning Checklist: Putting wellbeing at the centre of decision-making

The checklist is a short resource based on our Guiding Principles to use when planning activities, prioritising resources, developing policy, reviewing services, or commissioning new services. It will help us to consider health and wellbeing and health inequalities when we make important decisions. Each Guiding Principle is followed by questions and points for discussion.

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

Have we established the root causes of the issue we are seeking to address?

Are wider factors (eg housing insecurity, debt, low-income) driving wellbeing needs for the people we work with?

How could we work with partners to reduce the number of people facing these wider issues?

How does our offer actively seek to prevent ill-health?

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

What are the needs of the people our decisions will affect, what barriers prevent them improving their wellbeing?

How will we support and build on the assets of local people and our neighbourhood?

Have we engaged with people and taken their views into account to shape our actions?

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

How, when and where will we promote wellbeing and enable people to improve their personal wellbeing or the wellbeing of others?

How will we ensure our offer has a positive impact on people's physical and mental wellbeing, does it consider both physical and mental wellbeing at every step?

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

Where in the District will our offer have the most impact and who is most affected?

Have we identified and sought to address the wider barriers that would help overcome these factors?

Are we targeting our resource at the people and areas with the highest level of need?

Is our offer appropriate and accessible for those most in need?

Are those with greatest need accessing our offer the most? How have or how can we evidence this?

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

Do our actions support people to have more control, independence and increased resilience?

Does our offer take a holistic view of people in the context of their family, carers, community and their life?

Do we provide people with accurate, accessible information to help them care for themselves and navigate services?

Does our service work together and coordinate with other services that your customers may also be using?

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

How, when and where will we promote wellbeing and enable people to improve their personal wellbeing or the wellbeing of others?

How will we ensure our offer has a positive impact on people's physical and mental wellbeing, does it consider both physical and mental wellbeing at every step?

7. We work systematically to improve outcomes on a large-scale: we evaluate what difference our actions are making

Have we specified the intended outcomes of our activity and identified a way to measure them?

Have we identified strong, measurable steps and processes that will lead to delivery of our intended outcomes?

8. We want to get maximum value for the Bradford pound (£) and to ensure that the health and wellbeing sector is sustainable. There are three kinds of value:

Value through allocation of resource. Are we allocating resources to different groups equitably (allocating more or less according to need). Doing this helps to reduce need and manage demand for services, delivering better value for everyone.

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

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

The wording in this publication can be made available in other formats such as large print or Braille. Please telephone 01274 431352.

Connecting People and Place for Better Health and Wellbeing

How will we know that we have made a difference?

Draft

Background/purpose (1)

- Our Joint Health and Wellbeing Strategy sets out our ambition for a happy and healthy Bradford District, where people have greater control over their wellbeing, living in their own homes and communities for as long as they are able, with the right support when it is needed.
- We will know that we are making progress towards that ambition by people living longer, (measured by life expectancy), as well as people living more years in good health (measured by healthy life expectancy). Furthermore, a reduction in the gap between the most deprived and least deprived parts of the District will demonstrate a reduction in health inequalities.
- We know however that it takes time to see changes in life expectancy as a result of the action that we take today. In the first few years of this century when life expectancy was improving rapidly, men gained on average 1 additional year of life every 3.5 years, whist women gained on average 1 additional year of life every 5 years.

Background/purpose (2)

- Accordingly, we need to consider a range of other measures that can be monitored on a regular basis to provide assurance to the Health and Wellbeing Board that progress is being made against the Strategy. A logic model approach is one way of doing this.
- A logic model takes us from our strategies and plans, and the actions that we undertake as part of these plans, to the output measures that tell us how well we implemented these actions, and the outcomes that result from these actions.
- This paper sets out the overarching measures – linked to life expectancy – that should be monitored on an annual basis as part of the JHWS.
- It also proposes a logic model – one for each outcome of the JHWS –which describes the way in which we will deliver the JHSW, and how we will measure the impact of the strategy in the short, medium and long term.
- The logic models contain a number of medium and long term measures (see '*how will we know that we have made a difference* and *how will we know that we have improved peoples' health and wellbeing*?)

Background/purpose (3)

- All of these measures are routinely measured as part of existing outcomes frameworks, and are usually updated on an annual basis. These measures may change year to year, but the changes are likely to be small, with long term trend data needed to judge how much of a difference we are making. These measures are outcome focused.
- Understanding what impact we are having in the short term is more difficult. The logic model, however, proposes a number of indicators that can be measured more frequently and can provide the Health and Wellbeing Board with more regularly available information to support the monitoring of the JHWS. These measures may also be referred to as outputs and mostly involve counting the activities that we think will accumulate and result in improved outcomes, as specified in the logic model, for people in Bradford District.

Overarching outcomes

- **Life expectancy at birth (males & females).**
- **Gap in life expectancy between most and least deprived areas.**
- **Healthy life expectancy (males & females)**
- **Gap between healthy life expectancy and life expectancy.**

Life expectancy at birth– males The average number of years a person can expect to live based on contemporary mortality rates

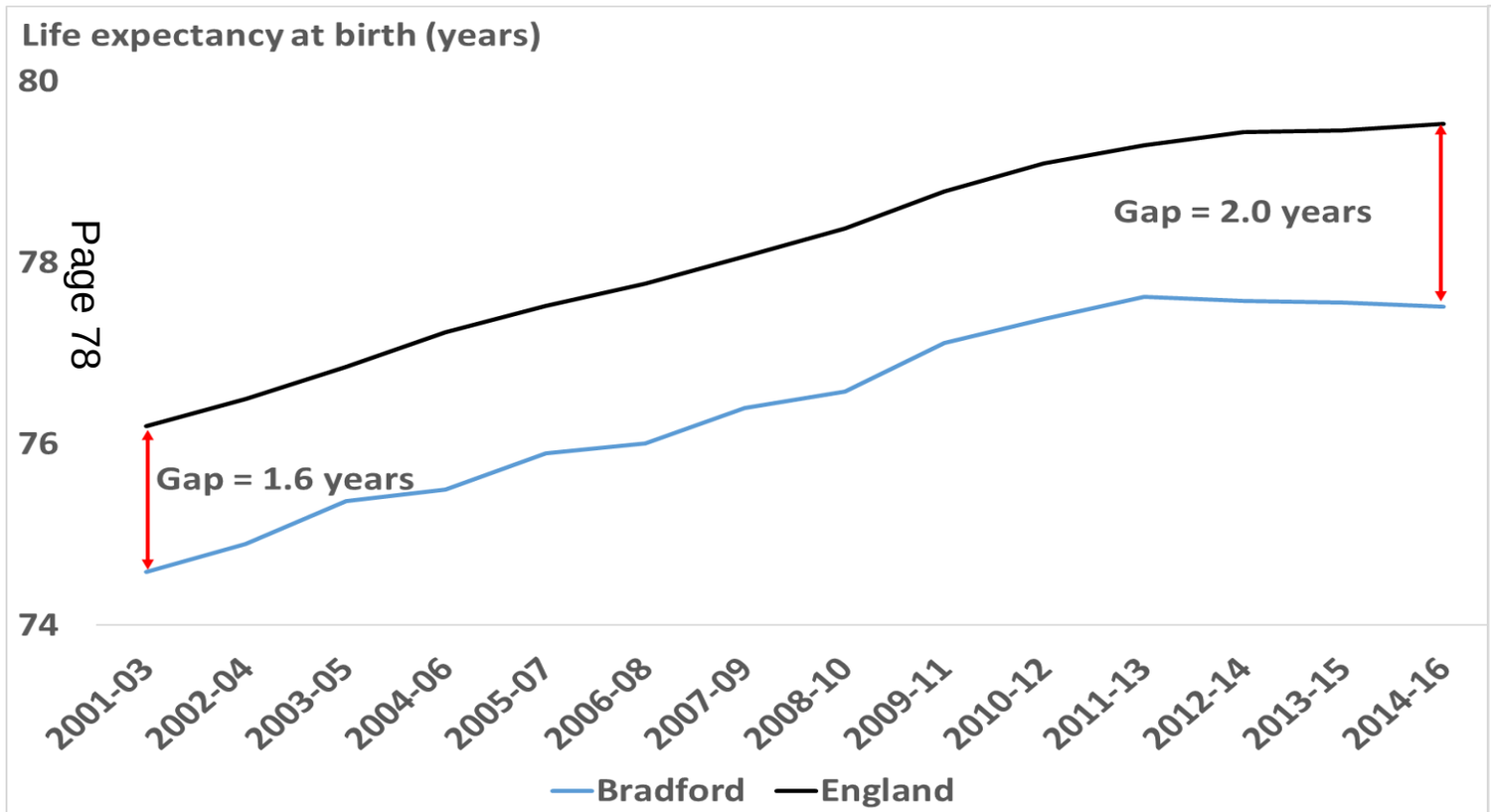
Latest value
77.5 years

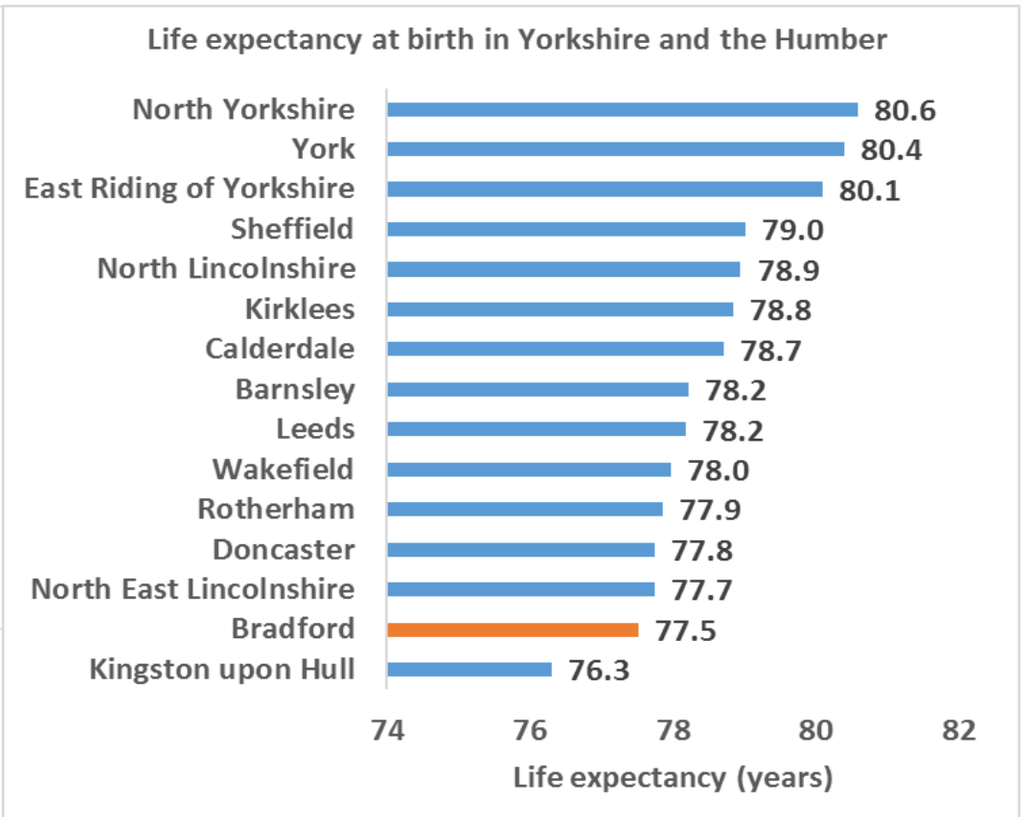
Most deprived quintile in Bradford
73.6 years

Gap in life expectancy
7.1 years

Least deprived quintile in Bradford
80.7 years

Year	National rank (ranked out of 150)
2001-03	113
2014-16	126





Life expectancy at birth for males in Bradford District has followed an upward trend; however since 2012-14 life expectancy has shown signs of levelling out and the gap between Bradford District and the average for England has widened. Bradford District has the second lowest life expectancy in the region and has seen its national rank fall. A male living in the most deprived quintile of deprivation can expect to live 7.1 years less than a male from the least deprived.

Life expectancy at birth– females The average number of years a person can expect to live based on contemporary mortality rates

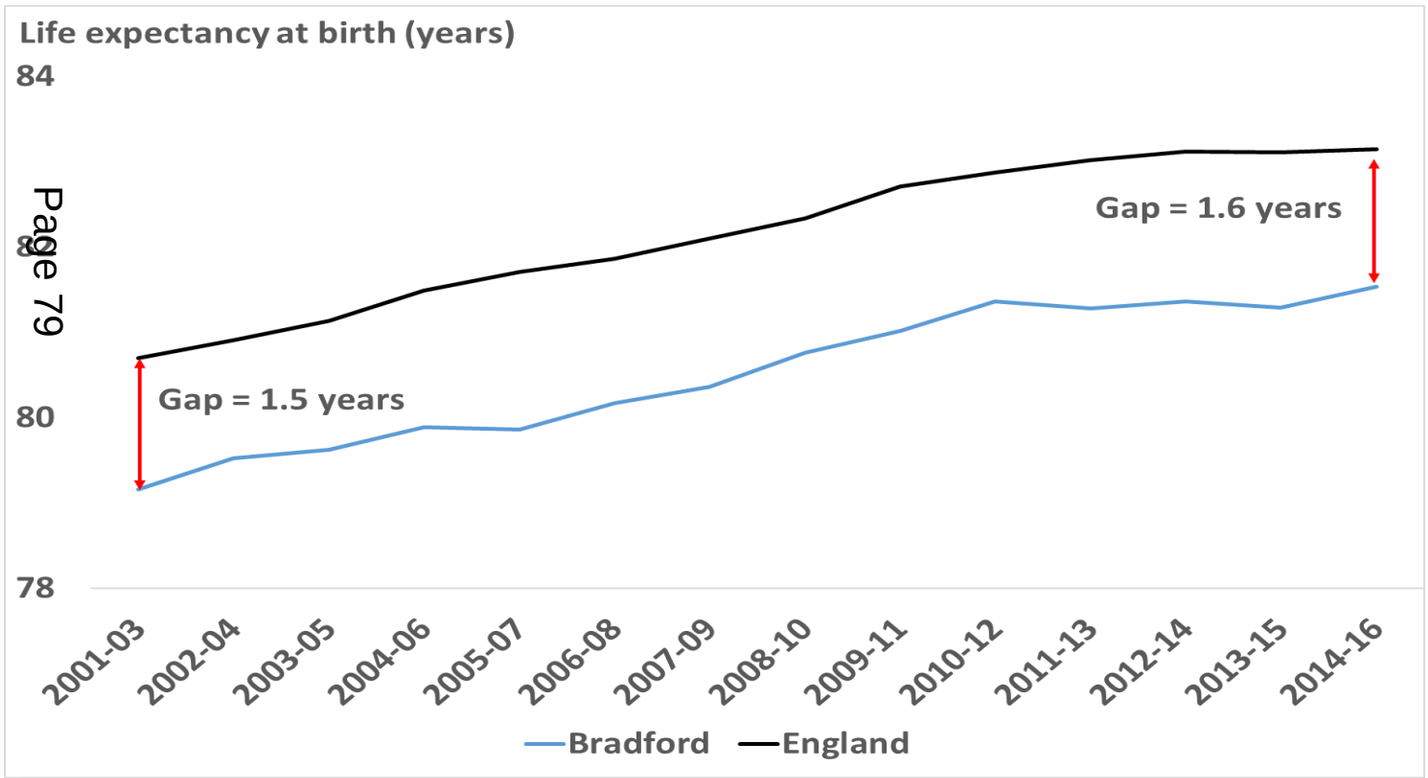
Latest value
81.5 years

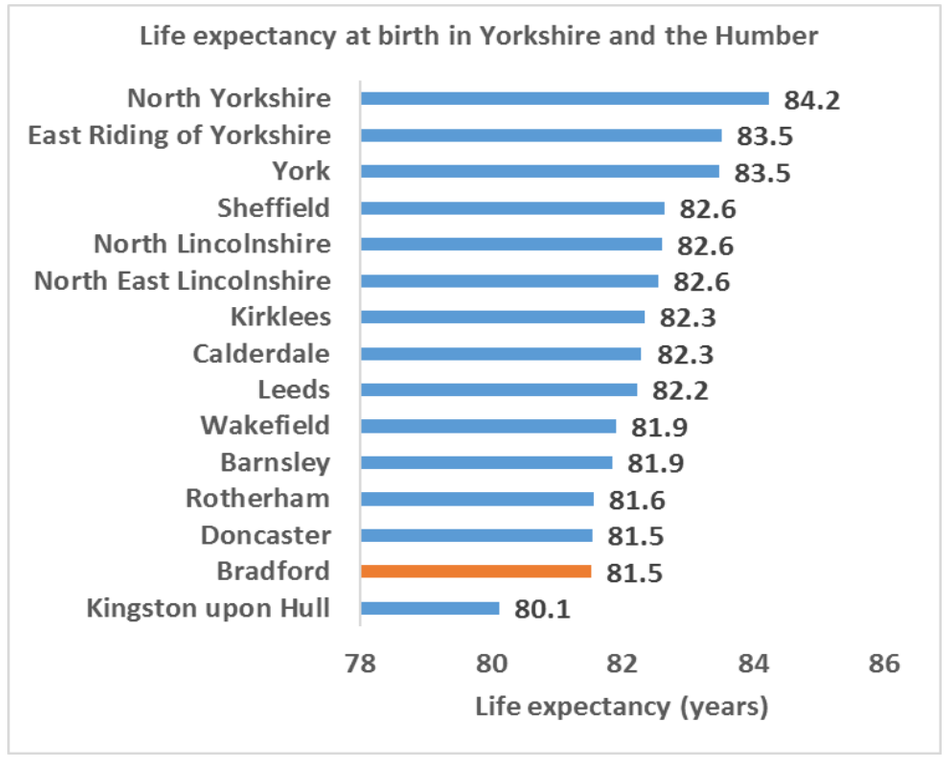
Most deprived quintile in Bradford
78.5 years

Gap in life expectancy
6.4 years

Least deprived quintile in Bradford
84.9 years

Year	National rank (ranked out of 150)
2001-03	128
2014-16	125





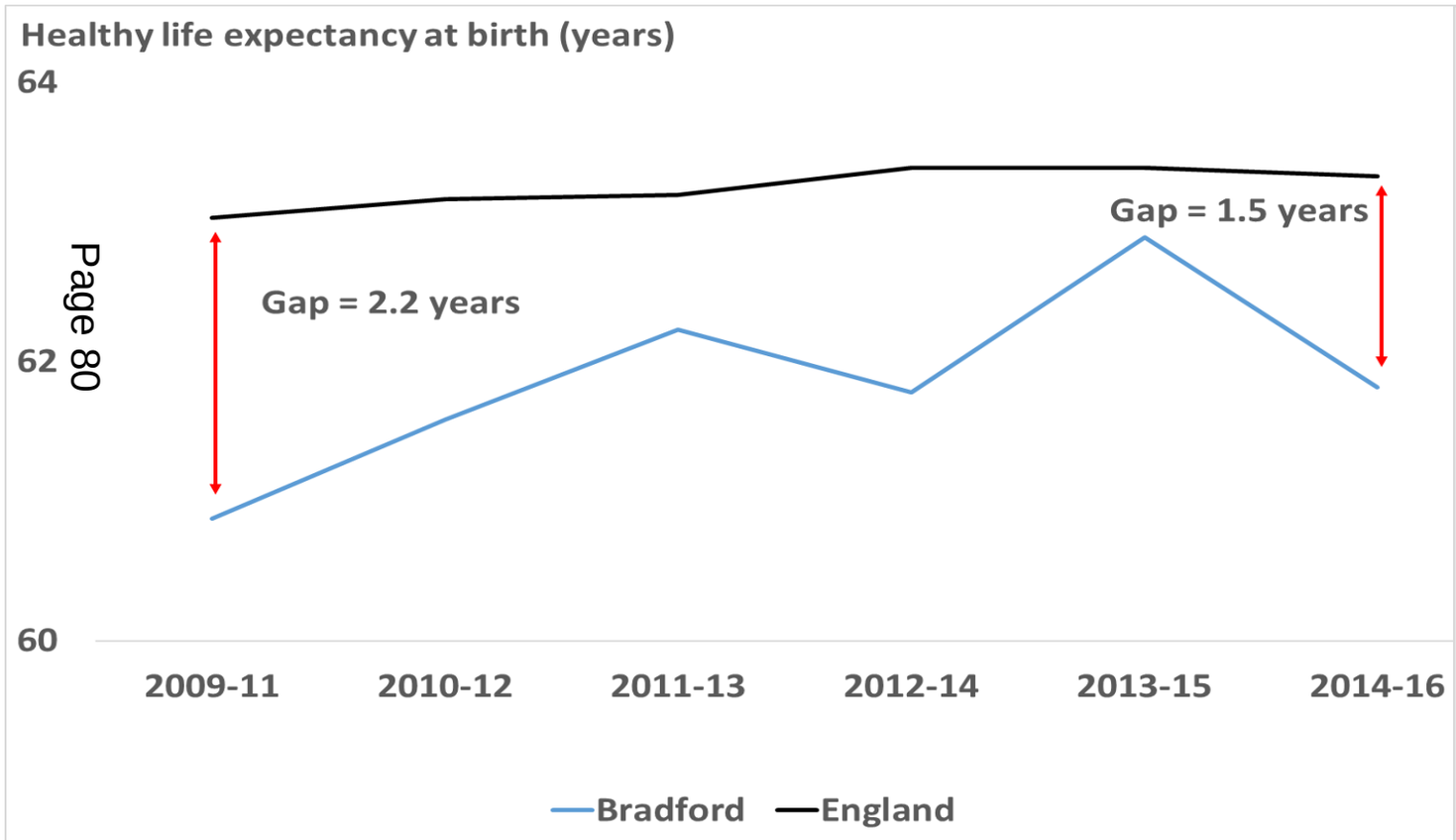
After a period of levelling off between 2012-12 and 2013-15, life expectancy at birth for females in Bradford District has risen in recent years. However the gap between Bradford District and the average for England has widened slightly. Bradford District has the second lowest life expectancy in the region but has seen its national rank rise slightly. A female living in the most deprived quintile of deprivation can expect to live 6.4 years less than a female from the least deprived.

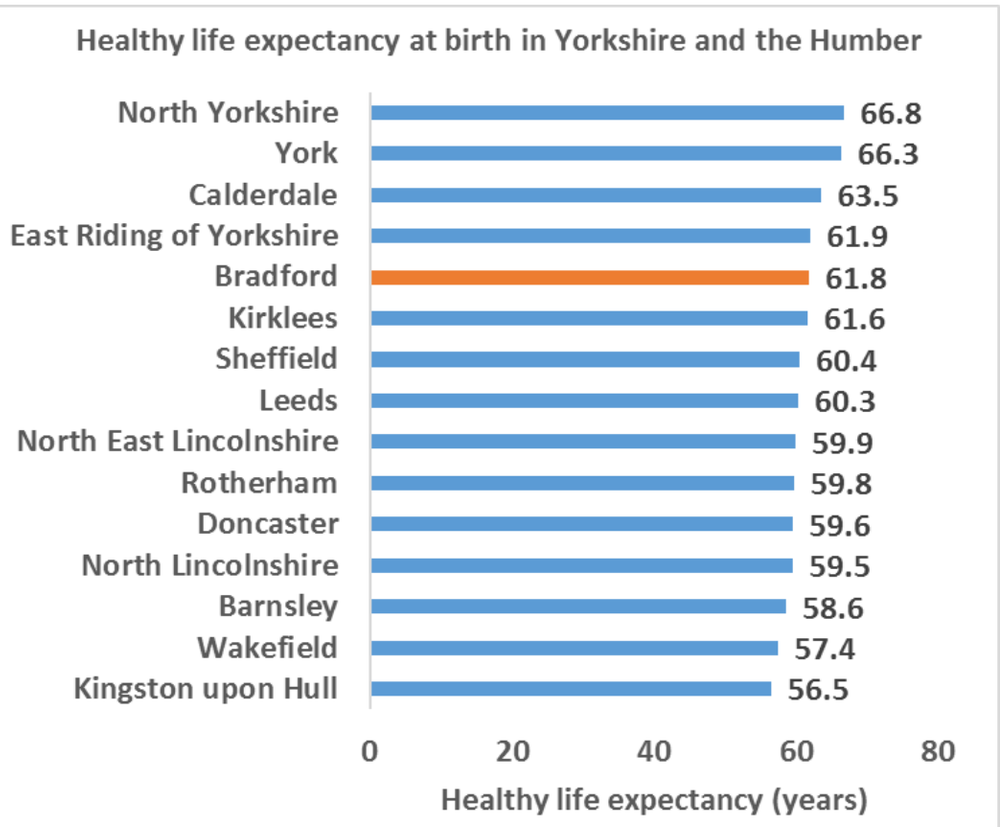
Healthy life expectancy at birth – males The average number of years a person can expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health.

Latest value
61.8 years

Healthy life expectancy at birth	Years of 'poor' health	Life expectancy at birth
61.8 years	15.7 years	77.5 years

Year	National rank (ranked out of 150)
2009-11	99
2014-16	88





Although healthy life expectancy at birth for males in Bradford District has risen sporadically and is below the average for England, the gap between Bradford District and the average for England has narrowed. Bradford District has the fifth highest healthy life expectancy in the region and has seen its national rank rise. A male living in Bradford District can on average expect to live 15.7 years in 'poor' health.

Healthy life expectancy at birth – females The average number of years a person can expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health.

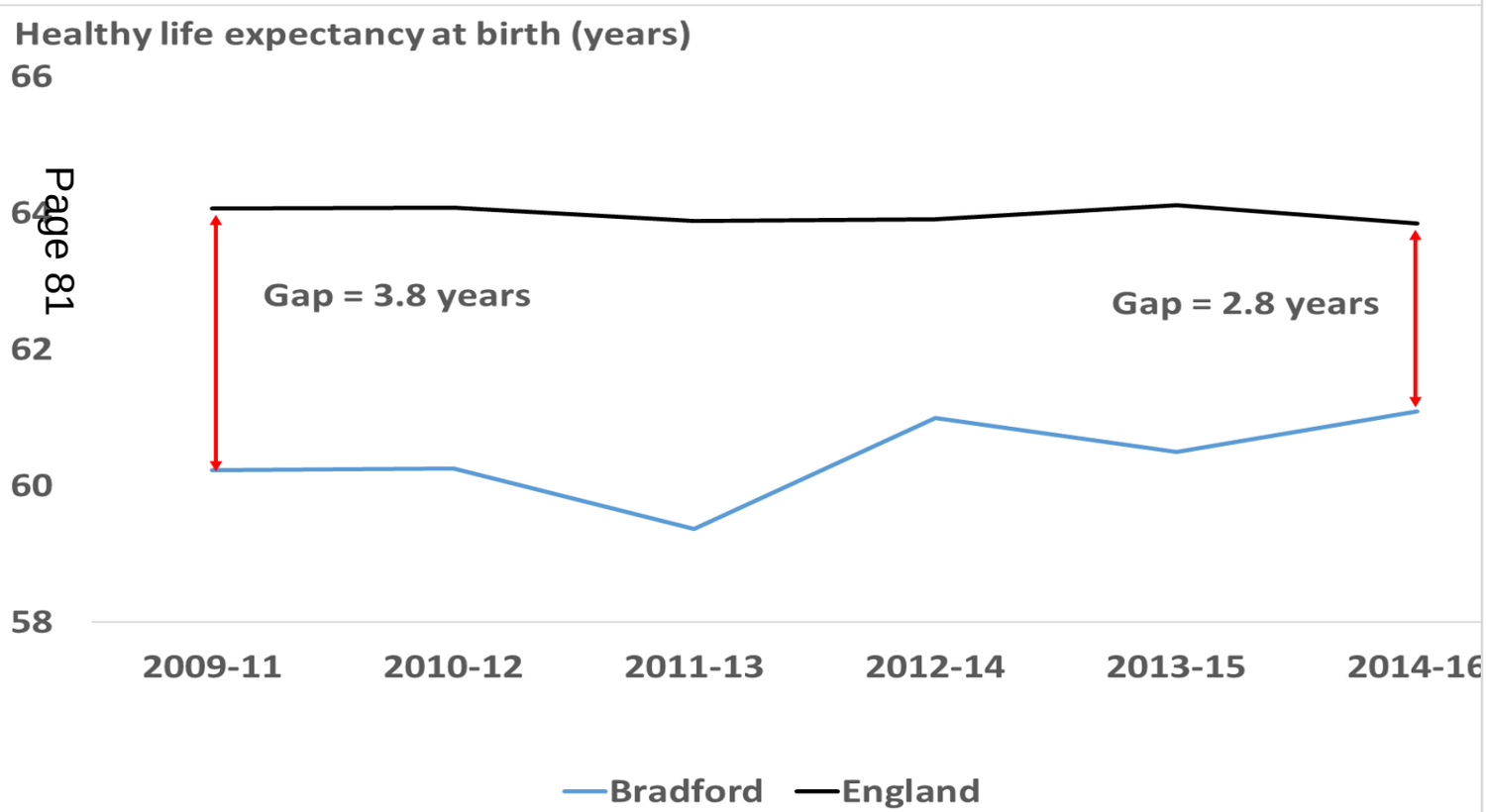
Latest value
61.1 years

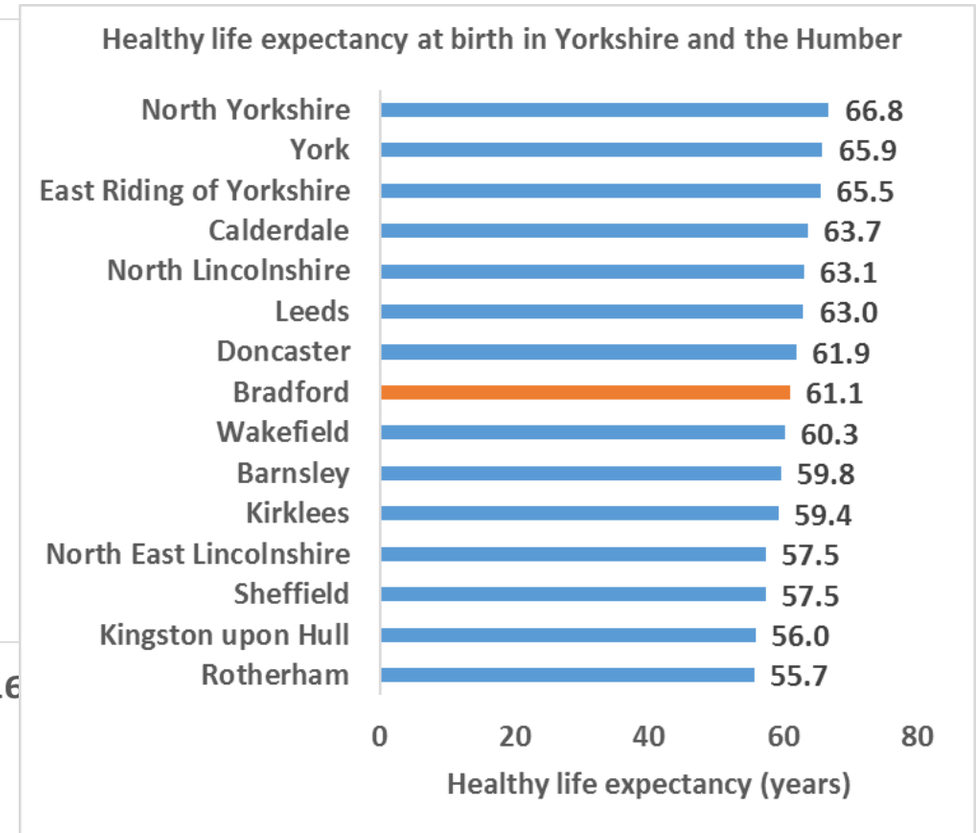
Healthy life expectancy at birth
61.1 years

Years of 'poor' health
20.4 years

Life expectancy at birth
81.5 years

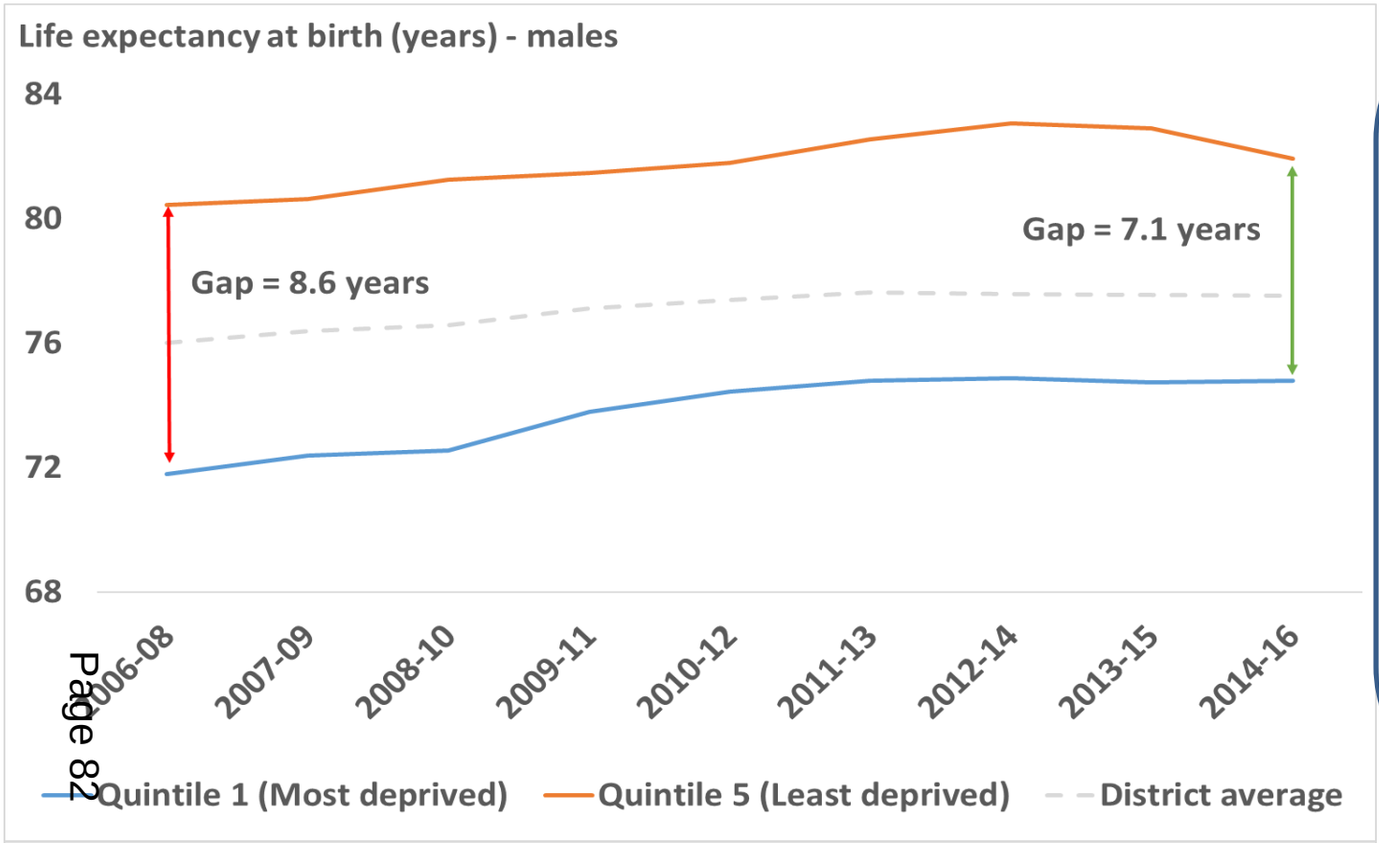
Year	National rank (ranked out of 150)
2009-11	110
2014-16	102

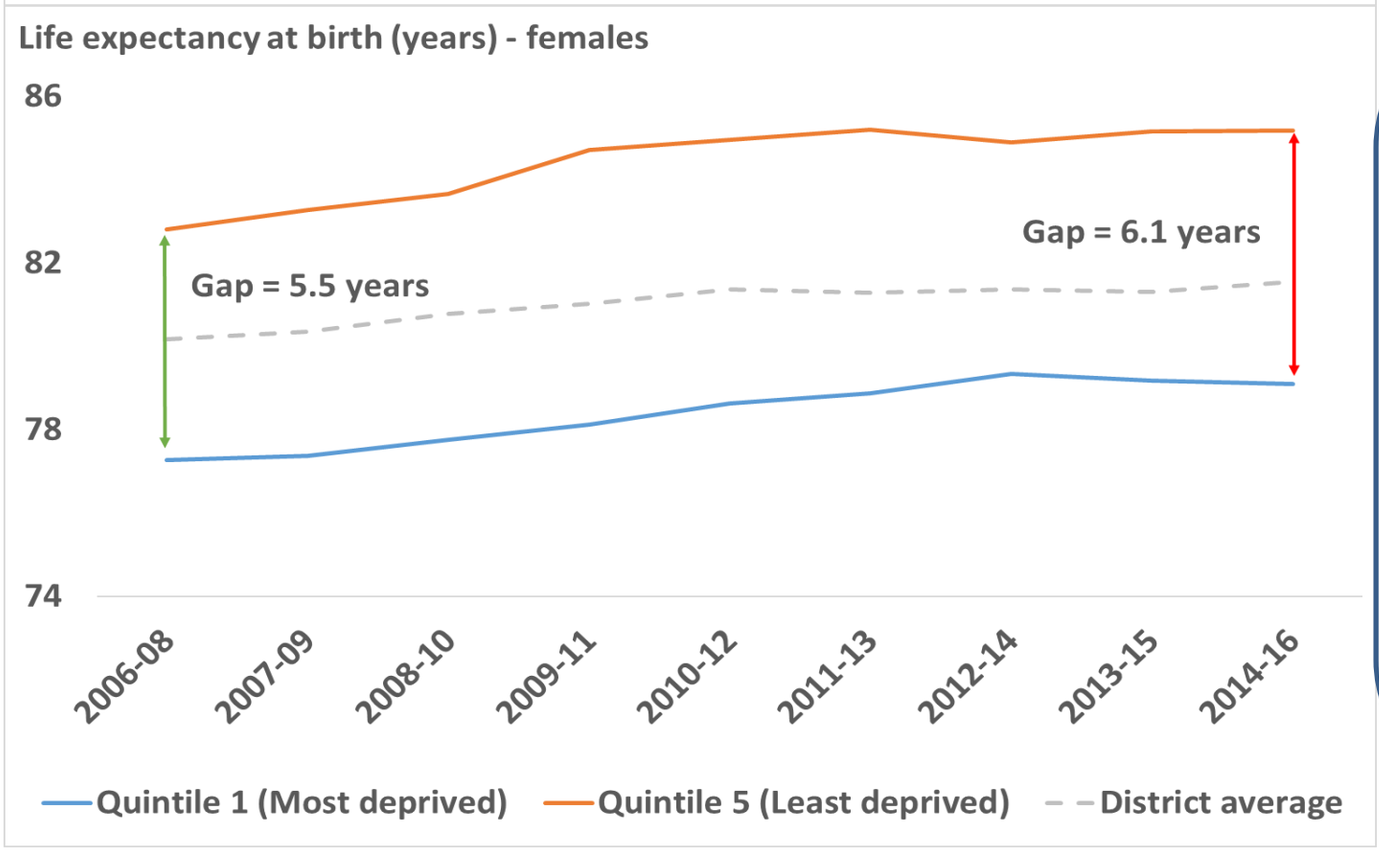




After a dip in 2011-13, healthy life expectancy has generally shown a rising trend for females in Bradford District, and the gap between Bradford and the average for England has narrowed, although remains below the average for England. Regionally Bradford District has the eighth highest healthy life expectancy in the region and has seen its national rank rise slightly. A female living in Bradford can on average expect to live 20.4 years in 'poor' health.

Health inequalities – Life expectancy at birth

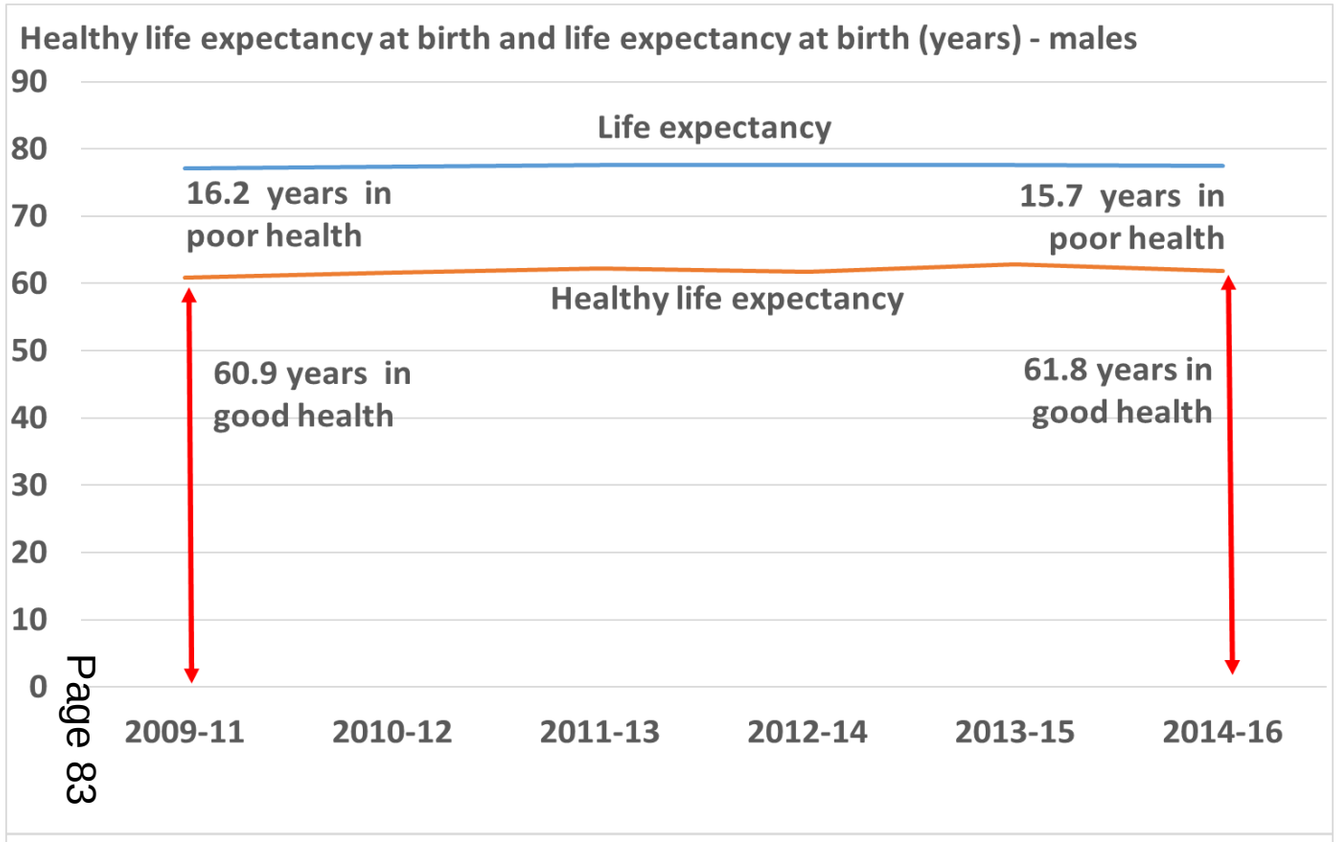




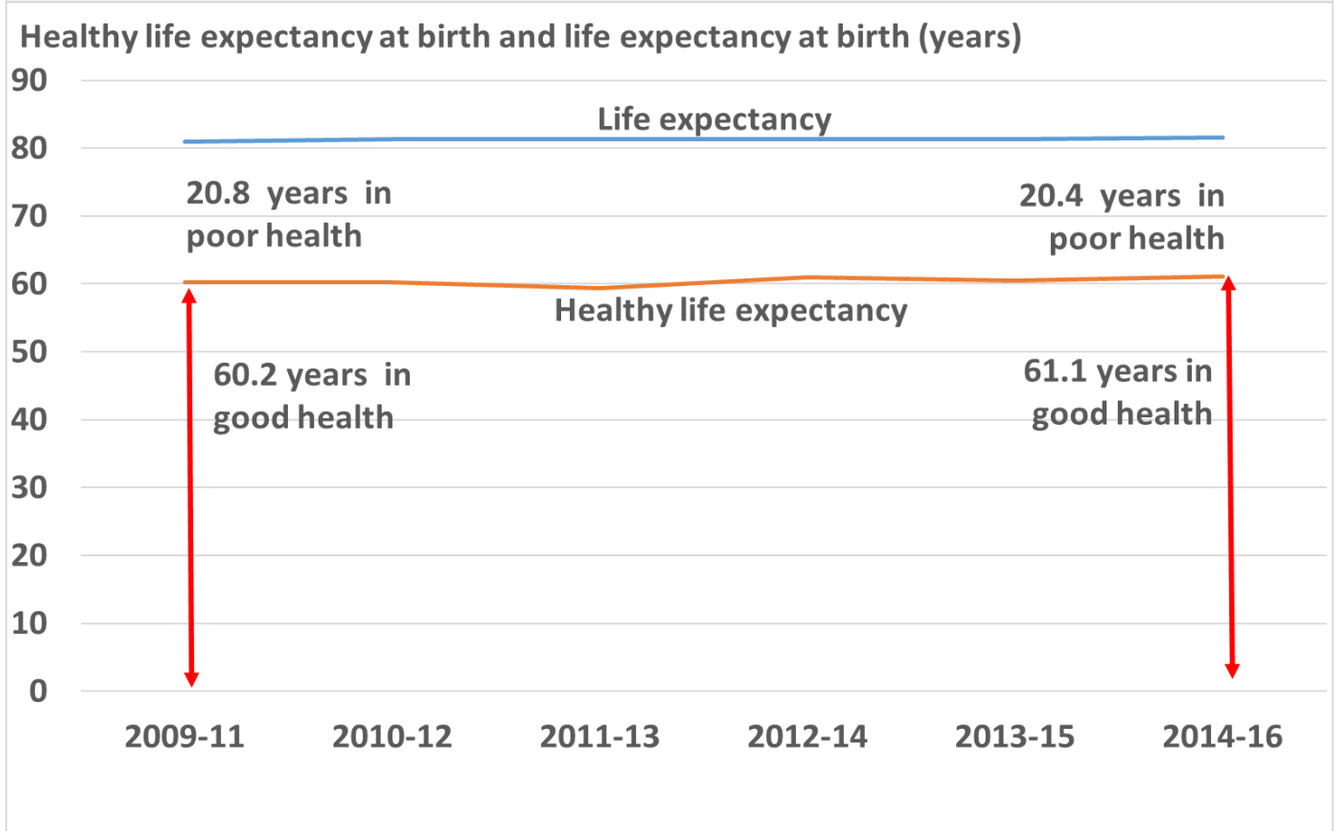
The gap between how much longer a male born in the least deprived areas of Bradford District and a male born in the most deprived areas has narrowed from 8.6 years to 7.1 years. However, this reduction was mainly seen between 2009 and 2011, with life expectancy stabilising in the most deprived areas from 2012 onwards. A fall in life expectancy in the least deprived areas from 2013-15 has also contributed to this narrowing of the gap.

Across Bradford District, females born across all areas of Bradford District can expect to live longer. However the gap between how much longer a female born in the least deprived areas of Bradford District and a female born in the most deprived areas has widened from 5.5 years to 6.4 years. This is mainly due to life expectancy improving more in the least deprived areas of the District than in the most deprived.

Health inequalities – Healthy life expectancy and life expectancy



Since 2009-11 the average years of life a male in Bradford District spends in good health has increased, whilst the average years of life a male spends in poor health has decreased. This change has been gradual, with larger changes seen in healthy life expectancy (+0.9 years) than life expectancy at birth (+0.4 years).



Since 2009-11 the average years of life a female in Bradford District spends in good health has increased, whilst the average years of life a female spends in poor health has decreased. This change has been gradual, with larger changes seen in healthy life expectancy (+0.9 years) than life expectancy at birth (+0.5 years).

Outcome 1: Our children have a great start in life

KEY OBJECTIVES	WHAT WE WILL DO	HOW WE WILL DO IT	HOW WE WILL KNOW WE HAVE DONE IT	HOW WE WILL KNOW THAT WE HAVE MADE A DIFFERENCE	HOW WE WILL KNOW THAT WE HAVE IMPROVED PEOPLE'S HEALTH & WELLBEING
CHILDREN ARE SCHOOL READY & ACHIEVE A GOOD LEVEL OF ATTAINMENT	Promoting integrated working across the early years workforce; helping parents to develop their knowledge & skills around parenting; rolling out learning from Better Start; Bradford Education Covenant; development of Education Hub; creation of new secondary school places; working with partners to raise aspirations.	• Children, Families & Young People's Plan • SEND Strategy • Integrated Early Years Strategy • PH 0-19 service (school nursing & health visiting commissioning) • Active Bradford • Healthy Bradford • Future in Mind • Better Start Bradford • Oral Health Improvement Action Plan • Every Baby Matters • Sport England LDP • Maternity, Children and Young People's Partnership Board • Economic Growth Strategy • Better Births (STP) • Saving Babies' Lives Bundle • Future in Mind • Innovation Plan Integrated Early Years Strategy • Journey to Excellence Transformation Plan • Ofsted School Improvement Action Plan • Anti-Poverty Strategy • Bradford Safeguarding Children Board	Number of unauthorised primary & secondary school absences; number of children missing from education in Bradford; number of looked after children who had a missing or absence incident; % of schools rated good or better	% of children achieving a good level of development at the end of reception Average Attainment 8 score for all pupils % achieving 5 A*-C GCSEs	NARRATIVE HERE **Still births: Rate of stillbirths (fetal deaths occurring after 24 weeks of gestation) per 1,000 births.** **Infant mortality: rate of deaths in infants aged under 1 years per 1,000 live birth** **% of all live births at term with low birth weight** **% of 5 year olds who are free from obvious dental decay** **Hospital admissions caused by unintentional and deliberate injuries** **Teenage pregnancy: rate of conceptions per 1,000 females aged 15-17**
CHILDREN & YOUNG PEOPLE ARE READY FOR LIFE & WORK	Work with businesses to prepare young people for working lives; develop the Bradford Pathways approach to support career progression; deliver a transition service which focuses on the most vulnerable; work with businesses and training providers to increase the number of apprenticeships; encourage participation of young people that enhance core skills.		Number of apprenticeships; % of schools with Bradford Pathways Programme; % of sixth form establishments rated good or outstanding% of young people participating up to age of 18.	% of 16-17 year olds NEET % first time entrants into youth justice	
SAFEGUARDING MOST VULNERABLE & PROVIDING EARLY SUPPORT	Implementation of Signs of Safety Model, working with social investors, establishment of a joint transitions team; reimagining how we structure and run residential units; supporting young people to access direct payments; development of a local approach to adverse childhood experiences.		Number of contacts to social care; number of children in care and child protection system; number of DV incidents where child present; number of young people accessing direct payments.		
REDUCING HEALTH & SOCIAL INEQUALITIES	See OUTCOME 3 – living well Maternity & CYP Partnership – actions to be inserted here when plan refreshed. Every Baby Matters – driving down infant morality and evidence based risk factors.		See Outcome 3 – living well measures; % of antenatal assessments occurring before 13 weeks;	% of all infants that are breastfed at 6-8 weeks; % of children in reception/Year 6 who are overweight/obese; % of women smoking at time of delivery; % uptake of childhood immunisations	

Outcome 2: People in Bradford District have good mental wellbeing

KEY OBJECTIVES	WHAT WE WILL DO	HOW WE WILL DO IT	HOW WE WILL KNOW WE HAVE DONE IT	HOW WE WILL KNOW THAT WE HAVE MADE A DIFFERENCE	HOW WE WILL KNOW THAT WE HAVE IMPROVED PEOPLE'S HEALTH & WELLBEING
EARLY ACTION AWARENESS & PREVENTION	Deliver improvement programme to raise awareness, increase capacity for self-management, deliver training, reduce stigma and discrimination, implement Suicide Prevention Strategy, develop community spaces, community spaces, provide support.	• Mental Wellbeing Strategy • Healthy Bradford • Active Bradford • Suicide Prevention Action Plan • Dementia Action Plan • Domestic & Sexual Violence Strategy • Self Care & Prevention Programme • Primary Medical Care Strategy • Core Strategy & Area Action Plans • Housing Strategy • Better Start Bradford • Early Help and Prevention	Number of MH champions in schools, organisations & businesses; number of hours of self referral support in community spaces; number of people accessing Mental Health Matters website, number of self referrals to My Wellbeing College.	% of the population with good mental wellbeing Suicide rate per 100,000 population % of service users/carers who have as much social contact as they would like	NARRATIVE HERE **Suicide rate per 100,000 population** **% of the population with good mental wellbeing** **Excess under 75 mortality rate in persons with serious mental illness** **Health related quality of life for people with mental illness**
BUILD RESILIENCE & PROMOTE WELLBEING	Develop healthy communities and places through community investment, regeneration and housing policy, promote mutual support, develop social and supported housing options, parent training & resilience, digital tools, work with employers & businesses.			% employment rate (see outcome 4) % of households in temporary accommodation	
EASY ACCESS TO INTEGRATED CARE	Deliver care that achieves parity of esteem between MH & physical health: awareness raising of the workforce, development of care pathways; physical health checks for people with SMI; targeted approach to people with medically unexplained symptoms; primary mental wellbeing service; integrated approach to MH in secondary care.		% of people with SMI who have had health check; number of people accessing IAPT (inc. LTC); number of people receiving a personal budget/ISF/direct payment; number of people accessing Safer Spaces and First Response	% of unnecessary attendance of people with MH concerns at A&E; Prescribing costs; IAPT recovery rate; % of people with a LTC who feel supported to manage their condition.	
SERVICES FOCUSED ON RECOVERY	Improve access to & quality of services & outcomes for CYP; develop specialist perinatal MH team; early intervention in psychosis; redesign CMHT offer, design care pathways for PD and eating disorders.		Number of people accessing Safer Spaces and First Response; number of people accessing perinatal MH service	% of people experiencing a first episode of psychosis to a NICE approved care package within two weeks of referral; number of tier 4 specialist eating disorder admissions; % of CYP with MH condition receiving treatment; % of people who use services who have control over their daily lives.	
TRANSFORMING SERVICES	Child & YP MHS transformation, acute care pathway collaboration, liaison & diversion.				

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

KEY OBJECTIVES	WHAT WE WILL DO	HOW WE WILL DO IT	HOW WE WILL KNOW WE HAVE DONE IT	HOW WE WILL KNOW THAT WE HAVE MADE A DIFFERENCE	HOW WE WILL KNOW THAT WE HAVE IMPROVED PEOPLE'S HEALTH & WELLBEING
PEOPLE ARE LIVING MORE ACTIVE LIVES	Raise awareness of how to achieve the benefits of physical activity and consuming a healthy balanced diet. Improve provision of sports and leisure facilities including green space and opportunities for play, promote school and community based programmes such as the daily mile, Beat the Street, and other mass participation events. Increase availability and access to free/ low cost opportunities to be physically active and access diet and nutrition advice including schools and workplaces. Offer personalised support and motivational interviewing for those who need extra help to change their lifestyles.	Healthy Bradford Active Bradford Sports and Leisure Strategy Self Care & Prevention Programme Legacy events e.g. TDY	Number of schools participating in the daily mile, number of people participating in Beat the Street, number of people accessing sports and leisure facilities, number of people accessing an integrated wellness service	% of adults who are physically active % of adults meeting the '5 a day' recommendation. % of all infants that are breastfed at 6-8 weeks. % of children in reception/Year 6 who are overweight/obese.	People will be supported throughout the lifecourse to make healthy lifestyle choices. As a result fewer people will develop long term conditions associated with lifestyle factors. If people do develop long term conditions they will be well managed, reducing the likelihood of complications. As a result fewer people will die as a result of CVD, respiratory disease, liver disease, or cancer, before the age of 75. **Under 75 mortality rate from CVD** **Under 75 mortality rate from cancer** **Under 75 mortality rate from liver disease** **Under 75 mortality rate from respiratory disease** **Health related quality of life for people with LTCs**
FEWER PEOPLE ARE SMOKING	Provision of smoking cessation services, BabyClear, CO screening during pregnancy, smokefree homes champions, very brief advice in clinical settings, specialist midwifery services, regional programmes to tackle illicit tobacco with WYCA.	Bradford Breathing Better Smoking Cessation Services BabyClear Breath 2025 CQUIN WY Cancer Alliance	Number of people screened in pregnancy (CO); number of people supported to stop smoking via smoking cessation services; number of adults screened for smoking status in hospital, number of eligible adults who are given very brief advice in hospital.	% of women smoking at time of delivery % of adults smoking	
PEOPLE ARE SUPPORTED & FEEL CONFIDENT MANAGING THEIR OWN HEALTH	Extended access to primary care, provide people with the information & support that they need to manage their health & wellbeing; train our workforce so that they can facilitate & promote independence, develop new models of care for people with LTCs that shift the focus to prevention and early intervention.	Self Care & Prevention Bradford Breathing Better Diabetes New Models of Care Bradford Healthy Hearts AWC New Models of Care Primary Medical Care Strategy	% of the health and care workforce trained in motivational interviewing; QOF indicators for managing LTCs; % of cancers diagnosed at an early stage;	% of people with a LTC who report feeling confident in managing their health. UNPLANNED HOSPITAL ADMISSIONS ?	

Outcome 4: Bradford District is a healthy place to live, learn and work (1)

KEY OBJECTIVES	WHAT WE WILL DO	HOW WE WILL DO IT	HOW WE WILL KNOW WE HAVE DONE IT	HOW WE WILL KNOW THAT WE HAVE MADE A DIFFERENCE	HOW WE WILL KNOW THAT WE HAVE IMPROVED PEOPLE'S HEALTH & WELLBEING
AIR QUALITY IMPROVES	Specific actions are still to be determined, but will be listed here when agreed.	• West Yorkshire Low Emissions Strategy • Feasibility Studies	This will be determined based on 'what we will do'	Reduction in the annual mean concentration of NO2 in air quality management areas and areas of concern.	The communities we are born, live, work and socialise in have a significant influence on our health and wellbeing. The wider determinants or social determinants of health determine the extent to which people have the physical, social and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances. By creating healthy places to live, learn & work fewer people will develop long term conditions and poor mental wellbeing. As a result people will live longer lives with more years of good health. **Under 75 mortality rate from CVD, cancer, liver disease & respiratory disease.** **Excess winter deaths index.** **Excess under 75 mortality rate in persons with serious mental illness** **Health related quality of life for people with LTCs**
PEOPLE HAVE ACCESS TO GREEN SPACE & PLACES TO PLAY	Improvement of existing green spaces and play areas, and the creation of new green spaces and play areas through new developments, the area action plans, and grant funding. Increase access and engagement through awareness raising & social prescriptions and making every contact count.	• Core Strategy • Area Action Plans • Planning for a Healthy & Happy Bradford Framework • Healthy Bradford • Active Bradford inc. LDP. • Better Start Bradford	The number of new play areas created; the number of play areas that have been improved; the number of new green spaces created; the number of green spaces that have been improved; the number of street closures for play approved; referrals to outdoors activities.	% of the District meeting the Accessible Green Spaces Standard % of people using outdoor spaces for exercise or health reasons.	
PEOPLE HAVE DECENT JOBS AND FINANCIAL SECURITY	Increase opportunities to support people into paid employment, maximise people's incomes via welfare advice. As set out in the Economic Growth Strategy we will grow our economy by increasing the number of productive businesses and supporting young and enterprising people to innovate, invest and build fulfilling lives in the district. Also see outcome 1 - children and young people are ready for life and work.	• Economic Growth Strategy • Welfare Advice Services • REED in Partnership • Commissioned Services • Anti-Poverty Strategy • Children, Families & Young People's Plan • Opportunity Area Programme	POPULATE BASED ON ECONOMIC GROWTH STRATEGY	% of children living in low income family; % of people aged 16-64 in employment; average weekly earnings; % of working age people qualified to NVQ level 3 or equivalent.	
THE DISTRICT HAS A HEALTHY WORKFORCE	Introduce a charter for employers outlining the steps that they can take to improve the health and wellbeing of their workforce	Healthy Bradford NHS health & wellbeing CQUIN	The number of employers who have signed up to the Healthy Bradford Charter; % achievement CQUIN	% of working days lost to sickness absence; % of employees who had at least 1 day off in previous week.	

Outcome 4: Bradford District is a healthy place to live, learn and work (2)

KEY OBJECTIVES	WHAT WE WILL DO	HOW WE WILL DO IT	HOW WE WILL KNOW WE HAVE DONE IT	HOW WE WILL KNOW THAT WE HAVE MADE A DIFFERENCE	HOW WE WILL KNOW THAT WE HAVE IMPROVED PEOPLE'S HEALTH & WELLBEING
HOMES, SCHOOLS & WORKPLACES ARE SAFE & ENERGY EFFICIENT	We will identify and support people most at risk of fuel poverty. We will raise awareness of the actions that people can take to keep their home warm, and refer the most vulnerable people to Green Doctors. Through our Housing Design Guide we will ensure that all new homes are safe & energy efficient.	• Housing Strategy • Warm Homes Healthy People • Housing Design Guide • Welfare Advice Services	Number of people receiving welfare advice; number of people receiving support from Green Doctors.	% of households in fuel poverty.	The communities we are born, live, work and socialise in have a significant influence on our health and wellbeing. The wider determinants or social determinants of health determine the extent to which people have the physical, social and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances. By creating healthy places to live, learn & work fewer people will develop long term conditions and poor mental wellbeing. As a result people will live longer lives with more years of good health. **Under 75 mortality rate from CVD, cancer, liver disease & respiratory disease.** **Excess winter deaths index.** **Excess under 75 mortality rate in persons with serious mental illness** **Health related quality of life for people with LTCs**
PEOPLE LIVE IN PLACES WHERE IT IS SAFE	To consult CSP and Place Team	• Core Strategy • Ward Plans • Community Safety Partnership • Healthy Bradford • Community Safety Partnership • DV/SV services	To be populated after wider consultation	The number of recorded incidents of anti-social behaviour; the number of recorded violent crimes; the number of recorded domestic abuse incidents; the number KSI on our roads.	
PEOPLE WITH ADDITIONAL NEEDS CAN ACCESS TRAINING, EDUCATION & EMPLOYMENT	Commission specialist support services to help people access training and employment including in work support, job clubs, employment courses and specialist support. Develop pathways to maximise uptake of existing support services. Work with businesses and employers to raise awareness.	• Mental Wellbeing Strategy • Commissioned Services (MH, Substance misuse, LD) • Social prescribing (Community Connectors) • REED in Partnership	Number of people accessing Steps into Employment; Number of people accessing REED in Partnership; number of people accessing employment support via LD and drugs and alcohol recovery services; number of people receiving support via Community Connectors.	% of adults with LD in paid employment; the percentage point difference between the rate of employment in the general population of working age (16-64) and the rate of employment amongst adults of working age with a mental illness; The percentage point difference between the rate of employment in the general population of working age (16-64) and the rate of employment amongst adults of working age with a long-term condition.	

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Chair to the meeting of Bradford and Airedale Health and Wellbeing board to be held on Tuesday 4th September 2018

E

Subject: Chair's highlight report

Chair's highlight report:
Sub group updates – ICB, ECB
Domestic Abuse and Sexual Violence Specialist services re commissioning

Summary statement:

The Health and Wellbeing Board Chair's highlight report summarises business conducted between Board meetings. September's report brings the updates from the Board's sub-groups and the Domestic Abuse and Sexual Violence Specialist services re commissioning report.

Bev Maybury
Strategic Director of Health and Wellbeing

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E-mail: pam.bhupal@bradford.gov.uk

Portfolio:

Healthy People and Places

Overview & Scrutiny Area:

Health and Care

1. SUMMARY

The Health and Wellbeing Board Chair's highlight report summarises business conducted between Board meetings. September's report brings the updates from the Board's sub-groups and Domestic Abuse and Sexual Violence Specialist services re commissioning report

2. BACKGROUND

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

3. OTHER CONSIDERATIONS

3.1 Working group Updates

3.1.1 Executive Commissioning Board (ECB)

The next meeting of the Executive Commissioning Board will take place on 28th September. However, since the last report the following work has taken place:

- Board members presented at a BCF best practice sharing event in Manchester arranged by the BCF National Team. The presentation focused on the Bradford approach to integration and joint commissioning and was well received.
- A finance subgroup has now been established to review BCF spend across the system, prior to the production of the BCF plan for 2019/20.
- ECB has now been established for 12 months and following best practice, the Chair and Vice Chair carried out an annual review of effectiveness. I order to improve the Boards effectiveness, the following changes were agreed:
    - all items would be required to be submitted in advance in the form of a paper, with the decision required by the Board clearly articulated.
    - all items will be taken by the Board on the basis that it meets a minimum of one of 3 criteria: a piece of joint commissioning work, a piece of work which would benefit from a joint commissioning approach (for example due to a policy change) or a piece of commissioning work that may have a wider impact of the health and social care system.
    - the risk log would be transformed into a system risk log
    - system impact would be added as a focus of the Board
    - an annual forward plan will be developed over the Autumn to schedule work in line with the CCG and Councils Procurement Plans
    - meetings would take place bi-monthly
    - The Boards effectiveness would be reviewed again in July 2019

3.1.2 Integration and Change Board (ICB)

- At the time of writing there has not been another formal ICB meeting since the meeting on 15th June which was reported to HWB in the Chairs highlight report in July. However in the intervening period progress has been made on the following ICB activities;
- Enabler groups (digital, estates, workforce, self care, system development) met to improve their collaboration communication and ability to provide a clear and coordinated enabling offer to the system.
- A 'system development' network (Organisational Development) has formed and commenced work on a system OD strategy, which will lead to improvements that better align our system with our strategy.

- Work has commenced on a multi agency communication network which will enhance our shared communications, primarily with people working in health and care in the first instance.
- ICB has progressed a review of its terms of reference and ways of working. This is expected to be concluded at the August meeting.

3.2 RE-COMMISSIONING PROGRAMME –SPECIALIST DOMESTIC ABUSE AND SEXUAL VIOLENCE SERVICES

3.2.1 Bradford Council and the combined Clinical Commissioning Groups provide funding for a range of specialist services to support people who are or who have experienced domestic and/or sexual violence.

3.2.2 These contracts are due to expire on the 31st March 2019 and it is important that a re commissioning programme, leading to a formal procurement process, is run to identify and purchase these services for the future.

3.2.3 The process is managed via a multi-disciplinary project team drawn from the following;

- The Council –Health and Wellbeing & Children and Young People's services; Place-Neighbourhoods and Housing services
- The Clinical Commissioning Group/s –Joint Mental Health Commissioner and operational staff
- West Yorkshire Police

3.2.4 To manage activities and time scales there is a formal Project Plan, including a risk register which is monitored fortnightly by the Project team

3.2.5 Officers have reviewed and evaluated existing services and investigated other models of service delivery; working with providers, service users and stakeholders to understand needs better. This has included an open event focussed on access pathways into services and 'gap mapping' in April 2018 and tender ready training for the 'market' in August 2018.

3.2.6 A Public Health consultant based in the Council has conducted a rapid evidence review into the efficacy of service responses to Domestic Abuse. Whilst a broader needs analysis relating to Intimate Partner Violence has also been produced by Public Health including the evidence underpinning current service options and good practice. Key themes and findings from this work include:

- More effective and consistent pathways into and out of service/s;
- Partnerships should adopt clear protocols and methods for information sharing
- A range of accommodation based options are needed; refuges; support in own home and dispersed units etc
- Therapeutic and trauma counselling services for families and children should be offered in a range of settings
- Perpetrators programmes can be effective; important ensure with conjunction with the support for partner
- Primary prevention programmes could be delivered for young people, this can be linked to the Government's ambition to support all young people to stay safe and prepare for life in modern Britain through Relationships and Sex Education (RSE)

- Sexual Violence services should strengthen links into the regional structures which are funded by West Yorkshire Police, the Ministry of Justice and the Police and Crime Commissionaires office for sexual assault.

3.2.7 The Project Team are also utilising the outcomes from the Strategic Needs Analysis for Domestic Violence completed in 2017/18, produced jointly by the Council and the Police, and the recommendations originating in the Joint Targeted Area Inspection (JTAI)-2017/18 into services for families and young people to inform strategic direction and service specifications.

3.2.8 The Domestic Violence Sexual Abuse re commissioning programme was presented to the Corporate Overview and Scrutiny committee on 18th July 2018 (attached), whereby the agreed recommendation was as follows:

"That the Committee recognises the breadth, importance and complexity of the work undertaken by providers in relation to the above services and supports the continuation of these via the new commissioning programme"

3.2.9 Therefore the item is coming to the Bradford and Airedale Health and Wellbeing Board for information purposes only. Recognising the joint nature of the funding base this report is made to ensure that the Bradford and Airedale Health and Wellbeing Board understand that this programme is part of their system oversight role.

4. FINANCIAL & RESOURCE APPRAISAL

None

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

None

6. LEGAL APPRAISAL

None

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

None

7.2 SUSTAINABILITY IMPLICATIONS

None

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

None

7.4 COMMUNITY SAFETY IMPLICATIONS

None

7.5 HUMAN RIGHTS ACT

None

7.6 TRADE UNION

None

7.7 WARD IMPLICATIONS

None

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

None

7.9 IMPLICATIONS FOR CORPORATE PARENTING

None

7.10 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

None

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

9.1 As this report is for information only there are no options which can be listed

10. RECOMMENDATIONS

10.1 That the progress of the sub groups be noted.

10.2 That the Board recognises the breadth, importance and complexity of the work undertaken by providers in relation to the Domestic Violence Sexual Abuse services re-commissioning and note the continuation of these via the new commissioning programme.

11. APPENDICES

Appendix one – Corporate Overview and Scrutiny Committee Report

12. BACKGROUND DOCUMENTS

None

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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Strategic Director Health and Wellbeing to the meeting of Corporate Overview and Scrutiny Committee to be held on 18th July 2018

C

Subject:

Commissioning of specialist services for domestic and/or sexual violence and those with multiple needs at risk of /or working in prostitution

Summary statement:

This is a report provided for information to advise members of the forthcoming procurement of a contract with a value of in excess of £2million

Bradford Council and the combined Clinical Commissioning Groups provide funding for a range of specialist services to support people who are or who have experienced domestic and/or sexual violence or who may have multiple needs and be working in /or at risk of working in the sex industry.

These contracts are due to expire on the 31st March 2019 and it is important that a re commissioning programme, leading to a formal procurement process, is run to identify and purchase these services for the future. Officers have already started to review and evaluate existing services and other models of service delivery; working with providers, service users and stakeholders to understand need better

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Portfolio:

Health and Wellbeing

Overview & Scrutiny Area:

Health and Wellbeing

1. SUMMARY

1.1 In line with Council Standing order 4.6.1 all contracts with an estimated value of over £2 million must be reported to the relevant Overview and Scrutiny Committee before inviting tender. This report details the above requirement in relation to specialist services offered in respect of Domestic and/or Sexual Violence and those who are working in or at risk of prostitution.

1.2 This report includes details of the work undertaken by the multi-agency project team to better understand the needs in these service areas; including work with a large range of providers; stakeholders and service users.

1.3 The activity undertaken accords with the plans as laid out in the departmental procurement plans in Health and Wellbeing as well as Children and Young People's services and the joint procurement plans which operate between the districts three Clinical Commissioning Groups (CCG's) and Bradford Council.

1.4 The new commission/s will also reflect the recommendations made as a result of the Joint Targeted Area Inspection (JTAI)-2017/18 into services for families and young people; findings from the West Yorkshire Police's Strategic Needs Analysis –SNA 2017; the Bradford Domestic and Sexual Violence Strategy 2015-20 and the outcome of the supplementary needs work undertaken by the Council's Public Health Department.

2. BACKGROUND

2.1 The services listed in Appendix 1 are either contracts or grants commissioned by the Council and/or the CCG's. Many but not all of these contracts/grants will end on the 31st March 2019. Funding comes from the CCG's and Bradford Council's Health and Wellbeing Department and Children and Young People's services.

2.2 There is also considerable investment in similar and related services from charitable sources, West Yorkshire Police and national sources, such as the Ministry of Justice. As part of the overall preparatory processes these additional services and funding sources have been mapped as much as possible. This commission however relates only to those funds as listed at item 4 Financial & Resources Appraisal and the services set out in Appendix 1.

2.3 There is one Council grant funded service included within scope which has never been formally commissioned and three grant funded services from the CCG's. Including these services in the programme will standardise the contract terms under both the Council and the CCG's standing orders/financial regulations and offer a more sustainable and accountable financial base for delivery in the future. The Council grant funded service is the main source of support; counselling and advocacy for women who have been sexually assaulted. The CCG's services are therapeutic based and support families; women and children who have suffered domestic and/or sexual abuse and/or bereavement.

2.4 In recognition of the complexity and joint nature of the funding regime a multi-agency project team has been formed and is guiding commissioning processes and other associated activity. The same team will lead the subsequent procurement processes.

3. OTHER CONSIDERATIONS

3.1 Identifying Needs & Service User' voices

3.1.1As part of commissioning activity the project team has gathered information from a number of sources and key work areas in order to identify and better understand the needs of the district, these are detailed below.

3.1.2 An open event was held on the 12th April 2018 and invitees included all current providers, providers funded through alternative sources, key public and private agencies and partners and stakeholders locally, regionally and nationally. Circa 90 people attended on the day, the focus of which was discussion and active mapping of pathways into and out of services.

3.1.3The questions asked in the workshops run on the 12th April 2018 are listed below along with some of the key themes and findings identified;

Someone who you suspect is experiencing violence in the home what might you do?

Key themes:

- Victim led services are important as is sensitivity' trust building
- Clear pathways are needed into and across services
- Emotional and practical support
- Preventative work is important -early intervention-education and publicity campaigns

What help and support is available for someone who actively wants to end the violence/intimate violence and abuse in the home?

Key themes

- Improved access routes into services for a range of vulnerable groups
- More housing options as a places of safety
- Support for children in recovery
- Working with perpetrators

What help and support is available for someone whose experience of violence/intimate violence and abuse is in the past but they still need support

Key themes

- Service options offered for a longer term and for victims of 'historic abuse'
- Trauma counselling for adults and children –therapeutic services

3.1.4 A Public Health consultant has conducted a Rapid Evidence Review and a broader needs analysis is being undertaken (by Public Health) into the efficacy and evidence underpinning current service options and good practice. Key themes and findings from this work include:

- Commissioners of health and social care services should ensure there are integrated care pathways for identifying, referring (either externally or internally) and providing interventions to support people who experience domestic violence and abuse, and to manage those who perpetrate it.
- Partnerships should adopt clear protocols and methods for information sharing
- Health and social care service managers and professionals should ensure frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such

- People who experience domestic violence and abuse have a mental health condition (either pre-existing or as a consequence of the violence and abuse), should be provided with evidence-based treatment for the condition.
- Primary prevention programmes could be delivered to young people, this should be linked to the Government's ambition to support all young people to stay safe and prepare for life in modern Britain through Relationships and Sex Education (RSE)
- Delivery of group and/or therapy/support must be considered for young people who have witnessed domestic violence
- There is strong evidence and support for delivery of perpetrator programmes.
- Sexual Violence services should strengthen links into the regional structures which are funded by West Yorkshire Police, the Ministry of Justice and the Police and Crime Commissionaires office for sexual assault.

3.1.5 Work has been undertaken to examine the efficacy and outcomes of all currently funded services through the analysis of returned performance management data to identify service demand and usage.

3.1.6 A strategic need analysis was produced in partnership between the Police and Public Health colleagues from the Council into the needs of women who are working in or at risk of prostitution.

3.1.7 In addition to the above, the Project Team are utilising the outcomes from the Strategic Needs Analysis for Domestic Violence completed in 2017/18, produced jointly by the Council and the Police, and the recommendations originating in the Joint Targeted Area Inspection (JTAI)-2017/18 into services for families and young people to inform strategic direction and service specifications.

3.1.8 There is also a separate workstream managed by a sub group of the Project Team predicated on understanding and hearing the voices of Service users. CCGs have identified a service user lead to support this part of the overall commissioning programme. The initial focus for this has been to examine the outcomes of current contract performance management returns through which each funded service is required to gather and interpret service user's satisfaction data and submit case studies.

3.1.10 A survey has been prepared to be sent to the Council's citizen's panel requesting their views on DVSV services and how they should be delivered. This is the first time the panel has been utilised in this way and it may help identify more around current gaps in service as well as eliciting personal views and /or experiences.

3.2 Outcomes

3.2.1The Project team will set key outcomes as an integral part of new contracting arrangements and based on the combined evidence and findings of work areas as identified in item 3.

3.2.2. High level outcomes will remain in line with the Strategic Objectives identified in the Bradford Domestic and Sexual Violence Strategy 2015 – 2020:

- Prevention - Developing models and programmes to stop violence from occurring in the first place is the most strategic (and cost-effective) medium to longer term positive outcomes. Early intervention prevents escalation, repeat victimisation and ultimately reduces high risk incidents of domestic and sexual violence

- Provision of Services - Access to a consistent range of co-ordinated support services is available that maximise safety, reduce repeat victimisation and acknowledge individual needs and experiences.
- Protection and Prosecution - Perpetrators are held accountable by a range of interventions that reduce risk, provide clear messages that their behaviour is not acceptable and are provided with specialist support to change their behaviour
- That services developed are focussed towards a whole family approach.

3.2.3. Complementing existing and new work with those mainstream services such as, primary care, children and young people social care, adult services, West Yorkshire Police is key in ensuring a full range of support is available and outcomes are met.

3.2.4 Consideration is being given to the use of 'transformational contracts' which can incorporate change processes and enable services to evolve over the life of the contract period. To create stability in the sector and to support change the project team would recommend contract lengths of 4 years plus one being offered, subject to Budget Council.

3.2.5 There are currently 48 resettlement units being used as 'move on' from the temporary accommodation that the refuges provide. The work undertaken already indicates that there may be a need to expand on this; creating some fixed 'dispersed units' which could facilitate housing more easily for women with older male children, women exiting prostitution and/or with multiple disadvantages, men fleeing violence, people from the gay, lesbian, bisexual, transgender and queer communities etc., opening up a choice which isn't freely available now. The time it may take to source additional accommodation is an example of where a transformational contract could be used.

3.2.6 It is particular important that family based therapeutic services are included in new commissions. This will reduce duplication and support the work streams and referral pathways which are already working between Children's Social Care and the more specialist services. It will also meet the needs of the recommendations in the JTAI.

3.3. Timetable and other commissioning considerations

3.3.1 The timetable means that it will be necessary to advertise tender opportunity/s in August 2018. This will allow the contract to be awarded in October 2018 giving a longer mobilisation period to accommodate staffing and/or property implications.

3.3.2 TUPE is likely to apply because a result of the commissioning process is that there may be a service provision transfer. TUPE Regulations apply in service provision transfers in situations where a new contractor takes over activities from another contractor (known as re-tendering).

3.3.3. Buildings such as refuges are leased from two registered social landlords Manningham Housing Association and Accent Group who built and own the properties. One refuge is also formally leased to one of the current contracted providers.

4. FINANCIAL & RESOURCE APPRAISAL

4.1 The total annual budget for specialist services for domestic and/or sexual violence is

£2.142m of which £1.6m is LA funded and the balance of £0.5m is funded by the CCG's. The estimated value for a four year contract is £8.5m, rising to £10.7m if the option to contract over a five year period is taken.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

5.1 The project is managed by a team including commissioners and appropriate operational staff drawn from the following;

- The Council –Health and Wellbeing & Children and Young People's services; Place-Neighbourhoods and Housing services
- The Clinical Commissioning Group/s –Joint Mental Health Commissioner and operational staff
- West Yorkshire Police

5.2 To manage activities and time scales there is a formal Project Plan, including a risk register which is monitored fortnightly by the Project team

5.3 The project team reports progress to the Executive Commissioning Board (joint commissioning forum between the Local Authority and the Clinical Commissioning Group/s), the Domestic and Sexual Violence Partnership Board, the Community Safety Partnership, as well as internal management boards and senior officers in the Council and the CCG's.

6. LEGAL APPRAISAL

6.1 These services will provide advocacy and direct support to vulnerable people; families and children and therefore help fulfil the Councils' statutory duties.

6.2 The statutory duties which fall to the Council arise under the following provisions;

a) Children's Act 1989 (and subsequent amendments)-duty of care to vulnerable children and their families
b) Part 7 Housing Act 1996-requiment to house vulnerable residents –specific categories for priority need include fleeing domestic violence
c) Crime and Disorder Act 1998 –introduction of community safety and the strategic partnerships required to manage services to ensure citizens quality of life and freedom from crime and disorder
d) Mental Capacity Act 2005
e) Localism Act 2011-extended the use of private sector accommodation offers as part of options available to local authorities to end homelessness duties
f) Care Act 2014-the requirement to ensure the health and wellbeing of vulnerable groups
g) Homelessness Reduction Act 2018-extended homelessness duties on local authorities and the requirement to provide housing advice and assistance

6.3 The Local Authority must also have regard to its public sector equality duties under section 149 of the Equality Act 2010 when exercising its functions and making any decisions. The Local Authority must carry out an Equalities Impact Assessment to enable intelligent consideration of any equality and diversity implications when commissioning services.

6.4 S149 of the Equality Act 2010 (the Public Sector Equality Duty) provides as follows

(1) A public authority must, in the exercise of its functions have due regard to the need to;
   a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010
   b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
   c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it

(3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to;
   a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
   b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
   c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

(4) The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

(5) Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to;
   a) tackle prejudice, and
   b) promote understanding.

(6) Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.

6.5 The Public Services (Social Value) Act came into force on 31 January 2013. It requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. The Act applies to the pre - procurement stage of contracts for services. Commissioners should consider social value before the procurement starts because this can inform the whole shape of the procurement approach and the design of the services required.

6.6. Commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could improve the social, environmental and economic well being of the area and also to consider how in conducting the process of procurement the commissioner might act with a view to securing that improvement.

6.7 In line with the Council's Social Value and Inclusive Growth Policy, the procurement for these services will include a 10% scored Social Value section, using the Social Value

Toolkit to demonstrate that bidders will meet social value objectives for inclusive growth

6.8 TUPE refers to the "Transfer of Undertakings (Protection of Employment) Regulations 2006" as amended by the "Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014". The TUPE rules apply to organisations of all sizes and protect employees' rights when the organisation or service they work for transfers to a new employer. TUPE has impacts for the employer who is making the transfer (also known as the outgoing employer or the transferor) and the employer who is taking on the transfer (also known as the incoming employer, the 'new employer' or the transferee).

6.9 All procurement activity must be undertaken in accordance with Council's Contract Standing Orders and in line with internal governance requirements.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

7.1.1Services provided through this commissioning and procurement processes are designed to support some of the most vulnerable residents in Bradford's communities. As such they are an important part of the approach to equality and diversity as they seek to empower those who may not have a voice. See Appendix 2 Equality Impact Assessment.

7.1.2 Although it is recognised that women (with or without children) are the largest group affected by domestic abuse; rape and/or sexual violence the need to open up services to people from the lesbian; gay; bisexual, transsexual and/or queer communities and men is an integral part of service delivery, service specifications will identify specific needs for different groups to ensure appropriate service responses are in place.

7.1.3 Prevention and early intervention are a particularly important part of the programme. The Project team acknowledges the need for training and awareness to be provided in schools; youth facilities and other settings where younger people congregate.
There is a greater opportunity to implement prevention based programmes with the new approached signalled by the Government in respect of the delivery of Personal and Social education modules in schools.

7.2 SUSTAINABILITY IMPLICATIONS

7.2.1. The need to develop new housing solutions over a period of time during the contract may require a building programme and additional capital investment. This may impact on the long term sustainability of the services if unable to be realised

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

7.3.1 The majority of service recipients will not maintain their access to personal vehicles unless remaining at home, through the Sanctuary scheme. There are small impacts anticipated on the environment through the use of public transport and project based vehicles.

7.3.2 The 'fixed' accommodation bases use gas fired boilers for heating and hot water these have not been examined to ensure there are operating at an optimum level.

7.3.3 Fuel poverty is an issue in the private sector in the district and there will be service recipients who experience debt and money management issues as a result.

7.4 COMMUNITY SAFETY IMPLICATIONS

7.4.1 As noted earlier in this report sexual and domestic violence are issues of particular concern to the Community Safety Partnership. As such the Project team updates this forum through members in Public Health and the portfolio holder.

7.4.2 Crime and fear of crime are both concerns across the district and services such as these can support people to tackle crime and use statutory agencies such as the Courts and the Police to greater effect

7.5 HUMAN RIGHTS ACT

7.5.1. The Human Rights act 1998 enshrines a person's right to the following;
A life; respect and a family life; right to marry and to have a family; right to liberty and security; prohibition of torture and inhuman and/or degrading treatment; prohibition of discrimination; slavery and forced labour; freedom of assembly; association and expression; the right to a fair trial and no punishment without law.
Service recipients may well be experiencing some or all of the above at the point that they seek support from these commissioned services. In this way the services offered can make a very real contribution

7.6 TRADE UNION

7.6.1 New service specifications may change the roles of staff and offer new and different opportunities to work together. This is unlikely to result in reduced staffing levels or any significant staffing implications but may require time and training support to move forward.

7.7 WARD IMPLICATIONS

7.7.1 Services are offered across the district and therefore will support the needs of families and individuals across all areas and wards

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

7.8.1. None

7.9 IMPLICATIONS FOR CORPORATE PARENTING

7.9.1 The services which form this commissioning and procurement programme are not specifically aimed at 'looked after children' or those for which the Council has a corporate parenting responsibility.

7.10 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

7.10.1 The performance management systems used to ascertain the effectiveness of the contracts issued will require anonymised data to be returned to the Council and Clinical Commissioning group/s to identify efficacy; demand and service usage trends.

7.10.2 There may be a need for partner agencies to share data however this would only be with the express permission of the service user in the full knowledge of why and what it would used for. General Data Protection Regulation (GDPR) principles relating to any individuals data and rights under the Data Protection Act 2018 will be respected.

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

9.1 As this report is for information only there are no options which can be listed

10. RECOMMENDATIONS

10.1 That the Committee recognise the breadth, importance and complexity of the work undertaken by providers in relation to the above services and support the continuation of these via the new commissioning programme

10.2 That the Committee consider any equality and diversity, TUPE and social value implications at this pre- procurement stage in accordance with Council Standing Orders in 4.6.

11. APPENDICES

Appendix 1
Appendix 2

12 . BACKGROUND DOCUMENTS

JTAI 2017/18
SNA 2017
Rapid Evidence Review

APPENDIX 1

Specialist services funded by Local Authority and/or or Clinical Commissioning Groups
DV /Sexual Abuse and Exiting Prostitution Support

Service	Outturns and outcome in 2016-17
Programme of support to children in recovery from Domestic abuse in the home. Also delivers the DART programme	The service worked with 76 families
Specialist work with children in refuge and accommodation settings	Specialist children's service supported 144 children and provided 1306 play sessions. 88% of school age children were attending school/college whilst in refuge
Provision of housing/ refuge accommodation and resettlement support to those fleeing violence and/or moving on from refuge or other temporary accommodation	24 units refuge accommodation housing 108 women, 144 children accommodated & 48 Resettlement floating supported housing 140 women
Crisis, outreach and prevention; support in safety planning, court support and other interventions as needed to remain in own home	Target 440 people (including a minimum of 24 units of specialist BAME provision and 24 for males and/or members of LGBT community) 812 people engaging in on-going support 345 people needs met
Target Hardening – installation of panic alarms and lock changes	250 - 300 people per annum minimum (stretch target) 192 alarms installed & 161 lock changes
Capacity Building delivers awareness raising sessions with professionals such as other housing related support providers and a range of different sectors	60 training days per annum 51 sessions delivered for Workforce Development 13 other sessions Freedom programme – 4 groups with 58 participants

Service	Outturns and outcome in 2016-17
Support to high risk victims as part of Multi-Agency Risk Assessment Committee (MARAC) -Independent Domestic Violence Advocate- IDVA.	Minimum 400 clients per annum
Perpetrator Programmes e.g. MAZE which is a RESPECT accredited 24 week Group programme for those 'willing or ordered by Court' to attend. Participants assessed by trainers for appropriateness	41 families supported At June 2017 there were 24 children in households of people participating in the programme 40 men per annum 6 women, or men in GBT relationships Families or partners of perpetrators as needed 23 enrolled in group 10 completed group 16 completing 1:1 work
Support to people who have experienced sexual abuse	224 service users supported
Support to people who have experienced sexual abuse	145 service users supported
Support to people who have experienced sexual abuse	400 counselling sessions offered for 48 women and girls
Support to people who have experienced sexual abuse	105 families supported
Services for women with complex needs and who are sex working	82 women on active caseload. 25 women known to service but not on caseload. 7 women not engaging with any service. Service saw 38 new women in previous 12 months. 29 of these were on street sex working. 18% successful exit from Prostitution.
Services for women with complex needs and who are sex working	Specialist health care; 4 women per clinic seen in 9 clinics per quarter & 161 women seen in year. 16 not initially registered with a GP

Airedale, Wharfedale and Craven Clinical Commissioning Group
Bradford City Clinical Commissioning Group
Bradford Districts Clinical Commissioning Group

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Equality Impact Assessment Form

Reference –

Department	Adult Services	**Version no**	1.0
Assessed by	Kerry James, Tony Sheeky, Hannah Hatchman	**Date created**	20/06/18
Approved by	Liz Barry	**Date approved**	20/06/18
Updated by	Sarah Possingham	**Date updated**	20/06/18
Final approval		**Date signed off**	

The Equality Act 2010 requires the Council and the Clinical Commissioning Groups to have due regard to the need to

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups

Section 1: What is being assessed?

1.1 Name of proposal to be assessed.

Domestic and Sexual Abuse Service contracts/grants currently funded by Bradford Council and the CCGs are due to expire on the 31 March 2019. The services are being reviewed to inform future commissioning

1.2 Describe the proposal under assessment and what change it would result in if implemented.

Services will be tendered in line with the outcome of the review Following the outcome of an appropriate commissioning programme; including needs work; service evaluation and performance and consultation and involvement work with providers and stakeholders a procurement process will be used to commission new services

Section 2: What the impact of the proposal is likely to be

2.1 Will this proposal advance equality of opportunity for people who share a protected characteristic and/or foster good relations between people who share a protected characteristic and those that do not? If yes, please explain further.

Yes, the proposal ensures provision of specialist services for domestic and/or sexual violence and those with multiple needs at risk of/or working in prostitution with protected characteristics. In particular those from different genders; the BAME and LGBTQ communities and those with mental health issues.

2.2 Will this proposal have a positive impact and help to eliminate discrimination and harassment against, or the victimisation of people who share a protected characteristic? If yes, please explain further.

Yes, the proposal ensures provision of specialist services for domestic and/or sexual violence and those with multiple needs at risk of/or working in prostitution services which will meet the needs of those with protected characteristics as listed above.

2.3 Will this proposal potentially have a negative or disproportionate impact on people who share a protected characteristic? If yes, please explain further.

No

2.4 Please indicate the level of negative impact on each of the protected characteristics?
(Please indicate high (H), medium (M), low (L), no effect (N) for each)

Protected Characteristics:	**Impact** (H, M, L, N)
Age	N
Disability	N
Gender reassignment	N
Race	N
Religion/Belief	N
Pregnancy and maternity	N
Sexual Orientation	N
Sex	N
Marriage and civil partnership	N
Additional Consideration:	
Low income/low wage	N

2.5 How could the disproportionate negative impacts be mitigated or eliminated?

(Note: Legislation and best practice require mitigations to be considered, but need only be put in place if it is possible.)

Not applicable

Section 3: Dependencies from other proposals

3.1 Please consider which other services would need to know about your proposal and the impacts you have identified. Identify below which services you have consulted, and any consequent additional equality impacts that have been identified.

Police – Additional IDVA provision, Conditional Cautions,
CCG – Primary & Secondary Care
Children's – Education & Early Years, Children's Safeguarding
Housing – Emergency accommodation, longer term accommodation
Safeguarding Adults

All of the above services are involved in the multi-agency project team for this commission.

Probation – work with perpetrators

Work with probation will be captured through the work with the Domestic Violence Partnership.

Section 4: What evidence you have used?

4.1 What evidence do you hold to back up this assessment?

Domestic Abuse and Sexual Violence Strategic Needs Analysis 2017
Prostitution Needs Assessment 2018
Domestic Abuse and Sexual Violence Rapid Evidence Review 2018
Joint Targeted Area Inspection 2017

Performance Reports from commissioned services
Outcomes from specialist event held in April for stakeholders and providers of services across this field

4.2 Do you need further evidence?

Supplementary work is being undertaken by Public Health.
Work is being undertaken to collate feedback from service users.
A survey has been prepared to send to the council's citizens panel requesting their views on domestic and sexual violence services to help identify any gaps in current provision.

Section 5: Consultation Feedback

5.1 Results from any previous consultations prior to the proposal development.

Consultations were undertaken as part of the previous procurement process in in 2014/15.

5.2 The departmental feedback you provided on the previous consultation (as at 5.1).

Services were tendered and awarded in March 2015.

5.3 Feedback from current consultation following the proposal development (e.g. following approval by Executive for budget consultation).

A consultation event was held with stakeholders on the 12th April 2018 which explored 3 areas; experiencing violence in the home, for those who want to end violence and for those experiencing violence in the past. The key themes from the day were:

- Victim led services-sensitivity' trust building-training for front line staff to assess risk better
- Clear pathways into and across services
- Emotional and practical support
- Wider housing options
- Preventative workstreams-early intervention-education and publicity campaigns
- Access routes into services for vulnerable groups
- Support for children in recovery
- Working with perpetrators
- Counselling
- Service options offered longer term and for victims of 'historic abuse'
- Trauma counselling for adults and children –therapeutic services

5.4 Your departmental response to the feedback on the current consultation (as at 5.3) – include any changes made to the proposal as a result of the feedback.