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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Agenda for a meeting of the Health and Social Care Overview and Scrutiny Committee to be held on Thursday, 6 September 2018 at 4.30 pm in Committee Room 1 - City Hall, Bradford

Members of the Committee – Councillors

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT	BRADFORD INDEPENDENT GROUP
Hargreaves Riaz	V Greenwood A Ahmed Hussain Mir Shabbir	N Pollard	K Hussain

Alternates:

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT	BRADFORD INDEPENDENT GROUP
Barker Senior	Akhtar Berry Godwin Iqbal H Khan	J Sunderland	

NON VOTING CO-OPTED MEMBERS

Susan Crowe	Strategic Disability Partnership
Trevor Ramsay	Strategic Disability Partnership
G Sam Samociuk	Former Mental Health Nursing Lecturer

Notes:

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- If any further information is required about any item on this agenda, please contact the officer named at the foot of that agenda item.

From: **To:**

Parveen Akhtar, City Solicitor
Agenda Contact: Palbinder Sandhu/Jane Lythgow
Phone: 01274 432269/432270
E-Mail: jane.lythgow@bradford.gov.uk

A. PROCEDURAL ITEMS

1. ALTERNATE MEMBERS (Standing Order 34)

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

2. DISCLOSURES OF INTEREST

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

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

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

Notes:

(1) Members may remain in the meeting and take part fully in discussion and voting unless the interest is a disclosable pecuniary interest or an interest which the Member feels would call into question their compliance with the wider principles set out in the Code of Conduct. Disclosable pecuniary interests relate to the Member concerned or their spouse/partner.

(2) Members in arrears of Council Tax by more than two months must not vote in decisions on, or which might affect, budget calculations, and must disclose at the meeting that this restriction applies to them. A failure to comply with these requirements is a criminal offence under section 106 of the Local Government Finance Act 1992.

(3) Members are also welcome to disclose interests which are not disclosable pecuniary interests but which they consider should be made in the interest of clarity.

(4) Officers must disclose interests in accordance with Council Standing Order 44.

3. MINUTES

Recommended –

That the minutes of the meeting held on 12 July 2018 be signed as a correct record (previously circulated).

(Palbinder Sandhu – 01274 432269)

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.

(Palbinder Sandhu - 01274 432269)

5. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

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

B. OVERVIEW AND SCRUTINY ACTIVITIES

6. HEALTHWATCH REPORT ON AUTISM SPECIALIST SUPPORT AND ACCESS TO WIDER SERVICES 1 - 10

The Manager of Healthwatch Bradford and District will submit **Document "F"** which sets out the findings from a new report by Healthwatch Bradford and District on the experiences of autistic people across the area. It sets out the challenges that people face accessing both diagnosis and support and the impact that these have on them and their families and carers. The report makes a number of recommendations to the Council and NHS.

The views of Members on the options contained in Document "F" are requested.

(Sarah Hutchinson – 01274 01535 665258)

7. PUBLIC HEALTH OUTCOMES FRAMEWORK 11 - 38

The Director of Public Health will submit **Document "G"** which provides an overview of local performance based on the Public Health Outcomes Framework, highlighting how indicators compare with England.

The report also provides additional focus on a number of indicators which are high profile; where the Committee has asked for more detail;

or where there have been noteworthy changes in performance.

Recommended –

That the content of the report be acknowledged and the Director of Public Health be requested to provide a further performance report on Public Health Outcome Framework indicators in 2019.

(Jonathan Stansbie – 01274 436031)

8. SAFEGUARDING ADULTS STRATEGIC PLAN AND IMPLEMENTATION OF THE MULTI-AGENCY SAFEGUARDING HUB 39 - 54

The report of the Strategic Director, Health and Wellbeing (**Document "H**") provides details of Bradford Council's Health and Wellbeing Department's safeguarding activities.

The views of Members are requested and it is:-

Recommended –

That the report be noted.

(Andrea Richards – 01274 436519)

9. MEMORANDUM OF UNDERSTANDING (MOU) FOR THE WEST YORKSHIRE AND HARROGATE HEALTH AND CARE PARTNERSHIP 55 - 100

The report of the Strategic Director, Health and Wellbeing (**Document "I**") is to inform Members of the increased local authority oversight of the West Yorkshire and Harrogate Health and Care Partnership.

A report seeking the Health and Wellbeing Board's approval of the Memorandum of Understanding for the Partnership is to be presented to the Health and Wellbeing Board on 4 September 2018.

Members are asked to note and comment on the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership.

(James Drury – 01274 431057)

10. HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME 2018/19 101 - 106

The Overview and Scrutiny lead will present the Committee's Work Programme 2018/19 (**Document "J"**).

Recommended -

That the information contained in Appendix A to Document "J" be noted.

(Caroline Coombes – 01274 432313)

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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of Healthwatch Bradford and District to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on September 6 2018

F

Subject:

Autistic Spectrum Conditions: access to support in Bradford and District

A report by Healthwatch Bradford and District

Summary statement:

This report sets out the findings from a new report by Healthwatch Bradford and District on the experiences of autistic people across the area. It sets out the challenges that people face accessing both diagnosis and support, and the impact that these have on them, and their families and carers. The report makes a number of recommendations to the Council and NHS.

Portfolio: Healthy People and Places

Overview & Scrutiny Area
Health and Social Care

Report Contact: Sarah Hutchinson,
Manager, Bradford and District
Phone: 01535 665258
E-mail: sarah@healthwatch.co.uk

1. **Summary**

Healthwatch Bradford and District

This report sets out the findings of a project on autistic spectrum conditions carried out by Healthwatch Bradford and District. The data set out here will shortly be published in a report. This builds on a report published in 2017 which set out the difficulties people faced in accessing a diagnosis of autism. Following publication of this report, we continued to hear from people with autism and their families, in particular about the limited support available to them, and the impact this has on their lives and wellbeing.

The forthcoming report focuses on autistic people's experiences of accessing support. We heard:

- People struggle to find information about the pathway for diagnosis, the support available, and about their condition.
- While increased resources have been made available for diagnosis, demand still far outstrips capacity, as the diagnosis service, Bradford and Airedale Neurodevelopment Service (BANDS), remains closed to new referrals.
- People therefore continue to wait a long time for an assessment. Their choices are therefore to attempt an Independent Funding Request through their GP for assessment out of area, pay for private assessment – which many cannot afford to do - or wait for it to reopen to new referrals.
- Specialist support for autism is vital to people's wellbeing, helping them socialise, learn skills, stay in education and employment, and manage their mental health. Despite this, we heard that people struggle to access the support they need.
    - Without a diagnosis, people are not entitled to specialist support, which means they can be waiting for help for years.
    - People are therefore referred to alternative forms of support, e.g. mental health or learning disability services which are not equipped to meet their needs.
    - The support that is offered can be short-term or inconsistent, and people can find the help they are getting is reduced after a while.
- There is a lack of understanding about ASC among GPs and other professionals including dentists, those working in schools, and social workers, which can make it difficult for people to access diagnosis and support, but can also leave them shut out of other support such as primary care.
- Because services do not understand their communication needs, autistic people often struggle to understand the information provided to them, or to engage effectively with healthcare professionals.
- The cumulative impact of these issues has an often devastating effect on the mental health of autistic people and their families.

We heard again and again about the impact that not being able to get a diagnosis, not having the information they need, and not being able to access effective and appropriate support has on every aspect of their lives. The effect on mental health was stark; so too the impact on people's education, their life chances, and their ability to live a life that they find fulfilling.

2. Background

Based on prevalence in the 2011 Census, it is estimated that 1.1 per cent of the UK's population is autistic.[1] This would mean that there are 5,877 autistic people in Bradford Metropolitan District.[2]

The report brings together autistic people's experiences of accessing both a diagnosis, and support for their autism. A number of people contacted us directly to share their experiences, and we also carried out 10 interviews with people currently receiving support services. Information was collected between February 2017 and February 2018.

In common with the people who have spoken to us, Healthwatch Bradford and District has found it difficult to find clear information about the pathway for diagnosis and support in the area. However, our understanding is as follows:

Children and young people

There are a number of different points of access for an autism diagnosis for children and young people, including midwives and health visitors, GPs, and SEN co-ordinators in schools or nurseries. SEN co-ordinators can help parents access an Education, Health and Care Plan, or parents can ask for an independent assessment for this, with or without a diagnosis. The Bradford Portage Service provides home visiting and an early education support group for pre-age children.

There are some services providing support to children and young people (and their families) locally, including AWARE and ASPIRE. Information about support available can be obtained through the Local Offer webpage.

Adults

To seek a diagnosis, an adult should be be referred to Bradford and Airedale Neurodevelopment Service (BANDS). However, this service has been closed to new referrals since April 2016. The reasons behind this do not appear to have been clearly communicated to people trying to access a diagnosis. Alternatives to diagnosis through BANDS are paying for a private diagnosis, or applying for an Individual Funding Request through their GP for an out-of-area diagnosis.

To access specialist autism support, adults require a formal diagnosis. Once they have this, a social worker will apply on their behalf to the Funding Panel to determine the level of support they are entitled to, and any contribution the individual needs to make to the costs of support services.

Bradford District and Craven Autism and other Neuro-diversity Strategy

This was developed by the Autism Partnership Board, which brought together organisations working with autistic people, commissioners and providers, and

[1] https://www.autism.org.uk/about/what-is/myths-facts-stats.aspx

[2] Based on ONS statistics about the population Bradford https://www.bradford.gov.uk/open-data/our-datasets/population/

Healthwatch. The strategy has recently been approved by the Transforming Care Partnership, and discussions are taking place about how to implement this.

Funding for the Autism Partnership Board, along with other partnership boards, has been reduced, and council officers are looking at how the involvement the Board offered can be continued.

West Yorkshire and Harrogate Health and Care Partnership

The Partnership has a commitment to collaborate across the area on autism, to drive improvement in provision. It is focusing on diagnosis, along with market and provider development.

National policy

National policy on autism is set out in two autism strategies: *Fulfilling and Rewarding Lives* from 2010, and *Think Autism,* published in 2014. In 2015, the government published Statutory Regulations on autism. These set out requirements and expectations for local authorities and NHS commissioners and providers.

These include:

- Local authorities, NHS bodies, and NHS Foundation Trusts should ensure autism awareness training is included within general equality and diversity training programmes for all staff working in health and care.
- Local authorities must, under the Care Act 2014, assess people who may be in need of community care services. This duty applies to people with autism, and is not dependent on them having been formally diagnosed as having autism.
- Local authorities should allocate responsibility to a named joint commissioner/senior manager to lead commissioning of care and support services for adults with autism in the area
- Local authorities and NHS bodies should jointly ensure the provision of an autism diagnostic pathway for adults including those who do not have a learning disability and the existence of a clear trigger from diagnostic to local authority adult services to notify individuals of their entitlement to an assessment of needs.

NICE guidelines state that people should wait no more than three months for a diagnostic assessment for autism.

In September 2017, the government announced that data on the length of time people wait for a diagnosis should be measured from April 2018, to be published in 2019.

3. **Report issues**

Access to diagnosis

Unsurprisingly, given that BANDS remains closed to new referrals, we have continued to hear from people who have experienced long waits for assessments. One person who contacted us, for example, had been waiting for three years. People told us how important accessing a diagnosis can be. In part, this is because it helps them understand themselves and their lives better; it is also vital as without one, people are left in limbo,

unable to access tailored supports to meet their needs. This has a significant impact on people's lives, affecting their access to education and employment, and their mental health and wellbeing.

Specialist support for autism

People told us that specialist autism support can be a 'lifeline':

"Gives me a change to socialise with people and get away from the house. I get to go to places I wouldn't expect to go."

"We look after each other really. I like to see my friends. I've got friends here."

However, we heard how people struggle either because they cannot access support while they are waiting for assessment, or because the support they are offered is insufficient to meet their needs. Where people do not yet have a formal diagnosis, we heard that people are often referred instead to mental health and other non-autism services that cannot help them with their autism. A lack of understanding of autism and how it affects people means that people can struggle to make use of mental health services.

We also heard that people felt that the social workers supporting them to access specialist services did not necessarily have the understanding of autism needed to fully understand their needs:

"Some social worker comments on assessments weren't accurate, are misleading."

"Adults with ASC will always have ASC and this will impact on them differently at different stages of their lives, access to support should be made available at any point when they need it." (Parent of child with autism)

Accessing funding for specialist support

Similarly, people found the process of securing funding for specialist support difficult. Access to a social worker is limited and can take a long time, and people feel the outcome can depend on the autism awareness and skills of the social worker. Some social workers were praised, but people felt that others were not equipped to support them.

"It was hard to get the funding and his social worker had to fight hard for him to receive funding to go four days a week. He was 'excited' when he found out the news."

"My child has support from two services now but only one is Autism specific, would have liked 5 days with them, but there is not enough funding."

"You have to find the right service for Autism, but social services won't fund it."

We also heard concerns that members of the Funding Panel may not have sufficient understanding of autism and how it affects people's lives.

Transition from child to adult services

Most of the people we spoke to who had moved from child to adult services told us that they found the transition difficult. In particular, we heard that information about transition was difficult to find, and hard to understand.

Access to primary care

Primary care, particularly GPs, can be vital in helping people to access diagnosis and support, but also to help people live well with ASCs, and manage their health. We heard that people have mixed experiences at their GP surgery, and that a lack of understanding of the condition among GPs and other practice staff can make it difficult to access health care.

People had mixed experiences with their GPs. While some GPs show a good understanding of the needs of autistic people, others appeared to lack awareness.

We heard of good practice from some GPs (and other primary care providers including dentists) including ensuring autistic people see the same doctor, and offering early or late appointments when the waiting room is quieter.

Accessing mental health services

We heard that mental health professionals often don't have a good understanding of autism, which affect's people's ability to access appropriate treatment. Communication is not always tailored to the needs of autistic people, meaning people can struggle to understand what's being said.

"Professionals encountered in mental health services and general health services had little to no understanding of ASCs, they tried to understand but didn't use correct approaches which often led to distress of [my] *son following appointments. Time frame was also short for ASC's needs, e.g. counselling sessions* [NHS standard] *were 6 weeks but didn't give enough time for my son to become comfortable."*

People also found that mental health services are not sympathetic towards people who struggle with appointments, or who need support to attend. This can lead to a merry-go-round of re-referrals, long waits, and no support in the meantime.

"I couldn't go to all my appointments at a [mental health service] *because of my anxiety. I tried ringing but they told me I had lost my CPN because of it. I am now in trouble and I need housing. I don't know where to go or what to do. I had CBT but it didn't help because I couldn't understand what she was talking about and came away in a worst state, she didn't understand me or Aspergers. People need to know I didn't not attend on purpose, I needed support to attend the appointments. I have now been told I need to go back to my GP and go on the waiting list for another CPN but that could take weeks."*

Impact on education

Although Healthwatch does not report on educational services, for many people we spoke to, difficulties getting the support they needed at school was an important part of their story. We heard that when children and young people struggled to get a formal diagnosis, it could have an ongoing effect on their education and their ability to socialise at school.

"Secondary school never gave me the social and emotional support. The SEN worker refused to contact CAMHS because the school I went to didn't recognise autism as existing."

The school environment can be challenging for a young person with autism, meaning that a good understanding of the condition, and appropriate support can be vital to enable people to be able to engage fully in their education.

"One school I was only at for a few months because it was too crowded and stressful. The younger I was, the harder my autism was to manage."

"I'm someone who likes a really settled routine. It was all over the place. Sometimes it [college] *finished at 5. Sometimes it finished at 12."*

Some schools were seen as offering important support. One parent told us how she felt lucky that her daughter's diagnosis had only taken 18 months: *"those on the spectrum can lead perfectly fulfilled lives if only the support is put in place early enough. I'm now struggling with obtaining an Education, Health and Care Plan as this has been difficult but my child needed additional support in school and the school fought hard to get it"*

Information and communication

We heard throughout that people struggle to access information about autism, and the pathways for diagnosis and support. This was reflected in the challenges we experienced trying to find information to share with people who contact us.

Where people do receive information, they told us this is often difficult to understand, and professionals do not have sufficient understanding of the communication needs of autistic people.

Since August 2016, all organisations that provide NHS care or publically funded adult social care are legally required to follow the Accessible Information Standard.[3] This sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment, or sensory loss.

Despite this, we heard that people with autistic spectrum conditions are often provided with information they cannot understand or process, and are asked to respond using methods they find difficult, for example by telephone rather than face-to-face.

"I need support to do all written things, and I struggle to read and process information."

"My experience was not good at all, there have been regular appointments but feel that communication is very poor, when asking questions services take the first answer but Autism is not taken into account. There are very few strategies to deal with Autism."

Accessing other support

We heard that the challenges people face in understanding forms and other information can make it difficult for them to access other forms of support.

[3] https://www.england.nhs.uk/ourwork/accessibleinfo/

We heard from support workers that autistic people often experience difficulties when accessing assessments under the Care Act, for personal budgets, for financial contributions, and when trying to access benefits and support such as Personal Independence Payments. Staff carrying out assessments often lack any understanding of the way in which autistic people may interpret what is being asked of them, or how autism can affect their day to day lives.

The effect on autistic people and their families

The cumulative effect of these challenges can have a devastating effect on people's mental health and wellbeing. Several people told us that they had felt desperate, vulnerable, and suicidal at times, or had self-harmed because support has not been in place, or had been reduced or withdrawn.

"The lack of emotional and psychological support has led to having poor mental health – the first time I wanted to kill myself was in year 8. When it really kicked in I was about 15."

We also heard about how parents and families can struggle because of the lack of support available to them, and to autistic people.

"As a carer I didn't know who to turn to when my son's mental health dipped with OCD and depression, I felt out of my depth e.g. a chat with a professional for mental health advice, CBT wasn't suitable for my son, filling in diaries wasn't helpful."

Conclusion

Autistic people in Bradford are currently struggling to get the help that they need to live a fulfilling, happy, and independent life. The ongoing problems with access to diagnostic assessment have left people in limbo, in some cases for several years. Without a diagnosis, adults in particular are unable to access support, which can make it difficult to live well, stay in education or employment. It can also have a negative effect on people's mental health.

However, even where people are able to secure a diagnosis and access specialist support, they often still struggle. While the support available is welcomed, people often feel that they are not offered enough. The process of accessing funding can be challenging, and professionals do not always have sufficient understanding of autism to help them.

A lack of autism awareness was reported across a wide range of professionals, including GPs, mental health workers, social workers, and those carrying out Care Act 2014 and other assessments. This can leave people without the support they need, and can be upsetting and frustrating.

There is limited information available about diagnoses pathways and support in Bradford, which can make it more difficult still to get support. Health and other information is often not tailored to the particular needs of people with autism which can affect their access to healthcare as well as other services.

It is vital that these issues are addressed. We welcome additional funding to address the waiting list for BANDS, but believe more needs to be done to ensure that people with autism can leave happy, healthy and independent lives – and to fully meet the statutory

regulations relating to autism. People need to be able to access support before receiving a formal diagnosis, and better information is urgently required to help people understand the pathway, and where to turn for help.

Greater awareness and understanding of autism is needed to ensure that people can live well and access the services to which they are entitled. All staff across the local authority and NHS who are likely to work with autistic people should be trained to have a proper understanding of how this affects people, and how to best support them.

We hope that the Council, NHS, voluntary sector and wider autism community can come together to work in partnership to improve support available to people with autism.

4. **Options**

1. The implementation of the Autism Strategy and other Neurodiversity including the Implementation Plan and Training Strategy, and the appointment of a named local lead for the local authority and CCG.
2. Provision of a service for diagnosing Autism and other Neurodiversity either by re-opening or re-organising BANDS so it is fit for purpose, or commissioning a new service to facilitate undertaking diagnoses of Autism to include those on the current waiting list and those waiting to be referred onto it.
3. Collection and publication of length of time to diagnosis for people with autism in Bradford.
4. Bradford should become an *Autism Friendly City,* with health services and the Council aiming for the National Autism Society's Autism Friendly Business accreditation. GP practices and other organisations who will support people with autism should be encouraged to apply for this.
5. Continuous professional development training should be made available, ideally compulsorily for NHS and council staff, to improve understanding of autism and how to ensure services are fully accessible to people with autism and other neuro-diversity. This should be made available to all staff who may come into contact with people with ASC, including those performing financial and Care Act assessments, mental health services, learning disabilities services, and Bradford's First Response service.
6. Access to autism-specific services should be improved, and made available while waiting for a diagnosis. This is particularly urgent while significant delays to diagnosis remain.
7. Clear and accessible information on Autistic Spectrum Conditions and other Neurodiversity, and on accessing diagnosis and support, including support for carers, in Bradford and District, should be easily available in one place. This should be co-designed with people with lived experience to ensure it meets their needs.
8. Support for parents, families, and carers should be expanded. This should include clear information about autism, diagnosis and support.
    - A clear pathway should be set out that enables parent/carers and autistic people themselves to identify where they are, and what help is available at

any points. This should include a pathway for transition from child to adult services.

- The Cygnet programme should be opened up to parents/carers who are waiting for diagnosis.
- Peer support should be easily available
- Online 'good practice' examples of other families' experiences, aspirations, and practical ways forward should be made available

5. Contribution to corporate priorities

Improving awareness of autism among professionals, and increasing access to support for autistic people and their families, will make a positive contribution to a number of the Council's corporate priorities. It will help to deliver the vision set out in the joint local plan, Happy, Healthy and at Home, and, by helping people stay in education and employment, help support the Economic Strategy.

6. Recommendations

The views of the Committee on the report and the options set out in Section 4 of Document requested.

7. Background documents

- Background documents are documents relating to the subject matter of the report which disclose any facts or matters on which the report or an important part of the report is based, and have been relied on to a material extent in preparing the report. Published works are not included.
- All documents referred to in the report must be listed, including exempt documents.
- All documents used in the compilation of the report but not specifically referred to, must be listed.

https://www.gov.uk/government/news/fulfilling-and-rewarding-lives-the-strategy-for-adults-with-autism-in-england

https://www.gov.uk/government/publications/think-autism-an-update-to-the-government-adult-autism-strategy

https://www.gov.uk/government/publications/adult-autism-strategy-statutory-guidance

http://www.healthwatchbradford.co.uk/sites/default/files/autistic_spectrum_conditions_report_jan_17_0.pdf

https://www.autism.org.uk/autismfriendlyaward

8. Not for publication documents

None

9. Appendices - None

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Director of Health and Wellbeing to the meeting of Health and Social Care Overview and Scrutiny Committee to be held on Thursday 6 September 2018

G

Subject:

Public Health Outcomes Framework (PHOF) Performance Report

Summary statement:
This report provides an overview of local performance based on the Public Health Outcomes Framework, highlighting how indicators compare with England. The report provides additional focus on a number of indicators; these are indicators which are high profile; or where the Scrutiny Committee has asked for more detail on available indicators; or where there have been noteworthy changes in performance.

Sarah Muckle
Director of Public Health

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Portfolio:
Healthy People and Places

Overview & Scrutiny Area:
Health and Social Care

1. SUMMARY

1.1 This report provides an overview of the health and wellbeing of the population of Bradford District, based on the indicators and sub indicators within the Public Health Outcomes Framework (PHOF).

1.2 The report summarises how indicators and sub indicators within the Framework compare against the average for England.

1.3 The report provides additional focus on a number of indicators; these are indicators which are high profile; or where the Scrutiny Committee has asked for more detail on available indicators; or where there have been noteworthy changes in performance.

2. BACKGROUND

2.1 The PHOF was introduced by the Department of Health (DH) in April 2013 as part of health and social care reforms which gave local authorities statutory responsibilities for the health of their population. The PHOF examines indicators that help to understand trends in public health and how well public health is being improved and protected.

2.2 The framework is broken down into a set of overarching indicators which relate to life expectancy and reducing inequalities in life expectancy, and healthy life expectancy between communities. The remaining indicators are grouped into four different domains:

- Wider determinants of health
- Health improvement
- Health protection
- Healthcare and premature mortality

2.3 Within the PHOF, data for all local authorities are presented for each indicator. Figures are generally based on annual information or an aggregate of years where numbers are small. Figures for each local authority are compared against the average for England and show if an indicator is 'significantly worse', 'not significantly different' or 'significantly better' than the England average.

3. REPORT ISSUES

3.1 A full list of all indicators and sub indicators along with their current figures are available in **Appendix A**. This shows current values, provides an indication of recent or previous years trends where available, and benchmarks our performance against the England average.

3.2 Of the 131 indicators and sub indicators where significance against the England average has been tested, 51 are significantly worse, 54 are not significantly different and 26 are significantly better. **Table 1** shows a breakdown of this information by domain.

Table 1: Comparison to England

Domain	Number of indicators	Significantly worse	Not significantly different	Significantly better
Overarching Indicators	8	7	1	0
Wider determinants of health	25	8	6	11
Health Improvement	47	19	22	6
Health protection	23	7	10	6
Healthcare and premature mortality	28	10	15	3

3.3 **Table 2** shows how each indicator has changed over recent years for each domain. Overall, of the 131 indicators and sub indicators 17 are 'getting worse', 31 are 'getting better' and 72 show no significant change over recent years.

Table 2: Performance over Time

Domain	Number of indicators	Getting worse	No significant change	Getting Better	No trend data available
Overarching Indicators	8	0	8	0	0
Wider determinants of health	25	2	9	14	0
Health Improvement	47	4	23	10	10
Health protection	23	10	7	6	0
Healthcare and premature mortality	28	1	25	1	1

3.4 The report will now provide more detail on specific indicators within PHOF. Charts showing trends over time for these specific indicators can be found in **Appendix B**. Because there are more than 100 indicators in PHOF it is not possible in this report to provide a detailed overview of them all. Accordingly, a number of indicators across the four specific domains, in addition to the main overarching indicators, have been selected, and a more detailed analysis has been provided. These indicators have been chosen primarily based on current and previous performance.

3.5 **Overarching indicators**:

3.5.1 **Life expectancy at birth**

Life expectancy at birth is the average number of years a person would expect to live based on death rates. It is one of the most important summary measures of the health and wellbeing of a population, and provides a measure of health inequalities.

Historically life expectancy has increased year on year in the District for both males and females; this trend mirrors the national picture. Most recent data shows that on average a male in the District can expect to live for 77.5 years; this compares to 79.5 years in England. On average a female in the District can expect to live for 81.5 years; this compares to 83.1 years in England.

In recent years the rising trend in life expectancy has levelled off. This is not unique to the District; the trend is similar to that observed at a national level. The reasons for this are not clear, however, there are a number of analyses

being conducted at a national level to better understand the observed trends.

3.5.2 **Healthy Life expectancy at birth**:
Healthy life expectancy is the average number of years a person would expect to live in good health. It is an important summary measure of the health and wellbeing of a population on its own, and also when combined with other information, for example on life expectancy.

Although healthy life expectancy at birth for males in the District has risen sporadically and is below the average for England, the gap between the District and the average for England has narrowed. For females, healthy life expectancy has generally risen in the District and the gap between the District and the average for England has also narrowed, although remains below the average for England.

Most recent data shows that a male living in the District can expect 61.8 years of healthy life compared to 63.3 years for England. On average a female living in Bradford can expect 61.1 years of healthy life compared to 61.5 years for England.

3.5.3 *Connecting People for Health and Place for Better Health and Wellbeing'* sets out how partners in the District will work together to improve the health and wellbeing of people in the District. As our Health and Wellbeing Strategy, owned by the Health and Wellbeing Board, it sets out the challenge and our ambition. There are four overarching outcomes: our children have a great start in life; people in Bradford District have good mental wellbeing; people in all parts of the District are living and ageing well; Bradford District is a healthy place to live, learn and work. 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.

3.5.4 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'.

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3.6 Wider determinants of heath: The wider determinants or social determinants of health are a range of social, economic and environmental factors which influence health and wellbeing. As defined by Public Health England, they 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. There are 25 indicators in the PHOF which relate to the wider determinants of health.

3.6.1 **School readiness**: School readiness is a measure of how prepared a child is to succeed in school. There are four indicators relating to school readiness and of these the District is significantly worse that the average for England for two these indicators – the percentage of children achieving a good level of development at the end of reception and the percentage of Year 1 pupils

achieving the expected level in the phonics screening check. However, in recent years all of these 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.

3.6.2 **Fuel poverty**: Fuel poverty exists when a household cannot afford to heat their home to an adequate level. In 2015 15.0% of households in the District experienced fuel poverty, higher than the 11.0% of households in England. This percentage has increased from 12.6% in 2011.

Fuel poverty remains an issue for the District primarily as a result of the large number of older Victorian and pre-Victorian housing which is a hard to insulate effectively. The District has an established winter warmth programme - Warm Homes - procured in 2017/18 for two years. The programme 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. There are also a number of programmes working across the Directorates of Health and Wellbeing and Place to design and support the development of greener, cleaner city and urban village designs which enhance and support healthy places to live including tackling fuel poverty.

3.7 **Health improvement**: There are 47 indicators in PHOF which relate to health improvement. These indicators generally describe a range of behaviours and lifestyle choices which contribute to healthy lives, such as smoking, physical activity, fruit and vegetable intake, and substance misuse,

3.7.1 **Child excess weight**

All children are weighed and measured in Reception and Year 6 as part of the National Childhood Measurement Programme. The proportion of Reception aged children who are either overweight or obese has fluctuated over recent years but has generally remained below or in line with the average for England (22.5%). Over the last ten years for which data is available, the percentage of children in the District who are overweight or obese has remained relatively static. Between Reception and Year 6 there is a significant increase in the percentage of children who are overweight or obese. 37.9% of children in Year 6 are overweight or obese – this compares to 34.2% in England. This proportion is increasingly slowly each year.

There is a huge amount of work going on across the District to tackle obesity. As part of our Healthy Bradford Plan we have been working with Public Health England and Leeds Beckett University to develop a whole systems approach to obesity. Recognising that the causes of obesity are complex, a whole systems approach means working with stakeholders across the council (education, transport, planning etc) and beyond (voluntary and community sector, NHS, private business) to identify, align and review a range of actions to tackle obesity in the short, medium and long term.

As we develop Healthy Bradford, we continue to provide a diverse offer that supports children and young people to be more active and eat a healthy diet. This includes Beat the Street. Public Health also fund Childrens Services to provide the Healthy Active Play Partners (HAPP) Programme which takes referrals from school nurses, primary care, other allied health professionals, teachers and parents. They provide a 6-week home based programme that aims to introduce the family to physical activity opportunities close to home and support to sustain attendance.

3.7.2 **Smoking status at time of delivery (SATOD)**

All women are asked about their smoking status at the time of delivery. 13.8% of women in the District report smoking at the time of delivery. Although this proportion is significantly worse than the average for England (10.7%), recent trends show improvement. In 2015/16 the figure for the District was 15.1%. This improvement is most likely the result of the huge amount of focus on this issue from partners across the local authority and NHS. Since April 2017, the children's centre clusters have had new KPIs to support smoking reduction in pregnancy. All clusters have staff trained to support parents to stop smoking and are working to achieve the outcome that 25% of midwifery referrals set a quit date. Furthermore, specialist midwifery support has been commissioned, we have developed smokefree homes champions, we have introduced BabyClear, and the CCGs have used additional funding to support the monitoring of smoking in pregnancy.

3.7.3 **Smoking prevalence in adults**

Smoking prevalence in adults remains stubbornly high in the District. 18.9% of adults in the District smoke; this compares to 14.9% in England. There are, however, signs of improvement. In 2017, the proportion of the population smoking fell to 18.9%, which is the lowest level recorded in Bradford District, and compares to 22.8% in 2013.

Stop smoking support in the District is provided by a team of specialists within a central service, and also via a network of providers in primary care and pharmacies. Within the secondary care setting support to quit smoking is provided by the specialist team on the ward. Efforts to further reduce the prevalence of smoking continue, with some additional funding coming into the District via the West Yorkshire and Harrogate Cancer Alliance.

3.7.4 **Cancer Screening coverage**

Screening is important because it helps identify people with some types of cancer in its earliest stages. There are 3 indicators relating to screening coverage in the PHOF (breast cancer, cervical cancer and bowel cancer). The District performs worse than England on all three of these indicators. Trends over the last eight years show a reduction in the proportion of the eligible population being screened for breast and cervical cancer (breast cancer: 2010 – 73.8%, 2017- 69.7%), cervical cancer: 2010-74.7%, 2017 – 70.5%). This trend is mirrored nationally. Coverage of bowel cancer screening is, however showing some signs of improvement, (2015 – 54.6%, 2017 – 55.8%), although as the programme has been running for less time, limited trend data is available.

A number of initiatives are in place to improve uptake, and this has been the subject of previous reports to the Overview and Scrutiny Committee. Examples of local initiatives include a pilot project using local GP and pharmacy staff to have a 'chat about health' with women from South Asian ethnic groups to encourage uptake of screening. There is a local screening group in the District led by NHS England which all screening providers attend to discuss initiatives to improve uptake. The District has also benefited from visits by the Cancer Research UK and MacMillan road shows in the past year.

3.8 **Health protection**: There are 23 indicators included in the health protection domain, which includes the control of infectious diseases.

3.8.1 **Tuberculosis**

Although the incidence of Tuberculosis (TB) remains above the average for England, incidence continued its year on year fall to 18.1 cases per 100,000 population compared to 22.2 in the previous year. Treatment completion for TB fell from the previous year from 89.4% in 2014 to 80.2% in 2015 but generally has shown signs of improvement over recent years.

3.8.2 **HIV late diagnosis**

Late diagnosis is the most important predictor of poor health and death among those with HIV infection. Although late diagnosis of HIV in the District is now significantly above the average of England (50.9% compared to 40.1%), the number of people diagnosed with HIV across the District continues its year on year decline. The local authority together with the NHS, continue to work to reduce the numbers of people diagnosed with HIV. Medication for people at very high risk of acquiring the infection will soon be available for those eligible to lower their chances of getting infected, and help prevent the spread of HIV.

3.8.3 **Measles, mumps and rubella (MMR) vaccination**

There are a number of indicators included in the PHOF relating to vaccination. The MMR is offered as part of the childhood immunisation programme. Children receive the first dose at 12/13 months and a second dose as part of the pre-school booster. There are 3 indicators relating to MMR – MMR for one dose (2 year olds), MMR for one dose (5 year olds) and MMR for two doses (5 year olds).

Whilst the District is not significantly worse than England for any of these indicators, recent trends show that the proportion of children vaccinated is falling for two of these indicators. In 2016/17 91.2% of children had received two doses of the MMR at age five; this compares to 93.2% in 2013/14. Similarly, in 2016/17, 93.1% of two year olds had received one dose of the MMR; this compares to 94.6% in 2013/14.

In recent months there have been recognised measles outbreaks in Leeds and Bradford. The outbreak in Bradford has afforded an opportunity for GP practices to review their MMR uptake and offer vaccination to those who may have missed either one or both doses of the vaccination. Work is also being

done in local areas through area teams to engage with residents from communities with low uptake rates, including supporting people to register with GP practices and take up the MMR vaccination.

3.9 **Healthcare and premature mortality**: A number of indicators in the PHOF relate to the number of people dying before the age of 75, and those living with preventable health issues. Most indicators relating to early death are worse than the England average, and are not improving. This is a similar picture to many urban areas in the north of England. Prevention of ill health is key to improving these indicators; this requires action across health improvement and the wider determinants of health, in order to have an impact in the long term. In the shorter term, improvements will come from the better management of long term conditions. Long term condition management has been prioritised by all three CCGs locally, for example, through diabetes new models of care, Bradford Breathing Better, and Bradford Healthy Hearts.

3.9.1 **Infant mortality**

The high levels of infant mortality have long been recognised in the District, Whilst substantial progress has been made over the last decade, the infant mortality rate remains higher than in England (5.9 per 1,000 live births compared to 3.9 per 1,000 live births in England). After year on year decreases since 2001-2003, the infant mortality rate has remained static for the last couple of years.

Work led by the Every Baby Matters Steering Group to reduce the risk of babies dying during the first year of life continues to support the health of all mothers, infants and children across the District. Reducing infant mortality continues to be a priority work programme for the District and working towards this target is recognised within the Bradford District Partnership, Children's Trust and Children and Young People's Plan, and within the three CCGs strategies and plans.

4. FINANCIAL & RESOURCE APPRAISAL

4.1 Tackling public health issues requires long term commitment and investment. Much of this already exists and is directed towards activity which will positively influence the indicators in the PHOF. The Public Health service is grant funded by the Department of Health; the total funding for 2018-19 is £41.826m and it is anticipated that the service will balance the budget. There are no financial issues arising from this PHOF performance report.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

5.1 The PHOF has been recognised as the most widely-understood and readily-available means of assessing the health and wellbeing of the population of Bradford and District. It is acknowledged that health and wellbeing depends upon joint work between the Council and its key partners in a variety of different multi-agency settings. The responsibility for delivering change and the actions designed to improve health and wellbeing, whilst reducing inequalities, has been interwoven into the Bradford District Partnership and its main strategic partnership groups. This

ensures accountability across all agencies.

6. LEGAL APPRAISAL

6.1 Part 1 of the Health and Social Care Act 2012 (the Act) places legal responsibility for Public Health within Bradford Council. Specifically, Section 12 of the Act created a new duty requiring Local Authorities to take such steps as they consider appropriate to improve the health of the people in its area. Section 31 of the Act requires the Director of Public Health to prepare an annual report on the health of the people in the area of the Council, which it must then publish. The contents of the report are a matter for local determination.

6.2 The Director of Public Health is obliged to pay regard to guidance issued by the Secretary of State for Health when exercising public health functions and in particular to have regard to the Department of Health's Public Health Outcomes Framework (PHOF). The PHOF identifies differences in life expectancy and healthy life expectancy between communities by measuring a series of health metrics, and is regularly reviewed.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

7.1.1 The Public Health Outcomes Framework is designed to focus public health activity on improving health outcomes AND reducing health inequalities. It is, therefore, reasonable to infer that better performance in each of the areas covered by this report will also lead to a reduction in inequality, and therefore greater equality.

7.2 SUSTAINABILITY IMPLICATIONS

7.2.1 The PHOF has been recognised as the most widely understood and readily available means of assessing the Health and Wellbeing of the population of the District. As such, it is used to guide all Public Health programmes and services, as well as

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

7.3.1 Some of the indicators in the PHOF have a direct impact on reducing the impact of climate change. For example, actions taken to reduce fuel poverty aim to improve housing and heat/light and power systems for vulnerable households. These make a direct difference for the occupants, creating warm and safer environments and in the process reduce carbon emissions from poor housing.

7.3.2 Actions to improve indicators in the PHOF may reduce greenhouse gas emissions. If people exercise outside more, it may reduce car ownership/use, and heating / lighting of premises that would be used for indoor activity. In turn, reduced car ownership/use may lead to reduced air pollution.

7.3.3 It is, however, important to recognise that energy and emissions can be linked with better standards of living - such as car ownership, domestic energy, good diet and

flights abroad. Work needs to take place to ensure that improvements in wellbeing do not therefore automatically lead to increased carbon emissions.

7.4 COMMUNITY SAFETY IMPLICATIONS

7.4.1 In broad terms, the health and wellbeing of communities includes perception of safety and security within the household and wider society. Specifically, the PHOF includes indicators which may give some indication of community safety, including complaints about noise and domestic violence indicators. Many of the indicators mentioned in the report could potentially have some impact upon individuals' perceptions of their own community.

7.5 HUMAN RIGHTS ACT

None

7.6 TRADE UNION

None

7.7 WARD IMPLICATIONS

7.7.1 PHOF indicators are complex and are influenced by differences in economic, cultural and social factors across populations and communities. Across the 30 wards of the District, achievement against each of the indicators will vary substantially. Upon request, the Public Health Intelligence team is able to advise on whether more detailed information is available at ward level, and whether any further analysis of this is valuable.

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 That members examine and comment on the report content

10. RECOMMENDATIONS

10.1 That the committee acknowledges the content of the report and seeks a further performance report on PHOF indicators in 2019.

11. APPENDICES

Appendix A: Public Health Outcomes Framework at a Glance. A list of all PHOF Indicators, there current value for Bradford, how each indicator compares to the average for England and any recent trends available.

Appendix B: Charts of specific indicators. A selection of charts showing recent trends in the selected indicators mentioned in paragraphs 3.5 to 3.9

12. BACKGROUND DOCUMENTS

Connecting People and Place for Better Health and Wellbeing 2018-2023. Available at: https://bdp.bradford.gov.uk/media/1331/connecting-people-and-place-for-better-health-and-wellbeing-a-joint-health-and-wellbeing-strategy-for-bradford-and-airedale-2018-23.pdf

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Public Health England

Public Health Outcomes Framework - at a glance

Bradford

Notes

- Value cells have a box shaded Red, Amber or Green to show significance compared to England, or where the value can be benchmarked against a goal.

- In the change columns, prev refers to the change in value compared to the previous data point; recent trend refers to the analysis done in the Fingertips tool which tests for a statistical trend. This is currently only available for certain indicator types, full details are available in the tool.

- Increases or decreases are only shown if they are statistically significant. An upwards arrow (either Red, Green or blue) represents a significant increase in the indicator value, a downwards arrow (either Red, Green or blue) represents a significant decrease. A sidewards arrow (Amber) is displayed if there has been no significant change. Indicators that are shaded blue rather than Red/Amber/Green are presented in this way because it is not straightforward to determine for these indicators whether a high value is good or bad.

- Statistically significant changes highlighted in the change from prev column have been calculated by comparing the confidence intervals for the respective time points. If the confidence intervals do not overlap, the change has been flagged as significant.Changes in the recent trend column are calculated using a chi-squared statistical test for trend.

- Where no arrow is shown, no comparison has been made. This may be due to the fact that the required data to make the comparison is not available for the time point, or that no confidence interval values are available for the indicator. Certain indicator types have not yet been included in the recent trend analysis.

- The arrows are coloured Green and Red for those indicators where a change can be described as improving or worsening respectively.

Bradford

Indicators at a glance

Key

Significance compared to goal / England average:

- Significantly worse
- Not significantly different
- Significantly better
- Significantly lower
- Significantly higher
- Significance not tested

- ↑ Increasing / Getting worse
- ↓ Decreasing / Getting worse
- ↑ Increasing
- → No significant change
- ↑ Increasing / Getting better
- ↓ Decreasing / Getting better
- ↓ Decreasing
- \- Could not be calculated

Overarching indicators

	Period	Local value	Unit	Change from prev	Recent Trend
0.1i - Healthy life expectancy at birth (Male)	2014 - 16	61.8	Years	→	-
0.1i - Healthy life expectancy at birth (Female)	2014 - 16	61.1	Years	→	-
0.1ii - Life expectancy at birth (Male)	2014 - 16	77.5	Years	→	-
0.1ii - Life expectancy at birth (Female)	2014 - 16	81.5	Years	→	-
0.1ii - Life expectancy at 65 (Male)	2014 - 16	17.6	Years	→	-
0.1ii - Life expectancy at 65 (Female)	2014 - 16	20.1	Years	→	-
0.2i - Inequality in life expectancy at birth ENGLAND (Male)	2014 - 16		Years	-	-
0.2i - Inequality in life expectancy at birth ENGLAND (Female)	2014 - 16		Years	-	-
0.2i - Inequality in life expectancy at 65 ENGLAND (Male)	2014 - 16		Years	-	-
0.2i - Inequality in life expectancy at 65 ENGLAND (Female)	2014 - 16		Years	-	-
0.2ii - Number of UTLAs where inequality in life expectancy at birth has decreased (Male)	2014 - 16		Count	-	-
0.2ii - Number of UTLAs where inequality in life expectancy at birth has decreased (Female)	2014 - 16		Count	-	-
0.2iii - Inequality in life expectancy at birth LA (Male)	2014 - 16	8.8	Years	→	-
0.2iii - Inequality in life expectancy at birth LA (Female)	2014 - 16	7.5	Years	→	-
0.2iii - Inequality in life expectancy at 65 LA (Male)	2014 - 16	4.9	Years	→	-
0.2iii - Inequality in life expectancy at 65 LA (Female)	2014 - 16	4.7	Years	→	-
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Male)	2014 - 16	-2.0	Years	→	-
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Female)	2014 - 16	-1.6	Years	→	-
0.2v - Inequality in healthy life expectancy at birth ENGLAND (Male)	2014 - 16		Years	-	-
0.2v - Inequality in healthy life expectancy at birth ENGLAND (Female)	2014 - 16		Years	-	-
0.2vi - Inequality in healthy life expectancy at birth LA (Male)	2009 - 13	19.1	Years	-	-
0.2vi - Inequality in healthy life expectancy at birth LA (Female)	2009 - 13	22.1	Years	-	-
0.2vii - Inequality in life expectancy at birth REGION (Male)	2014 - 16		Years	-	-
0.2vii - Inequality in life expectancy at birth REGION (Female)	2014 - 16		Years	-	-
0.2vii - Inequality in life expectancy at 65 REGION (Male)	2014 - 16		Years	-	-
0.2vii - Inequality in life expectancy at 65 REGION (Female)	2014 - 16		Years	-	-

Wider determinants of health

	Period	Local value	Unit	Change from prev	Recent Trend
1.01i - Children in low income families (all dependent children under 20)	2015	21.8	%	↓	↓

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	Period	Local value		Unit	Change from prev	Recent Trend
1.01ii - Children in low income families (under 16s)	2015	21.6		%	↓	↓
1.02i - School Readiness: the percentage of children achieving a good level of development at the end of reception	2016/17	67.6		%	→	↑
1.02i - School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception	2016/17	58.7		%	→	↑
1.02ii - School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check	2016/17	79.6		%	→	↑
1.02ii - School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2016/17	70.5		%	→	↑
1.03 - Pupil absence	2015/16	4.95		%	→	↓
1.04 - First time entrants to the youth justice system	2016	384.8		per 100,000	→	↓
1.05 - 16-17 year olds not in education, employment or training (NEET) or whose activity is not known - current method	2016	6.0		%	-	-
1.05 - 16-18 year olds not in education employment or training - historical method	2015	3.5		%	↓	↓
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	2016/17	88.8		%	→	↑
1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation	2016/17	74.0 $		%	↑	-
1.07 - People in prison who have a mental illness or a significant mental illness	2016/17			%	-	-
1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	2016/17	24.6		Percentage points	→	-
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate	2016/17	64.0		Percentage points	→	-
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	2016/17	59.2 $		Percentage points	→	-
1.08iv - Percentage of people aged 16-64 in employment	2016/17	67.2		%	→	↑
1.09i - Sickness absence - the percentage of employees who had at least one day off in the previous week	2014 - 16	1.9		%	→	-
1.09ii - Sickness absence - the percentage of working days lost due to sickness absence	2014 - 16	1.2		%	→	-
1.10 - Killed and seriously injured (KSI) casualties on England's roads	2014 - 16	35.8		per 100,000	→	-
1.11 - Domestic abuse-related incidents and crimes - current method	2016/17	26.6 ^		per 1000	-	-
1.11 - Domestic abuse - historic method	2014/15	22.7 ^		per 1000	-	-
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	2014/15 - 16/17	62.0		per 100,000	↓	-
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population	2016/17	30.5		per 1000	↑	↑
1.12iii- Violent crime (including sexual violence) - rate of sexual offences per 1,000 population	2016/17	3.3		per 1000	↑	↑
1.13i - Re-offending levels - percentage of offenders who re-offend	2014	26.4		%	→	→
1.13ii - Re-offending levels - average number of re-offences per offender	2014	0.90		per offender	↑	↑
1.13iii - First time offenders	2016	243.2		per 100,000	→	-
1.14i - The rate of complaints about noise	2015/16	4.2		per 1000	→	↓
1.14ii - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	2011	4.6		%	-	-
1.14iii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	2011	5.7		%	-	-
1.15i - Statutory homelessness - Eligible homeless people not in priority need	2016/17	0.3		per 1000	↓	↓
1.15ii - Statutory homelessness - households in temporary accommodation	2016/17	0.4		per 1000	→	↑
1.16 - Utilisation of outdoor space for exercise/health reasons	Mar 2015 - Feb 2016	12.4 $		%	→	-
1.17 - Fuel poverty	2015	15.0		%	-	↑
1.18i - Social Isolation: percentage of adult social care users who have as much social contact as they would like	2016/17	50.3		%	→	-
1.18ii - Social Isolation: percentage of adult carers who have as much social contact as they would like	2016/17	41.6		%	→	-

Note: ^ - Value estimated, $ - Data quality note

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Health improvement

	Period	Local value		Unit	Change from prev	Recent Trend
2.01 - Low birth weight of term babies	2016	3.58		%	→	↓
2.02i - Breastfeeding initiation	2016/17	71.5		%	↑	↑
2.02ii - Breastfeeding prevalence at 6-8 weeks after birth - current method	2016/17	41.9		%	→	-
2.03 - Smoking status at time of delivery - current method	2016/17	13.8		%	→	↓
2.03 - Smoking status at time of delivery - historical method	2016/17	13.7		%	→	↓
2.04 - Under 18 conceptions	2016	20.0		per 1000	→	↓
2.04 - Under 18 conceptions: conceptions in those aged under 16	2016	3.3		per 1000	→	↓
2.05ii - Proportion of children aged 2-2½yrs offered ASQ-3 as part of the Healthy Child Programme or integrated review	2016/17	- x		%	-	-
2.06i - Child excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2016/17	22.5		%	→	→
2.06ii - Child excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2016/17	37.9		%	→	↑
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2016/17	116.5		per 10,000	→	↓
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	2016/17	134.1		per 10,000	→	↓
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2016/17	145.1		per 10,000	→	↓
2.08i - Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March	2016/17	12.3		Score	-	-
2.08ii - Percentage of children where there is a cause for concern	2016/17	29.4		%	→	-
2.09i - Smoking prevalence at age 15 - current smokers (WAY survey)	2014/15	9.5		%	-	-
2.09ii - Smoking prevalence at age 15 - regular smokers (WAY survey)	2014/15	6.5		%	-	-
2.09iii - Smoking prevalence at age 15 - occasional smokers (WAY survey)	2014/15	3.0		%	-	-
2.09iv - Smoking prevalence at age 15 years - regular smokers (SDD survey)	2016			%	-	-
2.09v - Smoking prevalence at age 15 years - occasional smokers (SDD survey)	2016			%	-	-
2.10ii - Emergency Hospital Admissions for Intentional Self-Harm	2016/17	223.9		per 100,000	→	-
2.11i - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)	2016/17	54.7		%	→	-
2.11ii - Average number of portions of fruit consumed daily (adults)	2016/17	2.66		Average daily quantity	→	-
2.11iii - Average number of portions of vegetables consumed daily (adults)	2016/17	2.70		Average daily quantity	→	-
2.11iv - Proportion of the population meeting the recommended "5-a-day" at age 15	2014/15	49.6		%	-	-
2.11v - Average number of portions of fruit consumed daily at age 15 (WAY survey)	2014/15	2.45		Average daily quantity	-	-
2.11vi - Average number of portions of vegetables consumed daily at age 15 (WAY survey)	2014/15	2.25		Average daily quantity	-	-
2.12 - Percentage of adults (aged 18+) classified as overweight or obese	2016/17	63.7		%	→	-
2.13i - Percentage of physically active adults	2016/17	63.7		%	→	-
2.13ii - Percentage of physically inactive adults	2016/17	23.3		%	→	-
2.14 - Smoking Prevalence in adults - current smokers (APS)	2017	18.9		%	→	-
2.15i - Successful completion of drug treatment - opiate users	2016	5.7		%	→	↓
2.15ii - Successful completion of drug treatment - non-opiate users	2016	43.1		%	→	↑
2.15iii - Successful completion of alcohol treatment	2016	35.9		%	→	↑
2.15iv - Deaths from drug misuse	2014 - 16	5.1		per 100,000	→	-
2.16 - Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison	2016/17	38.3		%	→	-
2.17 - Estimated diabetes diagnosis rate	2017	83.7		%	→	-
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2016/17	727		per 100,000	→	-

Health improvement continued	Period	Local value		Unit	Change from prev	Recent Trend
2.19 - Cancer diagnosed at early stage (experimental statistics)	2016	50.8	☐	%	→	-
2.20i - Cancer screening coverage - breast cancer	2017	69.7	■	%	↓	↓
2.20ii - Cancer screening coverage - cervical cancer	2017	70.5	■	%	→	↓
2.20iii - Cancer screening coverage - bowel cancer	2017	55.8	■	%	→	-
2.20iv - Abdominal Aortic Aneurysm Screening - Coverage	2016/17	81.4	■	%	→	-
2.20v - Diabetic eye screening - uptake	2016/17	-		%	-	-
2.20vii - Infectious Diseases in Pregnancy Screening - HIV Coverage	2016/17	-		%	-	-
2.20viii - Infectious Diseases in Pregnancy Screening - Syphilis Coverage	2015	-		%	-	-
2.20ix - Infectious Diseases in Pregnancy Screening - Hepatitis B Coverage	2015	-		%	-	-
2.20x - Sickle Cell and Thalassaemia Screening - Coverage	2016/17	-		%	-	-
2.20xi - Newborn Blood Spot Screening - Coverage	2016/17	-		%	-	-
2.20xii - Newborn Hearing Screening - Coverage	2016/17	-		%	-	-
2.20xiii - Newborn and Infant Physical Examination Screening - Coverage	2016/17	-		%	-	-
2.22iii - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check	2013/14 - 17/18	72.0	■	%	-	-
2.22iv - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	2013/14 - 17/18	52.6	■	%	-	-
2.22v - Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check	2013/14 - 17/18	37.9	■	%	-	-
2.23i - Self-reported wellbeing - people with a low satisfaction score	2016/17	6.7	■	%	→	-
2.23ii - Self-reported wellbeing - people with a low worthwhile score	2016/17	4.4	■	%	-	-
2.23iii - Self-reported wellbeing - people with a low happiness score	2016/17	12.7	■	%	→	-
2.23iv - Self-reported wellbeing - people with a high anxiety score	2016/17	23.1	■	%	→	-
2.24i - Emergency hospital admissions due to falls in people aged 65 and over	2016/17	2031	■	per 100,000	→	-
2.24ii - Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79	2016/17	986	■	per 100,000	→	-
2.24iii - Emergency hospital admissions due to falls in people aged 65 and over - aged 80+	2016/17	5062	■	per 100,000	→	-

Health protection

	Period	Local value		Unit	Change from prev	Recent Trend
3.01 - Fraction of mortality attributable to particulate air pollution	2016	5.0	☐	%	-	-
3.02 - Chlamydia detection rate (15-24 year olds) < 1900 1900 to 2300 ≥ 2300	2017	1635	■	per 100,000	→	→
3.02 - Chlamydia detection rate (15-24 year olds) (Male)	2017	1079	☐	per 100,000	→	→
3.02 - Chlamydia detection rate (15-24 year olds) (Female)	2017	2217	☐	per 100,000	→	→
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	2016/17	100	☐	%	→	→
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2016/17	100	☐	%	→	→
3.03ii - Population vaccination coverage - BCG - areas offering universal BCG only	2016/17	- x		%	-	-
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old) < 90 90 to 95 ≥ 95	2016/17	94.1	■	%	→	↓
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old) < 90 90 to 95 ≥ 95	2016/17	95.9	■	%	→	↓
3.03iv - Population vaccination coverage - MenC < 90 90 to 95 ≥ 95	2015/16	96.6	■	%	→	-
3.03v - Population vaccination coverage - PCV < 90 90 to 95 ≥ 95	2016/17	94.0	■	%	→	↓
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old) < 90 90 to 95 ≥ 95	2016/17	93.4	■	%	↓	↓

Notes - Value Missing

Bradford

Health protection continued	Period	Local value	Unit	Change from prev	Recent Trend
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old) < 90 | 90 to 95 | ≥ 95	2016/17	95.7	%	→	↑
3.03vii - Population vaccination coverage - PCV booster < 90 | 90 to 95 | ≥ 95	2016/17	93.4	%	↓	↓
3.03viii - Population vaccination coverage - MMR for one dose (2 years old) < 90 | 90 to 95 | ≥ 95	2016/17	93.1	%	↓	↓
3.03ix - Population vaccination coverage - MMR for one dose (5 years old) < 90 | 90 to 95 | ≥ 95	2016/17	96.5	%	→	↑
3.03x - Population vaccination coverage - MMR for two doses (5 years old) < 90 | 90 to 95 | ≥ 95	2016/17	91.2	%	→	↓
3.03xii - Population vaccination coverage - HPV vaccination coverage for one dose (females 12-13 years old) < 80 | 80 to 90 | ≥ 90	2016/17	90.6	%	→	-
3.03xiii - Population vaccination coverage - PPV < 65 | 65 to 75 | ≥ 75	2016/17	74.6	%	→	↑
3.03xiv - Population vaccination coverage - Flu (aged 65+) < 75 | ≥ 75	2016/17	72.6	%	→	↓
3.03xv - Population vaccination coverage - Flu (at risk individuals) < 55 | ≥ 55	2016/17	49.6	%	↑	↓
3.03xvi - Population vaccination coverage - HPV vaccination coverage for two doses (females 13-14 years old) < 80 | 80 to 90 | ≥ 90	2016/17	89.7	%	↑	-
3.03xvii - Population vaccination coverage - Shingles vaccination coverage (70 years old) < 50 | 50 to 60 | ≥ 60	2016/17	48.0	%	↓	-
3.03xviii - Population vaccination coverage - Flu (2-4 years old) < 40 | 40 to 65 | ≥ 65	2016/17	28.3	%	→	-
3.04 - HIV late diagnosis < 25 | 25 to 50 | ≥ 50	2014 - 16	50.9	%	→	-
3.05i - Treatment completion for TB	2015	80.2	%	→	↑
3.05ii - Incidence of TB	2014 - 16	18.1	per 100,000	→	-
3.06 - NHS organisations with a board approved sustainable development management plan	2015/16	50.0	%	→	→
3.08 - Adjusted antibiotic prescribing in primary care by the NHS ≤ mean England prescribing (2013/14) | > mean England prescribing (2013/14)	2016	1.12	per STAR-PU	↓	-

Healthcare and premature mortality

	Period	Local value	Unit	Change from prev	Recent Trend
4.01 - Infant mortality	2014 - 16	5.9	per 1000	→	-
4.02 - Proportion of five year old children free from dental decay	2014/15	62.5	%	-	-
4.03 - Mortality rate from causes considered preventable	2014 - 16	213.1	per 100,000	→	-
4.04i - Under 75 mortality rate from all cardiovascular diseases	2014 - 16	102.5	per 100,000	→	-
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2014 - 16	63.1	per 100,000	→	-
4.05i - Under 75 mortality rate from cancer	2014 - 16	154.7	per 100,000	→	-
4.05ii - Under 75 mortality rate from cancer considered preventable	2014 - 16	90.1	per 100,000	→	-
4.06i - Under 75 mortality rate from liver disease	2014 - 16	18.8	per 100,000	→	-
4.06ii - Under 75 mortality rate from liver disease considered preventable	2014 - 16	16.7	per 100,000	→	-
4.07i - Under 75 mortality rate from respiratory disease	2014 - 16	51.4	per 100,000	→	-
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2014 - 16	27.9	per 100,000	→	-
4.08 - Mortality rate from a range of specified communicable diseases, including influenza	2014 - 16	9.5	per 100,000	→	-
4.09i - Excess under 75 mortality rate in adults with serious mental illness	2014/15	426.3	%	→	-
4.09ii - Proportion of adults in the population in contact with secondary mental health services	2014/15	4.8	%	↑	-

Healthcare and premature mortality continued	Period	Local value		Unit	Change from prev	Recent Trend
4.10 - Suicide rate	2014 - 16	9.2		per 100,000	→	-
4.11 - Emergency readmissions within 30 days of discharge from hospital	2011/12	12.0		%	→	-
4.12i - Preventable sight loss - age related macular degeneration (AMD)	2016/17	119.2		per 100,000	→	→
4.12ii - Preventable sight loss - glaucoma	2016/17	9.3		per 100,000	→	→
4.12iii - Preventable sight loss - diabetic eye disease	2016/17	4.1		per 100,000	→	→
4.12iv - Preventable sight loss - sight loss certifications	2016/17	44.2		per 100,000	→	→
4.13 - Health related quality of life for older people	2016/17	0.718		Score	→	-
4.14i - Hip fractures in people aged 65 and over	2016/17	611		per 100,000	→	-
4.14ii - Hip fractures in people aged 65 and over - aged 65-79	2016/17	273		per 100,000	→	-
4.14iii - Hip fractures in people aged 65 and over - aged 80+	2016/17	1588		per 100,000	→	-
4.15i - Excess winter deaths index (single year, all ages)	Aug 2015 - Jul 2016	15.0		%	→	-
4.15ii - Excess winter deaths index (single year, age 85+)	Aug 2015 - Jul 2016	5.5		%	↓	-
4.15iii - Excess winter deaths index (3 years, all ages)	Aug 2013 - Jul 2016	16.4		%	→	-
4.15iv - Excess winter deaths index (3 years, age 85+)	Aug 2013 - Jul 2016	18.6		%	→	-
4.16 - Estimated dementia diagnosis rate (aged 65+)	2017	81.3		%	-	-

≥ 66.7% (significantly) | similar to 66.7% | < 66.7% (significantly)

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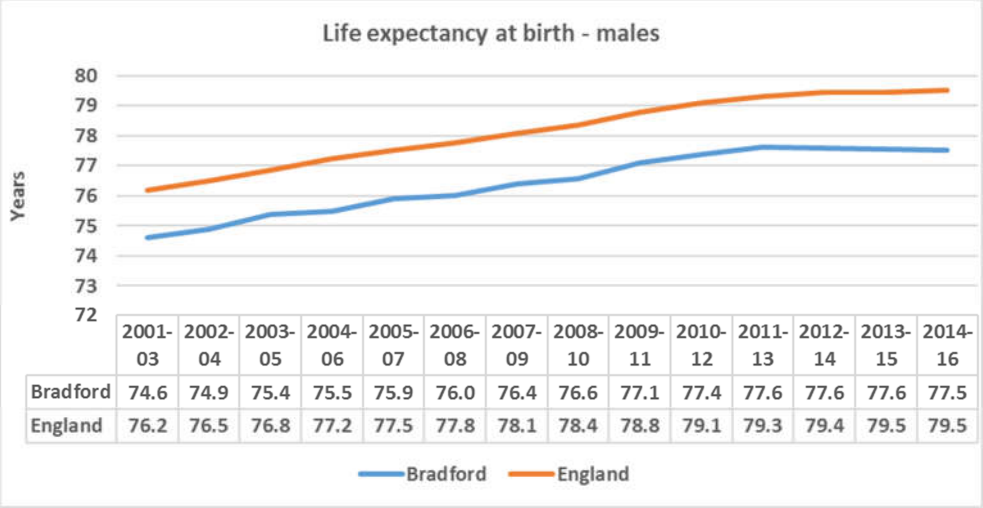
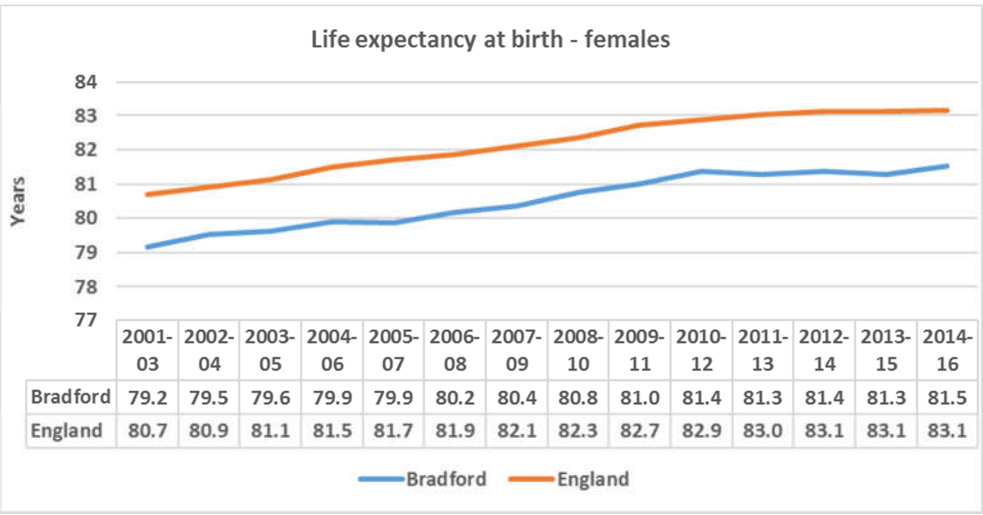
Appendix B – Charts relating to specific indicators

3.5.1 Life expectancy at birth

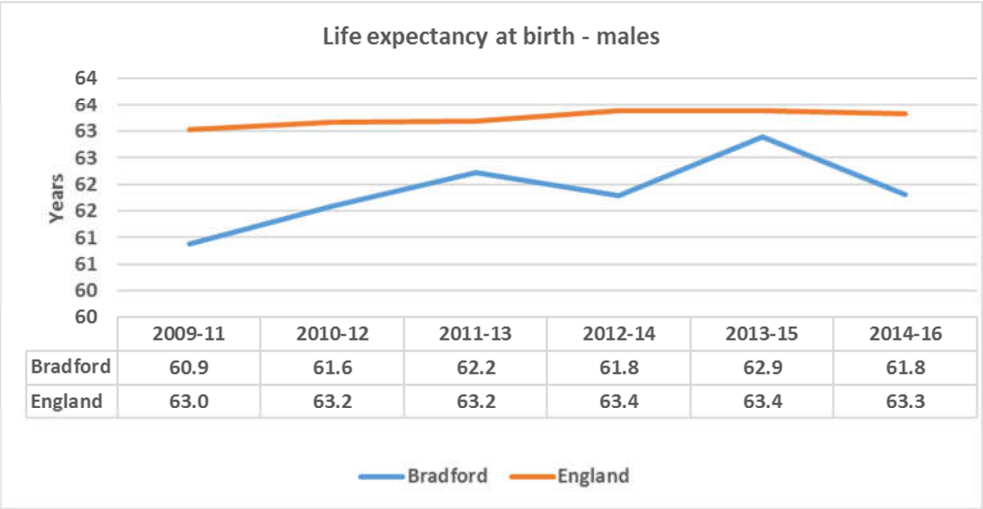


	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16
Bradford	74.6	74.9	75.4	75.5	75.9	76.0	76.4	76.6	77.1	77.4	77.6	77.6	77.6	77.5
England	76.2	76.5	76.8	77.2	77.5	77.8	78.1	78.4	78.8	79.1	79.3	79.4	79.5	79.5

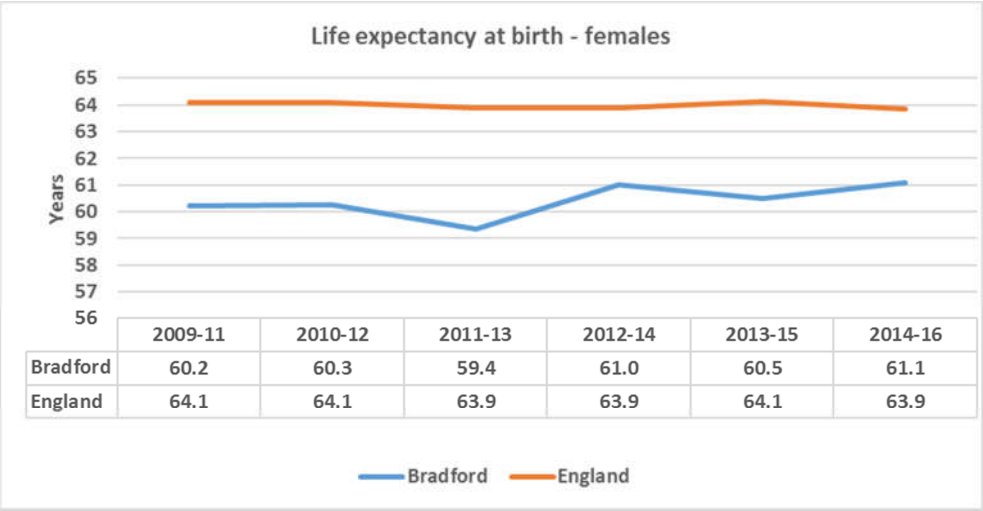


	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16
Bradford	79.2	79.5	79.6	79.9	79.9	80.2	80.4	80.8	81.0	81.4	81.3	81.4	81.3	81.5
England	80.7	80.9	81.1	81.5	81.7	81.9	82.1	82.3	82.7	82.9	83.0	83.1	83.1	83.1

3.5.2 Healthy Life expectancy at birth

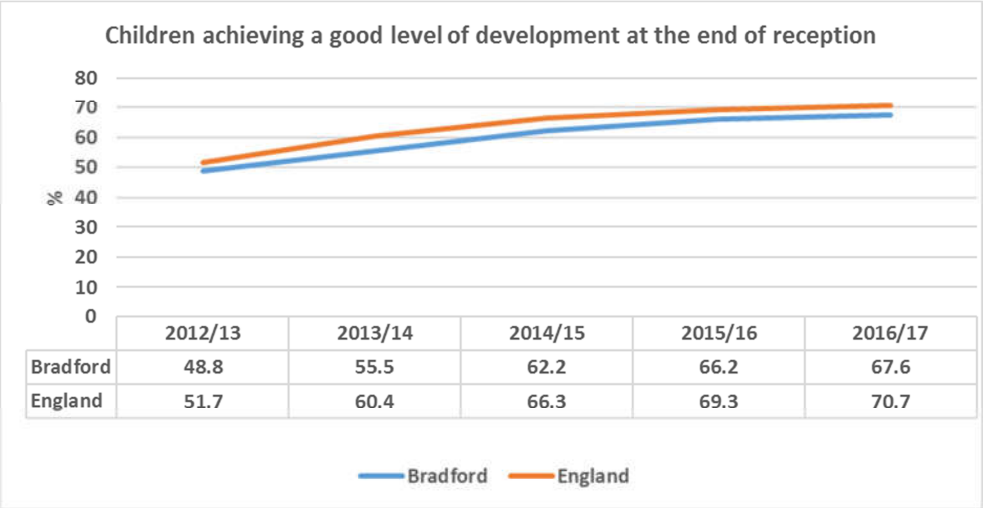


	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16
Bradford	60.9	61.6	62.2	61.8	62.9	61.8
England	63.0	63.2	63.2	63.4	63.4	63.3

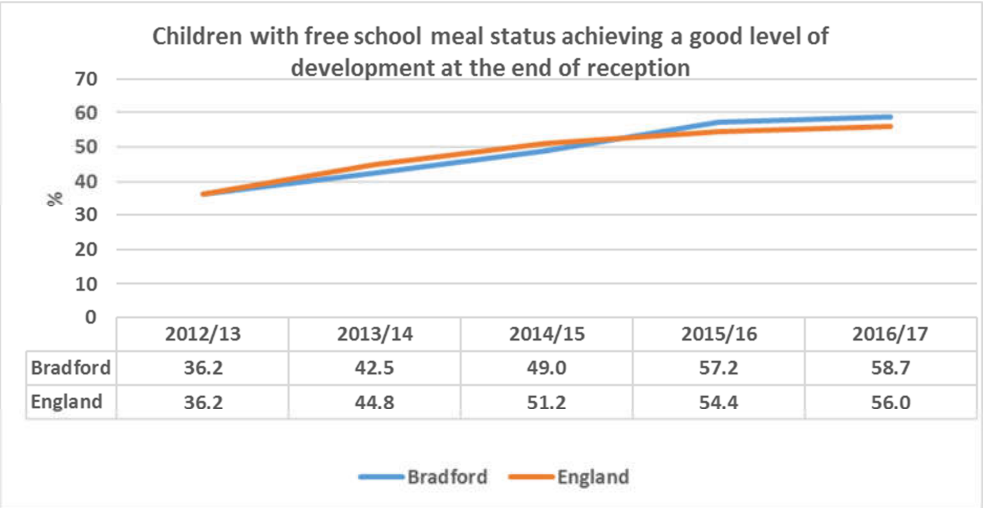


	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16
Bradford	60.2	60.3	59.4	61.0	60.5	61.1
England	64.1	64.1	63.9	63.9	64.1	63.9

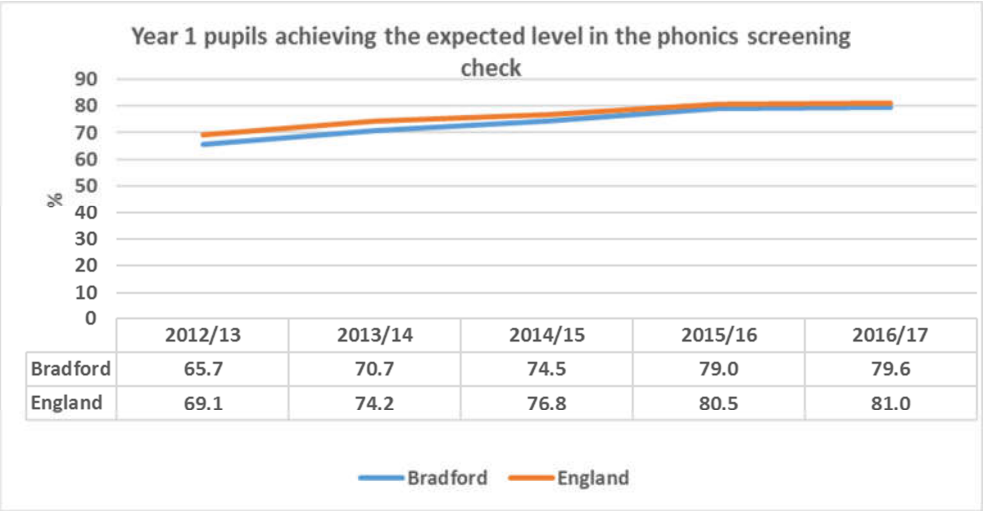
3.6.1 School readiness



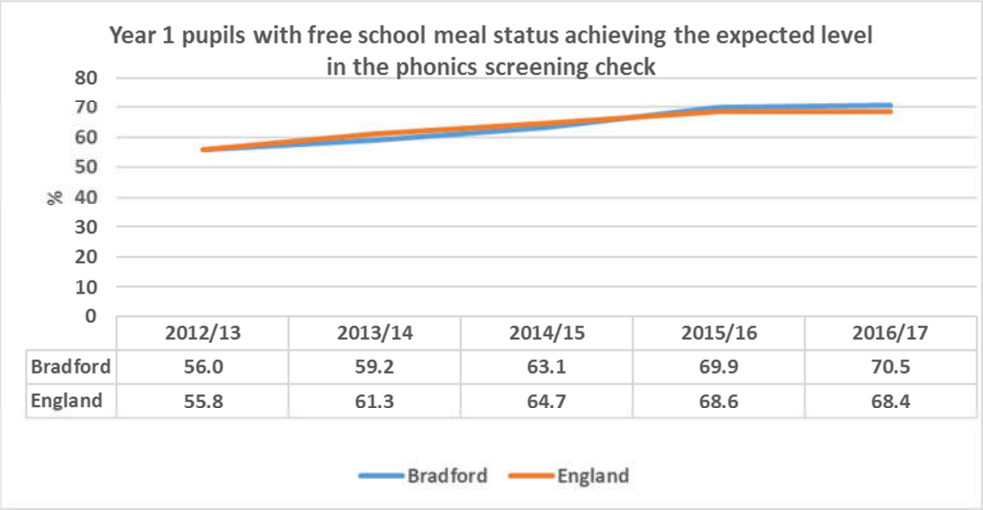
	2012/13	2013/14	2014/15	2015/16	2016/17
Bradford	48.8	55.5	62.2	66.2	67.6
England	51.7	60.4	66.3	69.3	70.7



	2012/13	2013/14	2014/15	2015/16	2016/17
Bradford	36.2	42.5	49.0	57.2	58.7
England	36.2	44.8	51.2	54.4	56.0

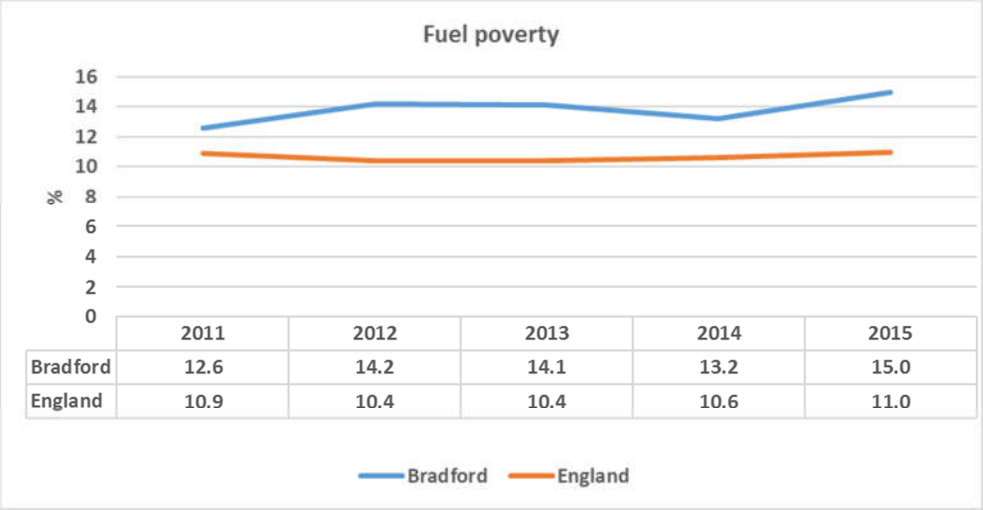


	2012/13	2013/14	2014/15	2015/16	2016/17
Bradford	65.7	70.7	74.5	79.0	79.6
England	69.1	74.2	76.8	80.5	81.0



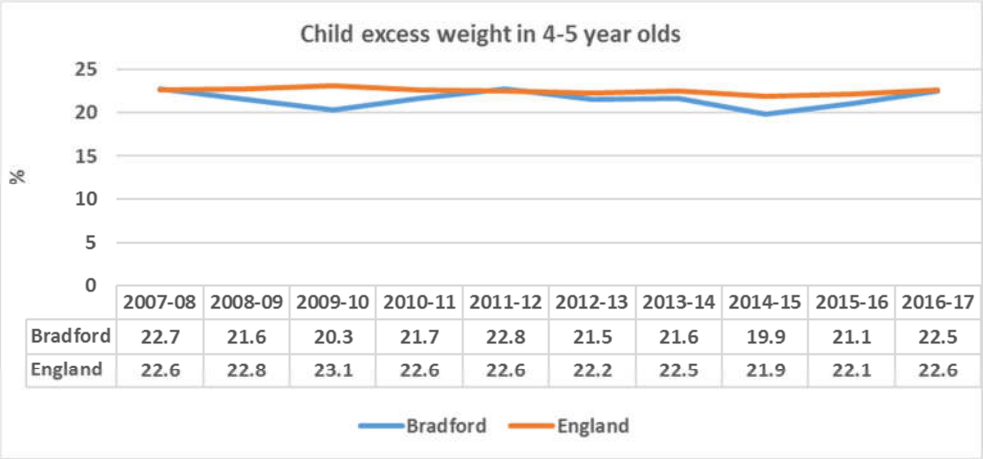
	2012/13	2013/14	2014/15	2015/16	2016/17
Bradford	56.0	59.2	63.1	69.9	70.5
England	55.8	61.3	64.7	68.6	68.4

3.6.2 Fuel poverty

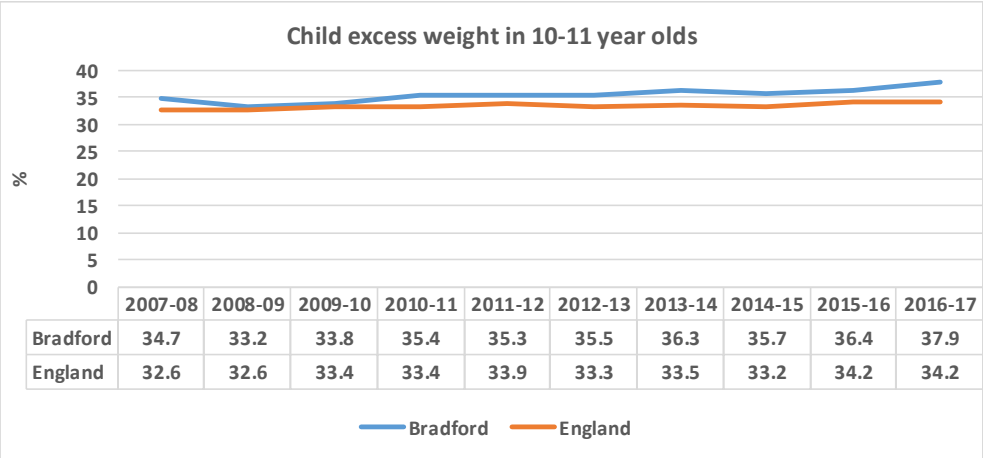


	2011	2012	2013	2014	2015
Bradford	12.6	14.2	14.1	13.2	15.0
England	10.9	10.4	10.4	10.6	11.0

3.7.1 Child excess weight

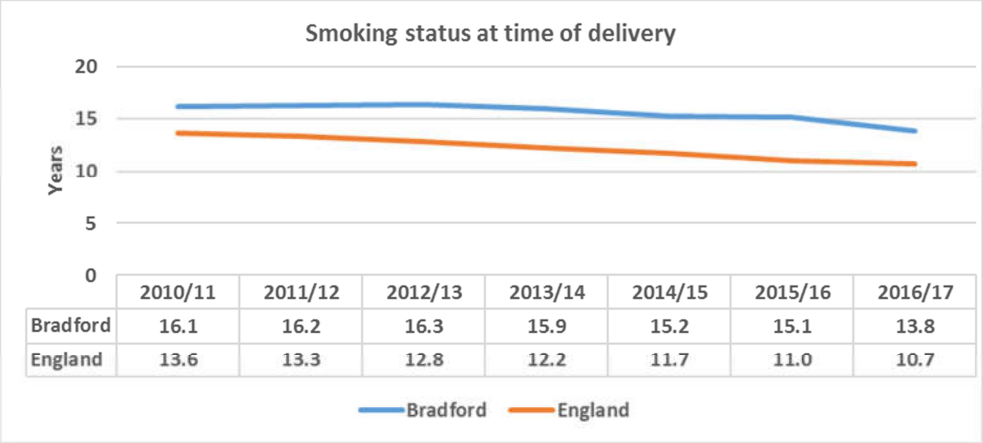


	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Bradford	22.7	21.6	20.3	21.7	22.8	21.5	21.6	19.9	21.1	22.5
England	22.6	22.8	23.1	22.6	22.6	22.2	22.5	21.9	22.1	22.6



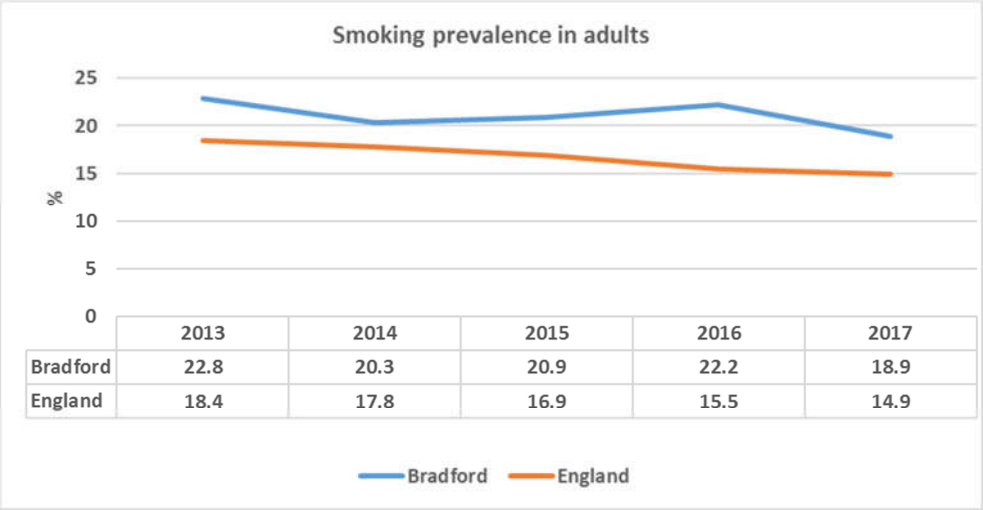
	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Bradford	34.7	33.2	33.8	35.4	35.3	35.5	36.3	35.7	36.4	37.9
England	32.6	32.6	33.4	33.4	33.9	33.3	33.5	33.2	34.2	34.2

3.7.2 **Smoking status at time of delivery**



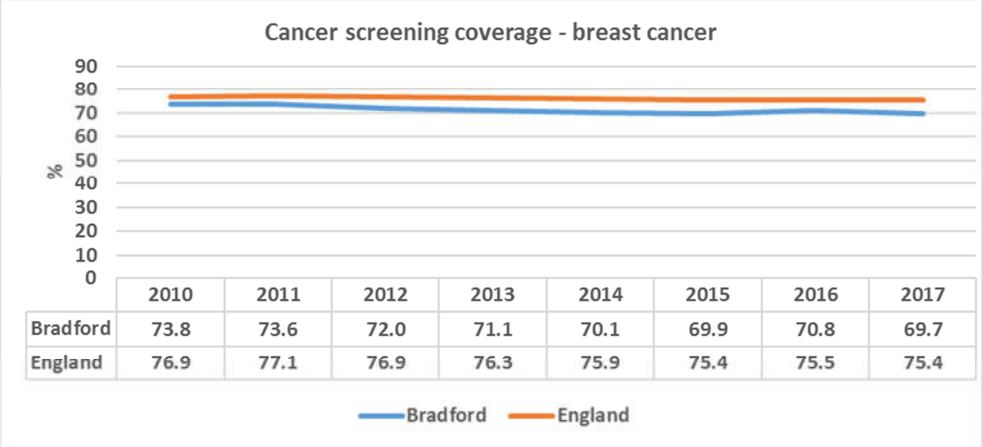
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Bradford	16.1	16.2	16.3	15.9	15.2	15.1	13.8
England	13.6	13.3	12.8	12.2	11.7	11.0	10.7

3.7.3 **Smoking prevalence in adults**

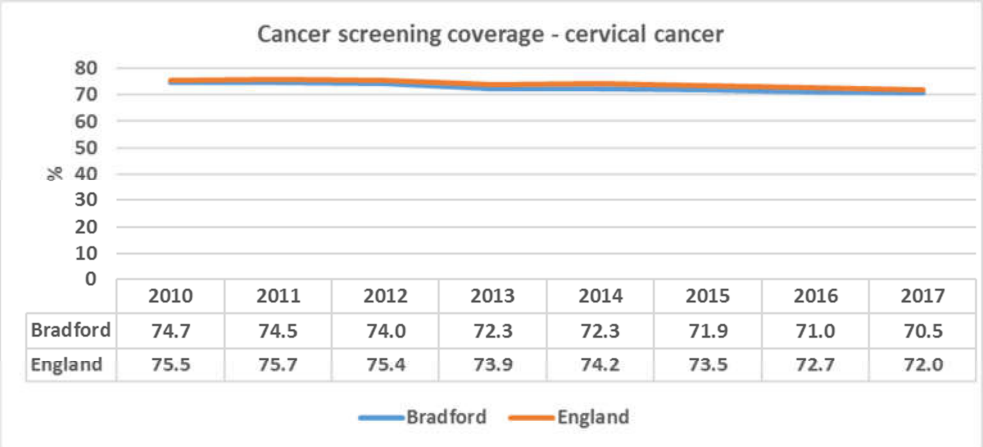


	2013	2014	2015	2016	2017
Bradford	22.8	20.3	20.9	22.2	18.9
England	18.4	17.8	16.9	15.5	14.9

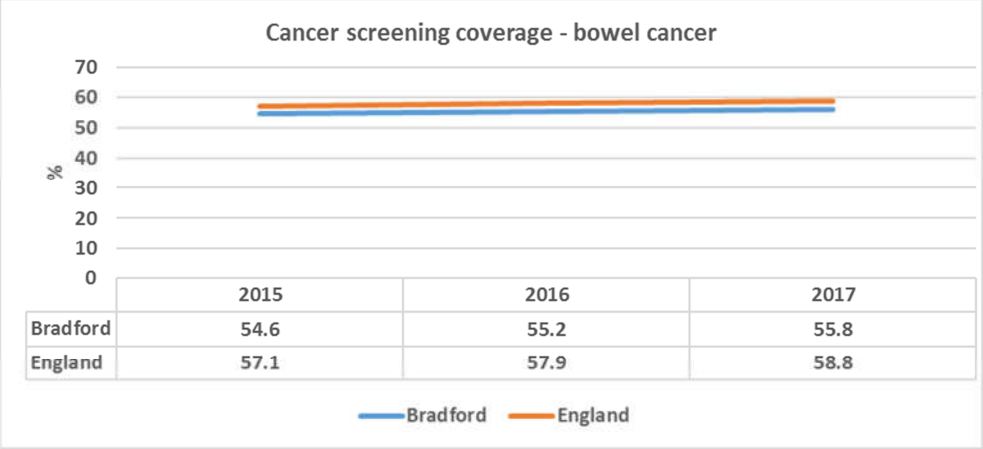
3.7.4 **Cancer Screening coverage**



	2010	2011	2012	2013	2014	2015	2016	2017
Bradford	73.8	73.6	72.0	71.1	70.1	69.9	70.8	69.7
England	76.9	77.1	76.9	76.3	75.9	75.4	75.5	75.4

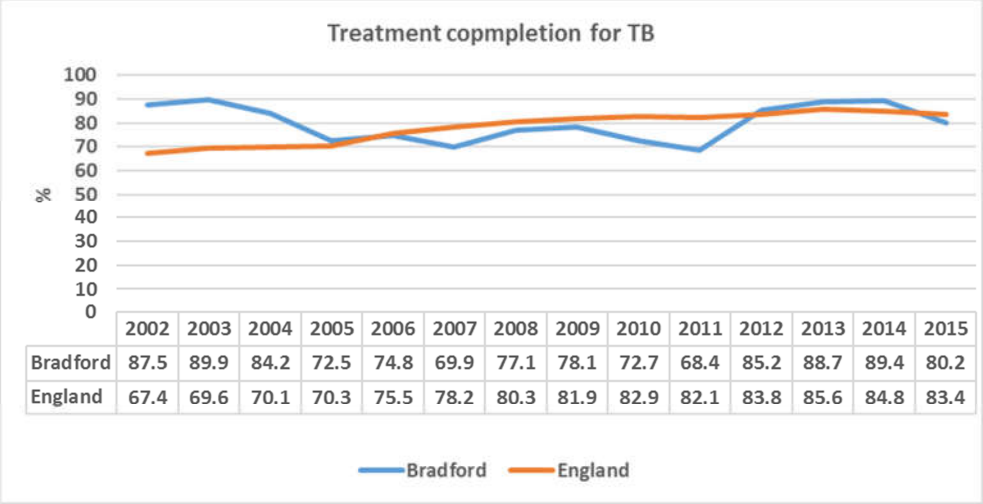


	2010	2011	2012	2013	2014	2015	2016	2017
Bradford	74.7	74.5	74.0	72.3	72.3	71.9	71.0	70.5
England	75.5	75.7	75.4	73.9	74.2	73.5	72.7	72.0

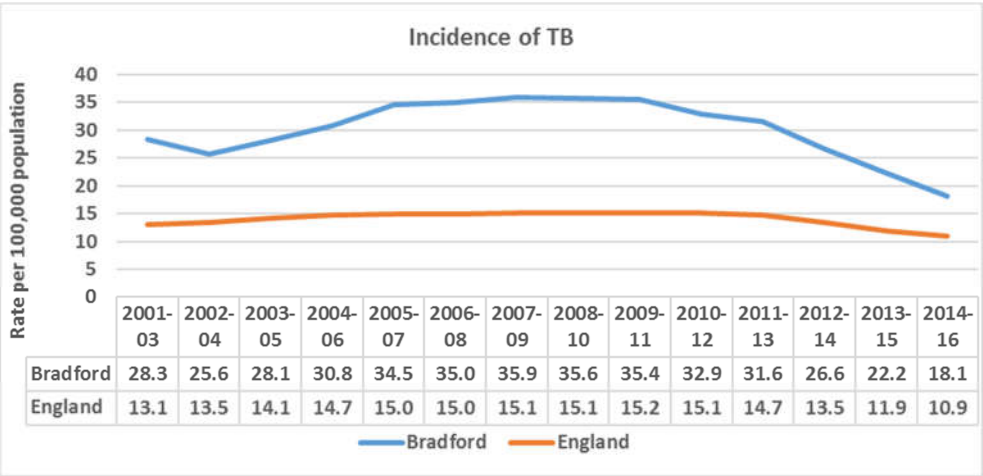


	2015	2016	2017
Bradford	54.6	55.2	55.8
England	57.1	57.9	58.8

3.8.1 **Tuberculosis**

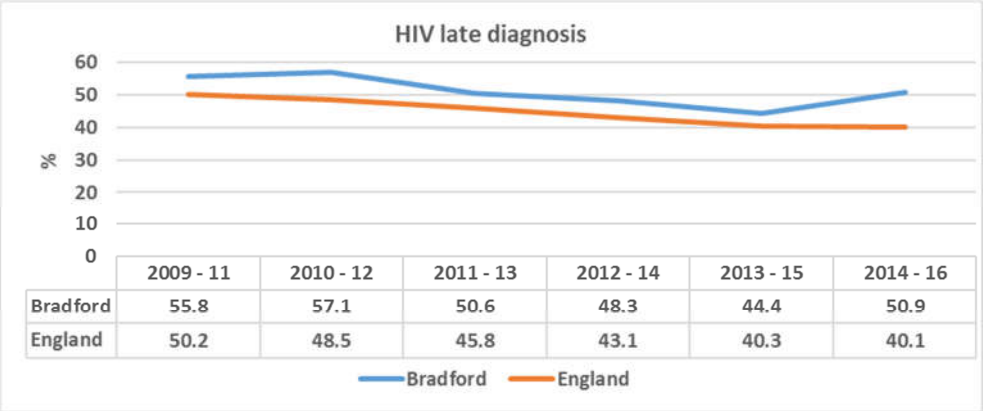


	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Bradford	87.5	89.9	84.2	72.5	74.8	69.9	77.1	78.1	72.7	68.4	85.2	88.7	89.4	80.2
England	67.4	69.6	70.1	70.3	75.5	78.2	80.3	81.9	82.9	82.1	83.8	85.6	84.8	83.4



	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16
Bradford	28.3	25.6	28.1	30.8	34.5	35.0	35.9	35.6	35.4	32.9	31.6	26.6	22.2	18.1
England	13.1	13.5	14.1	14.7	15.0	15.0	15.1	15.1	15.2	15.1	14.7	13.5	11.9	10.9

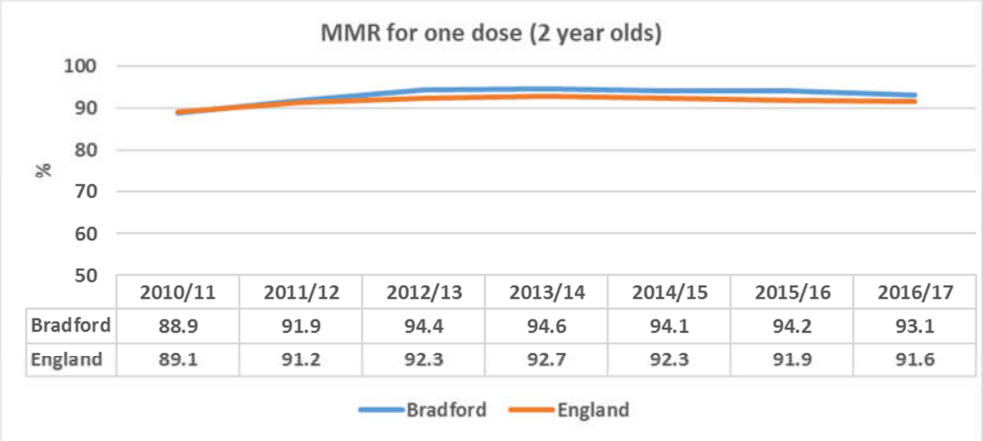
3.8.2 **HIV late diagnosis**



	2009 - 11	2010 - 12	2011 - 13	2012 - 14	2013 - 15	2014 - 16
Bradford	55.8	57.1	50.6	48.3	44.4	50.9
England	50.2	48.5	45.8	43.1	40.3	40.1

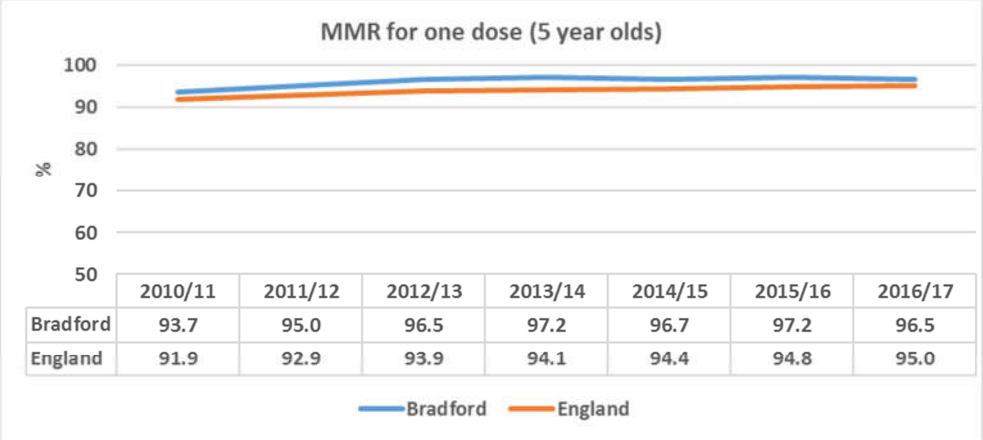
Bradford England

3.8.3 **Measles, mumps and rubella (MMR) vaccination**



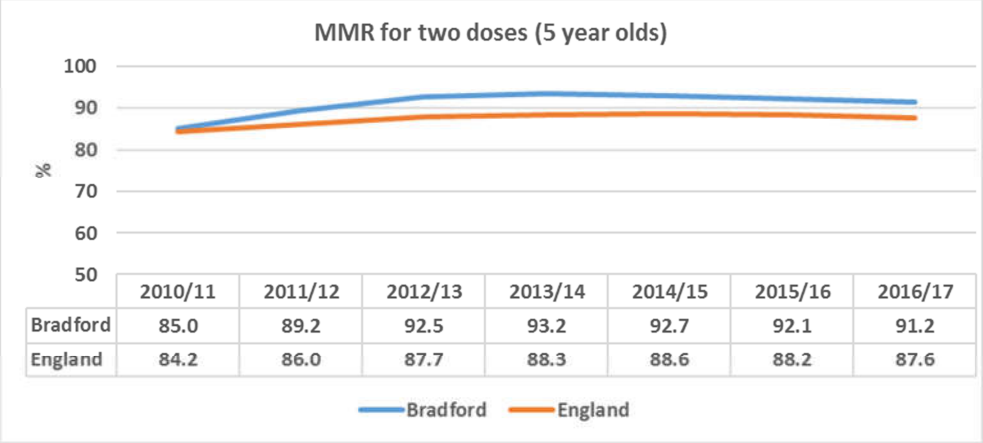
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Bradford	88.9	91.9	94.4	94.6	94.1	94.2	93.1
England	89.1	91.2	92.3	92.7	92.3	91.9	91.6

Bradford England



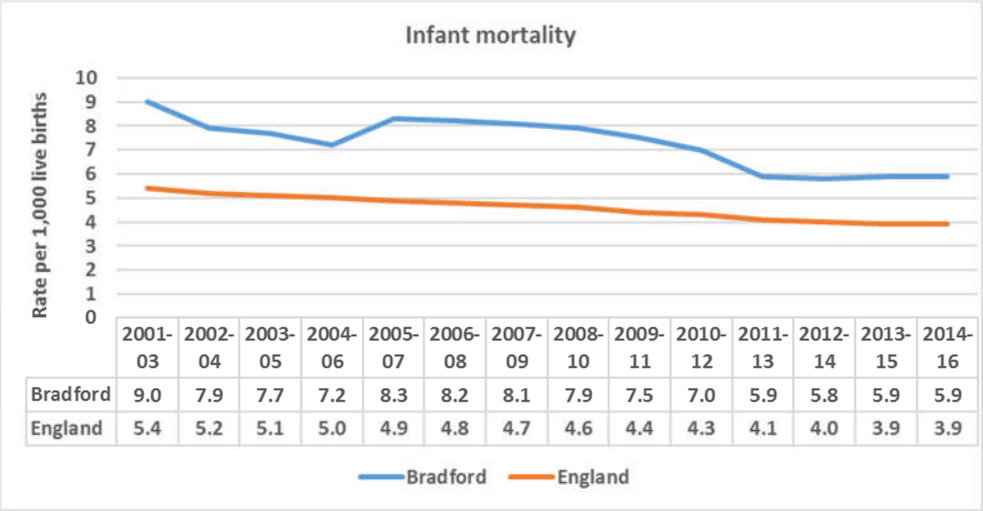
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Bradford	93.7	95.0	96.5	97.2	96.7	97.2	96.5
England	91.9	92.9	93.9	94.1	94.4	94.8	95.0

Bradford England



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Bradford	85.0	89.2	92.5	93.2	92.7	92.1	91.2
England	84.2	86.0	87.7	88.3	88.6	88.2	87.6

3.9.1 **Infant mortality**



	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16
Bradford	9.0	7.9	7.7	7.2	8.3	8.2	8.1	7.9	7.5	7.0	5.9	5.8	5.9	5.9
England	5.4	5.2	5.1	5.0	4.9	4.8	4.7	4.6	4.4	4.3	4.1	4.0	3.9	3.9

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Strategic Director of Health and Wellbeing to the meeting of Health and Social Care Overview and Scrutiny Committee to be held on 6th September 2018

H

Subject:

Safeguarding Adults at Risk of Abuse

Summary statement:

This report provides Scrutiny Committee Members with details about Bradford's Councils Health and wellbeing Departments safeguarding activities since the previous report in November 2017.

Bev Maybury
Strategic Director, Department of Health and Wellbeing

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Portfolio:

Healthy People and Places

Overview & Scrutiny Area:

Health and Social Care

1 SUMMARY

1.1 The Care Act 2014 sets out a clear legal framework for how local authorities should support and protect adults at risk of abuse or neglect. Bradford Council has a number of statutory safeguarding duties arising from the Care Act which the Council has continued to implement through changes to the structure and operating process in relation to safeguarding adults at risk of abuse including the provision of advocacy support.

1.2 The aims of the continued development of the Safeguarding Adults Team (SAT) is to provide a robust system for dealing with the increased numbers of concerns being raised whilst promoting the principles of 'Making Safeguarding Personal (MSP) to ensure that work with adults at risk remains outcome focused and person centred. Whilst ensuring key safeguarding principles of empowerment, prevention, protection, accountability, partnerships and proportionality are promoted.

2. BACKGROUND

2.1 The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should support and protect adults at risk of abuse or neglect. Bradford Council has a number of safeguarding duties arising from the Care Act including;

- Leading a multi-agency local adult safeguarding system that seeks to prevent abuse and neglect and stop it quickly when it happens
- making enquiries, or requesting other to make them, when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed
- establishing Safeguarding Adults Boards (SAB's), including the local authority, NHS and the Police, which will share, develop and implement a safeguarding strategy
- carry out Safeguarding Adults Reviews when someone with care and support needs dies and abuse or neglect is known or suspected, and there is a concern about how the local authority and its partners worked together to protect them, and establishing lessons learned
- arranging for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry or review, if required.

2.2 During the periods 17/18 and 18/19 Bradford Council have continued to review and evaluate the effectiveness of the changes being implemented as part of the Care Act responsibilities.

3. REPORT ISSUES

3.1 The purpose of this report is to provide information and assurance to elected members of the continued development of the Safeguarding Adults Service in Bradford. This is to ensure that Adults at Risk in Bradford receive a high quality, safe and effective service which promotes their health and wellbeing, whilst working with them to uphold their rights to live a life as independent as possible, and supporting them to make their own decisions and choices and remain in control of their lives, safe, happy and healthy.

3.2 Development work in terms of performance data and collection continues, including a focus on achieving qualitative, subjective data. This is fundamental for the continued development for safeguarding adults in Bradford including the need to gain feedback from adults that have experienced abuse or neglect; this promotes developing a personalised response for adults affected or experiencing abuse. This work is being undertaken by the 'Voice'- user sub group of the Safeguarding Adults Board

3.3 Safeguarding Adults Concerns (SAC) data for the period 17/18 has demonstrated a significant increase on the numbers of safeguarding concerns received with an increase of 57 % from 3064 in 16/17 to 4815 in 17/18. Previously only 20% of concerns indicated further enquiries where undertaken, in comparison to regional variations of between 37% and 100%. This has increased in Bradford in the period 17/18 to a conversion of 61%. This suggests that more enquiries are being made in response to concerns raised about Adults at Risk (AAR) in Bradford.

3.4 The increase, both on amount of concerns raised and the increased enquiries undertaken has significant resource implications to meet the increased demand. A business case is being completed to consider the necessary resources for the future sustainability of the safeguarding service in Bradford.

3.5 The regional Safeguarding Multi-Agency Policy and Procedures underwent a substantial review in 2017 completed by the 7 Safeguarding Adults Boards working together; Bradford, Calderdale, Kirklees, Leeds, York, Wakefield and North Yorkshire. On April 2nd 2018 the new revised regional Joint Multi-Agency Safeguarding Adults Policy and Procedures West Yorkshire, North Yorkshire and York were launched and are being implemented over the period 17/18.

3.6 A summary of the key changes of the new procedures is the move from a 7 stage process to a 4 stage process. This was to strengthen policy and update linked agendas. To move away from process driven practice and develop a simpler person centred approach; focussing on outcomes, the 6 key principles of safeguarding further embedding making safeguarding personal throughout safeguarding adults practice.

3.7 **Multi Agency Safeguarding Hub (MASH)**

Background

3.8 Bradford MASH was set up following a research project commissioned by the Bradford Safeguarding Adults Board (SAB). The research project identified a MASH model as best practice and process for working together to safeguard Adults at Risk in Bradford District. The aim of a MASH was to increase information-sharing, enhance partnership working and provision of an effective and efficient service for adults at risk of abuse across the District.

3.9 An adult MASH would bring significant benefits to those adults experiencing abuse and the wider community, who could access adult safeguarding services via one location. The unit should deliver a holistic service, providing support where appropriate or signposting to an alternative provider when more suitable.

3.10 A team of managers from West Yorkshire Police, Bradford CCGs and the Local Authority, worked together to produce the proposals in this report. The Project was led by Senior Managers from the three organisations, which provided direction and

strategic oversight.

3.11 Research

In formulating the MASH proposals research was conducted by the team, and key stakeholders consulted wherever possible. Time was spent working with staff in the Local Authority; in the Safeguarding Adults Unit, the Access Team and Area Social Care Teams. Wider discussion was held with the Vulnerable Adults Coordinators in the Police and Safeguarding Adult teams across the health economy.

3.12 Research has also been undertaken with the College of Policing, the Social Care Institute for Excellence (SCIE) and the Police Online Knowledge Area (POLKA), alongside a general internet search for MASH's across the United Kingdom. The predominant response to this fact-finding was that there is no national guidance on Adult MASH structures/process and that local arrangements vary widely, with some examples of good practice identified.

3.13 Conversations were held with Nottingham MASH and a visit undertaken to Leeds MASH. This provided an overview of potential structures and examples of good practice.

3.14 Challenges

Through the above consultation and observations a number of challenges have become apparent in determining the best way to receive, identify and deal with concerns around the safeguarding of Adults at Risk (AARs).

- Understanding and clarity of roles and responsibilities within and across organisations, including identifying where the decision-making sits at each stage and by whom.
- What the remit of a MASH is.
- Lack of joint action at early stages of a concern being raised.
- Staffing skill mix and numbers of staff in SAU.
- Communication between agencies; who to go to, timeframes, delays, reliance on goodwill/known contacts.
- Lack of a robust, comprehensive and informative concern submitted, particularly when raised by a partner agency/professional.
- Inconsistent or lack of feedback to referrers following concerns being raised.
- Reduced number of concerns being raised.
- Decision making / risk assessment without access to full information.
- IT System Issues (systems not able to 'talk' to each other and sharing and access rights)

3.15 In considering some of the challenges above it was viewed by the team that the implementation of a MASH would enable a thorough review of roles and responsibilities in accordance with the Multi-Agency Safeguarding Adult Procedures and provide clarity for all partner agencies.

3.16 The opportunity to identify a clear remit of the MASH and realistic expectations would enable the Multi-Agency procedures to be fully implemented, adhered to and outcomes measured, particularly in relation to Making Safeguarding Personal. It is proposed that the MASH would receive concerns about the wider safeguarding issues and, in accordance with the proposed model, respond accordingly.

3.17 A more robust risk assessment process and the opportunity to discuss safeguarding adult concerns will further support practitioners to develop confidence in raising a concern and responding to a concern in a proportionate and timely manner, always considering the Adult at Risk.

3.18 An on-going issue is the lack of 'talking' between IT service user record systems. During the scoping exercise it was identified that there are a wide range of systems used by agencies, with some organisations having a number of internal IT systems in addition to SystmOne, which the LA now use. It is noted that the issue of sharing and access rights across SystmOne are currently being discussed at a senior strategic level.

3.19 Model of implementation agreed

From the original research project plan Model 1B was implemented in October 2017.3.20 This model reflects the basic role of a MASH in facilitating information-sharing and risk assessment when a concern about an Adult at Risk is raised and submitted. It envisages a basic structure of an assessment hub, through which all safeguarding concerns are properly risk-assessed using information from the Local Authority, Police and Health agencies. These are provided expeditiously and a joint decision made on the priority level of the concern.

3.20 • *Incoming Concerns*

All adult safeguarding concerns are directed into the Local Authority via the safeguarding adults Team. This is intended to cut down on barriers to reporting adult safeguarding concerns, and make it as simple as possible for members of the public and Adults at Risk themselves to report abuse.

3.21 Professionals from key partner agencies who are raising concerns would be expected to adhere to their organisation's safeguarding adult's policy and procedures, and still be encouraged to complete an online form to raise a concern, which is available via the Local Authority website and accessible by all.

3.22• *Daily MASH Meeting*

On a daily basis, the MASH administrator would compile all SG Concerns received in the last 24 hours. These would be logged on SystmOne and disseminated to each agency representative in the MASH first thing in the morning. Reps would be responsible for researching all relevant information from their own organisations and bring/feed this into the daily meeting. The administrator would also contact designated Safeguarding Leads in outside agencies, particularly 3rd sector, requesting them to feed back any relevant information by a specified time.

3.23The meeting itself would be chaired by each of the representatives on a rotating basis, and all discussions and actions recorded in the minutes by the administrator. Based on the full information picture, the daily MASH meeting would identify whether the concern is a Response A, B or C in accordance with the previous Multi-Agency West and North Yorkshire and York Safeguarding Adult procedures.

3.24These options include;

- Issues resolved by initial enquiries or adult has declined further action (Response A in the previous Multi-Agency West and North Yorkshire Safeguarding Adult Procedures).

- Multi-Agency information shared with the allocated Social Worker if this is already an open case to Adult Social Care.

- Risk Management Response (currently Response B), when s42 criteria are met but the MASH is satisfied that a sufficient protection plan is already in place. In these cases, the MASH representative would still discuss if there are any additional measures that could be implemented to safeguard the AAR.

- A formal enquiry is needed to establish the facts and how to safeguard the adult (or others) and the concern will be taken through safeguarding procedures for a strategy meeting via Tier 2 of the MASH (currently Response C).

3.25 At a minimum, each verified Safeguarding Concern would be risk assessed, identify an immediate protection plan in partnership with the AAR and relevant others involved, and rationale recorded as to whether this case is being escalated to a Formal Enquiry or not. All parties who have submitted concerns, will receive feedback to inform them that the case has been discussed in a Multi-Agency setting. Any further disclosures on the outcomes of the discussion will depend on the referrer, i.e. professional or member of the public. Professionals would be provided with clarity on the actions agreed, and also the expectations on them to continue to monitor and safeguard the AAR. This both provides reassurance but also precludes any risk of confusion that professionals may feel that their responsibilities are relinquished by making the referral.

3.26 • *Domestic Abuse*
The MASH would be a daily recipient of the Daily Risk Assessment Meeting (DRAM) document, which is sent to partners each weekday before 9am. This outlines brief details of all High Risk Domestic Abuse incidents in the last 24 hours. The MASH Administrator/s would check the document for any cases relevant to Adult Safeguarding and feedback any relevant information. If there are safeguarding concerns for the adult, a MASH representative would dial into the DRAM video conference – this would form part of the Strategy Discussion outlined below.

3.27 The MASH would also obtain a Login authority for the online MARAC portal, so that similar checks can be conducted for all MARAC cases. Where Adults at Risk are discussed at MARAC, the MASH would send a representative to the MARAC, ideally a Safeguarding Coordinator from the SAU.

3.28 Conversely, when Domestic Abuse issues are identified in a safeguarding concern, the police representative would check if these matters were already known to the police. If not, they would be fed in, either through the DRAM/MARAC if deemed High Risk, or to the Domestic Abuse Unit if Medium/Standard Risk. Referrals to specialist DA support services would also be considered as part of the protection plan for the Adult at Risk. These measures would ensure far better information sharing between the worlds of adult safeguarding and domestic abuse, and allow more informed risk assessment and action-planning.

• *Advantages*
- Simplified entry route for all concerns, encouraging more concerns to be raised, particularly from members of the public and AARs themselves.
- Immediate/timely information-sharing, allowing decisions to be made with all available

information
- Formalised risk-assessment, prioritising those adults most at risk
- Accountability through recorded rationale and feedback to referrers
- Joint responsibility for decision-making between agencies
- Enhanced information packages provided to Social Work Teams, who are allocated cases for Formal Enquiries

3.29 Evaluation A recent review of this process has been undertaken by both Adult Social Care and the Police.

3.30 From an Adult Social Care perspective it has been identified that the increased volume of work has impacted significantly on the resources deployed within MASH. The effect of this is that an increased amount of work has had to be sent out to other teams for the risk assessment and response to be undertaken. This is contradictory to the principles of setting up the MASH as sufficient resource has not been available to respond as timely as anticipated in at the outset.

3.31 Also recent business process mapping has indicated a disparity between the policy and procedures and social work practice in Bradford for safeguarding adults. This is now being addressed with a service improvement plan which considers the training needs of staff within Adults Social Care, system development for effective information sharing and also roles and responsibilities across all partner agencies.

3.32 Given the significant increase in Care Act (CA) section 42 enquiries being undertaken Adult Social Care proposes an increase in staff resources to be able to complete the relevant enquiries whilst ensuring responses are person centred and outcome focused as part of 'Making Safeguarding Personal'. Staff training will also be on-going to ensure staff have sufficient knowledge and skills to respond effectively to concerns that are being raised. Quality audits will be undertaken at regular intervals to ensure a continuous learning and improvement approach is implemented.

3.33 Currently work is being undertaken to supplement the current data collection systems that are in place, following a gap analysis being undertaken. Once implemented a more robust system will allow further analysis of information coming through to safeguarding which is hoped to further inform training and development and resource allocations.

3.34West Yorkshire Police have also completed a review of the MASH model. Currently strategic meeting are being undertaken to consider the effectiveness of the model and an evaluation as to what other work is needed to improve the service delivery and customer journey.

3.**35The Safeguarding Adults Board (SAB), continued development work- Joint Partnership working with Children's and Community Safety Partnership Boards- shared resources across linked agendas.**

Joint Communications and Engagement Group.

This group now includes representatives from Children's, Adults and Community Safety partnership Boards. The group have recently developed a joint communication

strategy. It is intended to produce a user friendly version for service users and the general public. The group have also formulated a timeline and will commence work to develop a proactive, innovative and consistent approach to communications going forward.

3.36 Serious Case Reviews

Collectively there is much more collaboration between Boards in relation to the 3 groups that deal with case reviews. The Bradford Strategic Children's Board (BSCB) Case Review sub-group will be leading on a shared knowledge library. Safeguarding Adults Reviews (SAR), Serious Case Reviews (SCR) and Domestic Homicide Reviews (DHR) often produce similar learning points. This will look at previous learning and how agencies have responded and improved with a view to retaining some organisational memory. It is hoped that this library will allow the groups to access similar learning and assess if necessary changes have been implemented and to identify "what works" for spec if actions.

3.37 Joint development day

The BSCB held a development day in June, with representation from the SAB and CSP, focussing upon complex Safeguarding. The day allowed the audience to develop an understanding and awareness around such topics as criminal exploitation, Modern day Slavery and Organised Crime Groups. Discussion led to a definition of complex safeguarding and number of areas that Bradford should progress to support vulnerable people and communities. A task and finish group from all 3 Boards will progress this agenda.

3.38 **Strategic plan –Safeguarding Adults Board**

The Safeguarding Adults Board (SAB) has a statutory responsibility to complete a strategic plan. The Board is in the process of collating its three year strategic plan. The plan is a culmination of information, discussions and deliberations obtained by engaging with people, professionals and community groups within Bradford.

3.39 The SAB has only recently appointed a new chair (June 2018). Although the strategic plan has been in progress over the period February to June 2018, a recent meeting of SAB partners it has been recommended that some further priorities may need to be included. Therefore in addition to the plan attached it is suggested that other priorities are included.

3.40 The priorities that will be added to the plan include working with adults with complex needs, review of working practice as part of the transitions from children's into adults.

3.41 Consultation of public, professions and community groups were sought over a four week period in July 2018. The feedback was very positive from the consultation with an agreement on the Safeguarding Boards vision of 89% and 96% respectively of survey respondents and easy read version.

3.42 The first priority regarding making safeguarding personal was also highly rated with a response of 98% agreement to this priority. Similar responses where indicated in both surveys when asked about priority areas and how we plan to achieve the priorities. The mean response was 95%.

See draft strategic plan in Appendices

3.43 Safeguarding Adult Reviews (SAR's)

The Safeguarding Adults Board (SAB) has a statutory responsibility under section 44 of the Care Act to undertake a Safeguarding Adults Review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, where the adult has died, and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died). Or in the case that the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

3.44 Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to identifying the lessons to be learnt from the adult's case, and applying those lessons to future cases.

3.45 During the period April 2017 to March 2018, two SAR's were complete. Of the SAR's completed, one was an independent joint SAR/Mental Health Review which identified lessons learned from 20 recommendations, these included the practice of a local provider and local and national commissioning arrangements. At this stage, the Safeguarding Adults Board continues to monitor the recommendations to be assured that lessons continue to be learned both by the provider and that commissioners are accountable for commissioning arrangements locally and nationally, especially in the circumstances that Adults at Risk are moved out of area.

3.46 The second SAR considered the circumstances where an adult at risk experienced neglect whilst he was being cared for in a local care home. The lessons learned in this case focused on professional learning and development regarding the Mental Capacity Act 2005,

3.47 A further SAR has commenced in the period 2017-2018. This SAR is being undertaken by an Independent author and is in its final review stage, professional feedback/scrutiny. This should be concluded in October 2018.

4. FINANCIAL & RESOURCE APPRAISAL

4.1 The Department continues to significantly invest in the safeguarding service within Bradford, which has been under resourced in previous years.

4.2 A business plan to fully staff the department to safe levels is currently being proposed

and is proposing that there will be an additional cost of £906k. This will be the subject of a report which will go to the Executive in the very near future.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

5.1 The safeguarding service needs to be resourced sufficiently to ensure appropriate responses are made when allegations of abuse are raised. Without sufficient resource there remains a risk that adults at risk in Bradford will not receive the support, advice or guidance as needed, to safeguard them from harm and abuse and that the local authority will breach its Care Act statutory responsibilities towards AAR in Bradford.

5.2 Within the safeguarding team there was previously a backlog of 1000 cases for the period 2014-2017, concerns raised where not addressed sufficiently by the then under resourced service. The backlog was addressed by using additional resources; unfortunately the impact of this was a further overspend in the Department. Extensive work has been undertaken to mitigate the risk of this reoccurrence and the future resourcing of the Safeguarding service is paramount to mitigating this risk. Additional resources allowed for further scrutiny of concerns raised over a 5 year period, to ensure no adults at risk were left in unsafe situations as a result of the backlog.

5.3 The resourcing of the safeguarding adult's team is now to a maximum, this allows for the effective screen and triage of all concerns coming through to Adult Care. Development continues

6. LEGAL APPRAISAL

The Council's legal obligations relating to safeguarding are set out in Sections 42-47 of the Care Act 2014. It must make enquiries and then decide whether any action should be taken when it has reasonable cause to suspect that an adult in its area:

i. needs care and support, or
ii. is experiencing, or is at risk of, abuse or neglect, and is unable to protect himself or herself

In this context "abuse" includes having money or other property stolen, being put under pressure in relation to money or other property, and having money or other property misused.

It must also establish a Safeguarding Adults Board (an "SAB") for its area to help and protect adults in its area. The SAB must achieve this objective is by coordinating and ensuring the effectiveness of what each of its members does.

The SAB must arrange for a Safeguarding Adult Review of any case involving an adult in its area with needs for care and support where there is reasonable cause for concern about how the safeguarding authorities worked together to safeguard the adult.

Schedule 2 of the Care Act also requires the SAB to provide an annual report and submit it to the Chair of the Health and wellbeing Board. The report must set out:

(a) what it has done during that year to achieve its objective,

(b) what it has done during that year to implement its strategy,

(c) what each member has done during that year to implement the strategy,

(d) the findings of the SAR's arranged by it which have concluded in that year (whether or not they began in that year),

(e) the SAR's arranged by it under that section which are ongoing at the end of that year (whether or not they began in that year),

(f) what it has done during that year to implement the findings of reviews arranged by it under that section, and

(g) where it decides during that year not to implement a finding of a review arranged by it under that section, the reasons for its decision.

Legal appraisal of this report was sought on 22nd August 2018.

The safeguarding role of the Council is complex, multi-faceted, and potentially applies during all of its interactions with the public. It is required to make arrangements to be kept informed about the safety of any adult's at risk within its area, to investigate and then make any necessary assessments of actual or potential risk or harm to such individuals; and to arrange any necessary protection. Legal advice has been sought in relation to al aspects of the role. The backlog of safeguarding cases referred to earlier in this report has also been the subject of frequent review, and legal advice has been sought as and when required.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

7.2 SUSTAINABILITY IMPLICATIONS

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

7.4 COMMUNITY SAFETY IMPLICATIONS

7.5 HUMAN RIGHTS ACT

Consideration to the impact of any service changes will always take into account the local authority's legal obligation in regards to the relevant articles within the Human Right Act 1998.

7.6 TRADE UNION

7.7 WARD IMPLICATIONS

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

7.9 IMPLICATIONS FOR CORPORATE PARENTING

7.10 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

8. NOT FOR PUBLICATION DOCUMENTS

9. OPTIONS

10. RECOMMENDATIONS

- That the contents within the report are noted.
- Request for any further comments or considerations from elected members.

11 APPENDICES

- Draft Strategic plan 2018-2021

12. BACKGROUND DOCUMENTS

Bradford Safeguarding Adults Board Vision

Working together to safeguard people's right to live fulfilling lives feeling safe, healthy and happy - FREE from abuse and neglect

Who we are

The Safeguarding Adults Board (SAB) is a multi-agency partnership which has statutory functions under the Care Act 2014.

The main job of the Safeguarding Adults Board is to ensure that in Bradford District safeguarding arrangements work effectively so that adults at risk due to health needs, social care needs or disabilities are able to live their lives free from abuse or neglect.

What do we do?

- Work with partner agencies, organisations and people in our communities to raise awareness on adult abuse.
- Adults who have been harmed, or are at risk of harm, are placed at the centre of everything we do; they are respected and listened to when planning how we support them to safeguard themselves from abuse
- Work with partners to ensure that everyone who needs it, receives appropriate training to make sure they are able to identify and respond to abuse.
- Collect and analyse data related to the safeguarding of adults in Bradford and use this to develop services for adults at risk and their families.
- Identify and promote good safeguarding practice with other boards, organisations and operational staff.
- Learn and improve from circumstances when things go wrong
- Review policies and guidance in light of statutory development to make sure we are constantly improving.
- Hold Board organisations in Bradford to account.

Our Strategic Statement

The work of the Safeguarding Adults Board is a partnership. We will work together with partner organisations and people in our communities so that adults with care and support needs can live the best lives they can with their rights and wellbeing supported, safe from abuse and neglect. All the work we do will be underpinned by the following Safeguarding Principles: Empowerment; Protection; Proportionality; Prevention; Partnership and Accountability.

We have identified three priority areas of work which we think are very important. We will continue to work with our partners to make sure that by 2021 these priorities are achieved.

EMPOWERMENT & PROPORTIONALITY People and Outcomes	
PRIORITY 1	**Making Safeguarding Personal and supporting adults at risk to achieve the outcomes they want**
This means	• The Adult will be empowered to have choice and control when going through the safeguarding journey. Their views and wishes will be at the heart of any decisions made. • The Adult decides what is important to them and will feel supported throughout the journey. Staff across all organisations will make sure they keep checking what the adult wants. • We will ensure the voices of adults with care and support needs, carers and the wider public are heard. • Where an Adult has difficulty in understanding information staff across all organisations will ensure they get the necessary support to make their views understood.
What we will do to meet and measure our priorities • Develop methods for ensuring Making Safeguarding Personal (MSP) is implemented by partner agencies and across Bradford, empowering people to achieve the outcome they want - We will develop and implement a survey to evaluate the adult's safeguarding journey. - We will develop quality case auditing – for both single and multi-agencies. • The Safeguarding Voice group will continue to work with us to inform and shape our future work - We will do more work with other user led groups so that the voices of wider diverse groups are heard. - We will work with partners to deliver public workshops to educate and empower local people to stay safe.	

PREVENTION & PROTECTION Systems, Processes & Performance	
PRIORITY 2	**Making sure that all services have appropriate systems and processes in place to support and safeguard adults effectively**
This means	• We will seek assurance that all work by partners, organisations and communities will comply with the law, including the Care Act, Mental Capacity Act, Mental Health Act and Human Rights Act. • We will ensure the new regional Safeguarding Adults Policy and Procedures are implemented. • We will work together with our partners to develop new local guidance on roles and responsibilities. • We will work together to promote a multi -agency timely response when concerns are raised. • We will ensure that an effective prevention approach is undertaken

	in developing a communication and training strategy.

What we will do to meet and measure our priorities

- We will ensure that partners and organisations collect data that is relevant and this will be monitored and evaluated to develop support and services
  We will do this by:
  - Reviewing national and regional data and compare with local information.
  - Implementing a new training strategy and action plan to ensure that multi-agency staff and volunteers have appropriate training to recognise and respond to abuse and understand their own roles and responsibilities.
  - Auditing the quality of multi-agency training to ensure continuous improvements are made.
  - Monitoring and evaluating the roll out of the new Safeguarding Adults Policy and Procedures and consider if this is in line with the local safeguarding training programme, local guidance and legal compliance.
  - Implementing a joint communication strategy and action plan in partnership with the Community Safety Partnership and Safeguarding Children's Boards. This will explain what work we will do over the coming years to raise awareness in the following priority areas:
    - mate and hate crime
    - fraud, scams, doorstep crimes and online/social media abuse
    - modern slavery and human trafficking
    - self-neglect and hoarding
    - safeguarding people with care and support needs who experience domestic abuse
    - safeguarding people with dementia
    - preventing abuse in care settings
    - vulnerabilities around radicalisation
    - information about advocacy and support services.

PARTNERSHIPS & ACCOUNTABILITY **Organisations, Professionals & Communities**	
PRIORITY 3	**Partners, organisations and communities work together to prevent abuse from happening. And if abuse is happening then to recognise it, report and respond appropriately.**
This means	• Organisations work effectively together, making sure that they have a skilled workforce that understands their own roles and responsibilities. • Partners and organisations are held to account for their actions. • Information sharing agreements are reviewed and assurance is obtained that all partners are sharing relevant information in a timely manner. • Partner agencies to ensure that their own internal governance arrangements are aligned with the SAB • Learn and improve how we work when things go wrong.

What we will do to meet and measure our priorities

- We will look at training requirements by carrying out a multi-agency training needs analysis.
- We will review partner's self-assessment questionnaires.
- We will continue our work with the Chair and Peer scrutiny sessions.
- We will obtain and review feedback from single agency and multi-agency case audits.
- We will carry out Safeguarding Adults Reviews to learn lessons on what went wrong when an

adult at risk dies or has experienced serious abuse or neglect.

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the strategic director to the meeting of Health and Social Care Overview and Scrutiny Committee to be held on Thursday 6th September

I

Subject:

A Memorandum of Understanding (MOU) for the West Yorkshire and Harrogate Health and Care Partnership

Summary statement:

The purpose of this report is to inform members of the Heath and Social Care overview scrutiny are sighted on the increased local authority oversight of the West Yorkshire and Harrogate Health and Care partnership.

Strategic Director for Health and Wellbeing – Bev Maybury

Report Contact: James Drury
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Portfolio:

Healthy People and places

Overview & Scrutiny Area:

Health and Social care

1. SUMMARY

The purpose of this report is to inform members of the Heath and Social Care overview scrutiny are sighted on the increased local authority oversight of 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 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. REPORT ISSUES

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.

3.2.4It 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

3.4.1By 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

Members of the Health and Social Care Scrutiny committee are asked to note and provide comment on the MoU for West Yorkshire and Harrogate Health and Care Partnerships

11. APPENDICES

Annex 1 – Draft Memorandum of Understanding

12. BACKGROUND DOCUMENTS

None

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
- 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 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 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

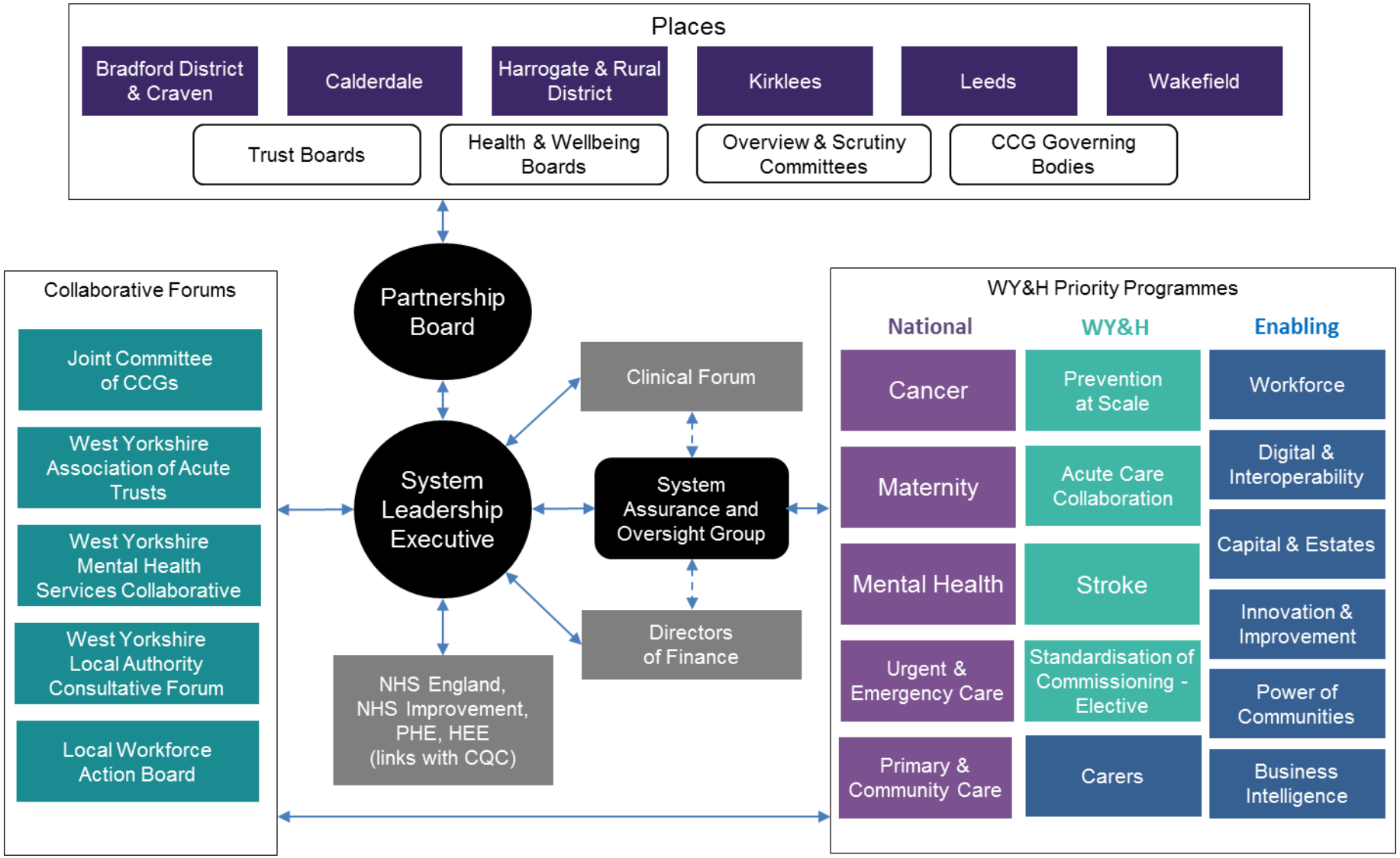
Transformation Funds	Discretionary, non-recurrent funding made available by NHSE to support the achievement of service improvement and transformation priorities
Values and Behaviours	shall have the meaning set out in Paragraph 3.3 above
WY&H	West Yorkshire and Harrogate
WYAAT	West Yorkshire Association 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 City Solicitor to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 6 September 2018

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Subject: Health and Social Care Overview and Scrutiny Committee Work Programme 2018/19

Summary statement:
This report presents the work programme 2018/19

Parveen Akhtar
City Solicitor

Portfolio:

Healthy People and Places

Report Contact: Caroline Coombes
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1. Summary

1.1 This report presents the work programme 2018/19.

2. Background

2.1 The Committee adopted its 2018/19 work programme at its meeting of 12 July 2018.

3. Report issues

3.1 **Appendix A** of this report presents the work programme 2018/19. It lists issues and topics that have been identified for inclusion in the work programme and have been scheduled for consideration over the coming year**.**

4. Options

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

5. Contribution to corporate priorities

5.1 The Health and Social Care Overview and Scrutiny Committee Work Programme 2018/19 reflects the ambition of the District Plan for 'all of our population to be healthy, well and able to live independently for a long as possible' (District Plan: Better health, better lives).

6. Recommendations

6.1 That the Committee notes the information in **Appendix A**

7. Background documents

7.1 Constitution of the Council

8. Not for publication documents

None

9. Appendices

9.1 **Appendix A** – Health and Social Care Overview and Scrutiny Committee work programme 2018/19

Democratic Services - Overview and Scrutiny

Appendix A

Health and Social Care O&S Committee

Scrutiny Lead: Caroline Coombes tel - 43 2313

Work Programme

Agenda	Description	Report	Comments
Thursday, 4th October 2018 at City Hall, Bradford			
Chair's briefing 19/09/2018. Report deadline 21/09/2018			
1) Clinical Commissioning Groups' Annual Performance Report	Annual report	CCSs (Michelle Turner / Julie Lawreniuk)	
2) Adult and Community Services Annual Performance Report 2017/18	Annual report	Bev Maybury	
3) Health and Wellbeing Board Annual Report	to include information on progress towards the delivery of a whole systems approach to health social care and wellbeing, the delivery of the Joint Health and Wellbeing Strategy for Bradford and Airedale and the progress of the Healthy Bradford Plan	James Drury	
4) Reimagining Days	Update on progress	Julie Robinson-Joyce	Committee resolution of 7 December 18

Health and Social Care O&S Committee

Scrutiny Lead: Caroline Coombes tel - 43 2313

Work Programme

Agenda	Description	Report	Comments
Thursday, 25th October 2018 at City Hall, Bradford			
Chair's briefing 10/10/2018. Report deadline 12/10/2018			
1) Care Quality Commission (CQC)	Annual update on social care inspection activity in the District	Sarah Drew (CQC)	
2) Bradford District Care NHS Foundation Trust CQC Inspection: outcome and response	Update on progress against the Trust's action plan following the CQC inspection judgement of 'Requires Improvement'	Andy McElligott (BDCFT)	Resolution of 22 March 2018
3) Bradford Teaching Hospitals NHS Foundation Trust CQC Inspection published 15 June 2018	The Trust received a rating of 'requires improvement'.	Tanya Claridge (BTHFT)	
4) Bradford District and Craven Integrated Workforce Programme's workforce strategy	Update	Michelle Turner	Resolution of 7 December 2017
Thursday, 22nd November 2018 at City Hall, Bradford			
Chair's briefing 07/11/2018. Report deadline 09/11/2018			
1) Progress report on the Health and Social Care Industrial Centre of Excellence (ICE) Programme	Item to involve representatives from the schools involved in the programme	Stacey Jobson	Committee resolution of 7 December 2017
2) Respiratory health / smoking cessation / lung cancer	Item to include the involvement of the Clinical Lead and service users	Toni Williams	Resolutions of 6 April 2017. Report delayed due to legal advice regarding the pre-election period
Thursday, 6th December 2018 at City Hall, Bradford			
Chair's briefing 21/11/2018. Report deadline 23/11/2018			
1) Mental Health	Item to be scoped but to include the involvement of people with a lived experience of mental health issues and representatives of the voluntary sector	TBC	Recommendations of 2 March 2017
Thursday, 24th January 2019 at City Hall, Bradford			
Chair's briefing 09/01/2019. Report deadline 11/01/2019			
1) Health & Wellbeing budget and financial outlook	Annual report	Bev Maybury	

Health and Social Care O&S Committee

Scrutiny Lead: Caroline Coombes tel - 43 2313

Work Programme

Agenda	Description	Report	Comments
Thursday, 24th January 2019 at City Hall, Bradford			
Chair's briefing 09/01/2019. Report deadline 11/01/2019			
2) Housing support for older people	To be scoped, but to include: Great Places to Grow Old review / affordable housing provision / finance / issues around housing and dementia	Adult Services and partners, including the voluntary sector	Resolutions of 6 July 2017 and 12 April 2018
3) Support for people with dementia and their carers post diagnosis	Report to focus on the gap between diagnosis and specialist dementia care services	NHS / Council / Voluntary Sector	Resolution of 12 April 2018
Wednesday, 20th February 2019 at City Hall, Bradford			
Chair's briefing 05/02/2019. Report deadline 07/02/2019			
1) Primary medical care update - Bradford District and Craven	Annual update on the initiatives that CCGs and primary care providers are undertaking to improve the quality of services delivered, including access and how they are engaging patients in the process	Clinical Commissioning Groups	Resolution of 8 February 2018
2) Bradford and Airedale Stroke Service	Update on the action plans to improve the Bradford and Airedale Stroke Service	Kath Helliwell	Resolution of 8 February 2018
Thursday, 21st March 2019 at City Hall, Bradford			
Chair's briefing 06/03/2019. Report deadline 08/03/2019			
1) Advocacy Services	Update following the recommissioning of advocacy services to include performance on meeting statutory requirements	Alex Lorrison / Kerry James (service users and voluntary sector to be involved)	Resolution of 7 September 2017
2) Digital Health	To be scoped but to include the use of technology in primary care, care homes and in people's own homes	TBC but to include providers and stakeholders	Resolution of 12 April 2018

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