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Agenda for a meeting of the Health and Social Care Overview and Scrutiny Committee to be held on Thursday, 4 October 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
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:

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

From: **To:**

Parveen Akhtar
City Solicitor
Agenda Contact: Jane Lythgow
Phone: 01274 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. 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.

(Jane Lythgow - 01274 432270)

4. **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

5. **HEALTH AND WELLBEING BOARD ANNUAL REPORT** 1 - 52

The Bradford and Airedale Health and Wellbeing Board is the statutory partnership with leadership responsibility for health and wellbeing across the local health, care and wellbeing sector. The Strategic Director of Health and Wellbeing will submit **Document "K"** which highlights the work undertaken by the Board.

Recommended –

That the Committee note and comment on the report (Document "K").

(Pam Bhupal – 01274 431057)

6. **REIMAGINING DAYS** 53 - 58

Previous reference: Minute 51 (2017/2018)

The Strategic Director of Health and Wellbeing will submit **Document "L"** which provides an update on the work taking place to re-think the Department's approach to daytime activities.

Recommended –

(i) That the contents of the report (Document "L") be noted.

(ii) That the overall direction of travel of Reimagining Days be supported.

(iii) That the option for the Council to support apprenticeships for people with a learning disability and take a more active part in Project Search be considered.

(Julie Robinson-Joyce – 01274 434143)

7. CLINICAL COMMISSIONING GROUPS' ANNUAL PERFORMANCE REPORT 59 - 82

The Bradford City, Bradford Districts and Airedale and Wharfedale and Craven Clinical Commissioning Groups will submit **Document "M"** which presents performance against the NHS England Clinical Commissioning Group Improvement and Assessment Framework for 2017/18.

Recommended –

That the report (Document "M") be noted.

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

8. ADULT SOCIAL CARE ANNUAL PERFORMANCE REPORT 2017/18 83 - 102

The Strategic Director of Health and Wellbeing will submit **Document "N"** which sets out a summary of performance within Adult Social Care and how performance reporting and business intelligence processes are being improved.

Members are invited to comment on the report.

(Paul Swallow– 01274 435230)

9. HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME 2018/19 103 - 108

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

Recommended –

That the information in Appendix A of Document "O" be noted.

(Caroline Coombes – 01274 432313)

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 Thursday 4th October

K

Subject:
The Annual report of the Bradford and Airedale Health and Wellbeing Board to the Health and Social Care Overview and Scrutiny Committee.

Summary statement:

This report highlights the work undertaken by the Bradford and Airedale Health and Wellbeing Board. The Board is the statutory partnership with leadership responsibility for health and wellbeing across the local health, care and wellbeing sector.

Bev Maybury
Strategic Director of Health and Wellbeing

Report Contact: Pam Bhupal
Phone: (01274) 431057
E-mail: Pam.bhupal@bradford.gov.uk

Portfolio:

Healthy People and Places

Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

This report highlights the work undertaken by the Bradford and Airedale Health and Wellbeing Board. The Board is the statutory partnership with leadership responsibility for health and wellbeing across the local health, care and wellbeing sector.

2. BACKGROUND

The annual report of the Bradford and Airedale Health and Wellbeing Board was last presented to the Health and Social Care Scrutiny Committee on 16th November 2017. This report will look at:

- The activity of the Board from November 2017 to October 2018
- The changes to the Board
- The strategic work undertaken by the Board

The Board continues to provide strategic leadership and direction in key areas to improve health and wellbeing outcomes for Bradford District citizens.

3. Report Issues

3.1 Refresh of Terms of Reference and Changes to the Board

3.1.1 In December 2017, additional members were co-opted onto the Bradford and Airedale Health and Wellbeing Board to enable a focus on the wider determinants of health and to support alignment between the strategic delivery partnerships. In March 2018, the Council's Executive Board approved these changes to the local partnership arrangements, and the recently co-opted members became full members of the Board.

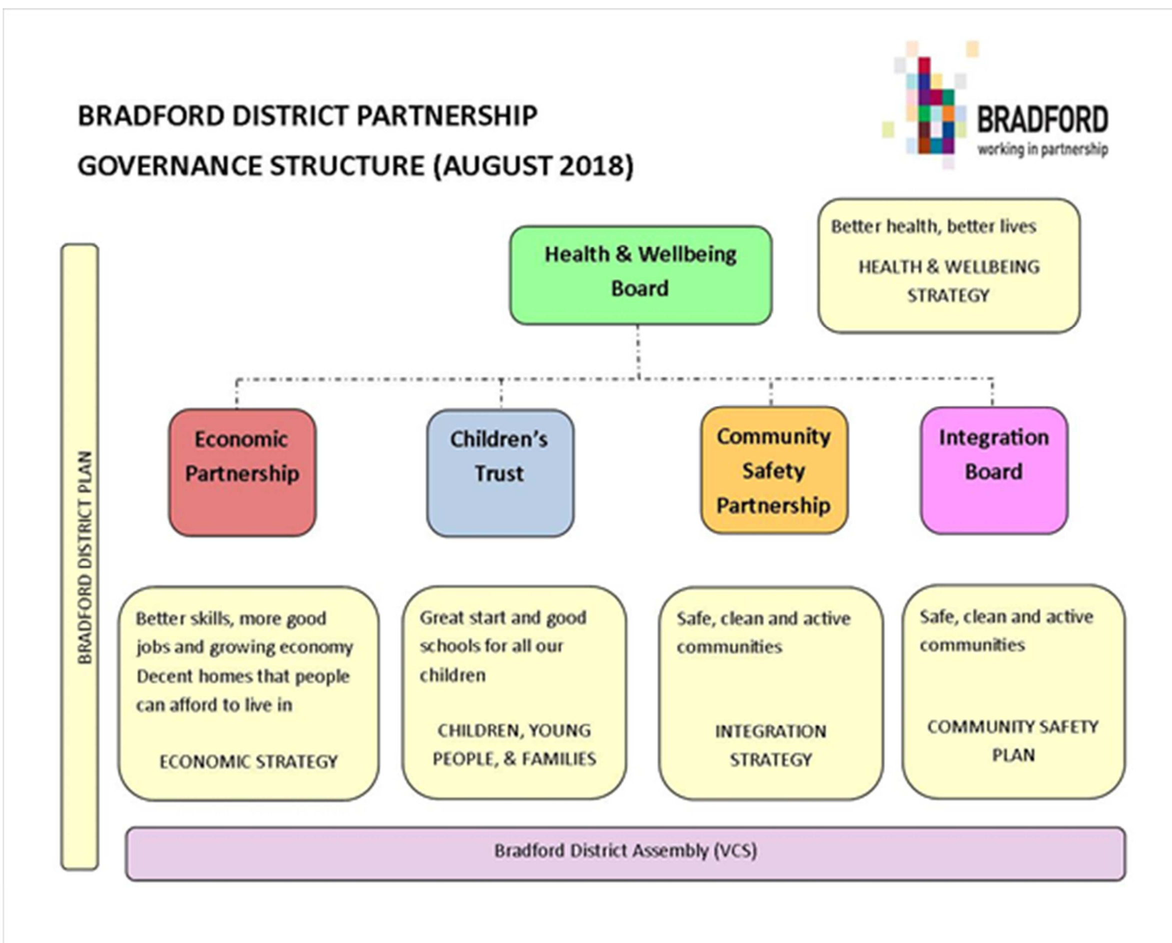
3.1.2 These changes to the Health and Wellbeing Board's Terms of Reference were presented in April 2018 board meeting (See Append ix 1), highlighting changes to the role and remit of the Health and Wellbeing Board in particular, the focus of the Board on the wider determinants of health and wellbeing and the changes to the governance arrangements of the Bradford District Partnership under which the Health and Wellbeing Board takes additional responsibilities as the senior strategic partnership. The Board is leading a series of linked strategic partnerships to collectively deliver the five outcomes of the Bradford District Plan (which can be found at the following https://www.bradford.gov.uk/media/2312/bradford-district-plan-final.pdf); in widening the membership, the Board is able to cover a range of responsibilities and yet tight enough that focus on core health and wellbeing activity is not lost. The four new additional members added to the Health and Wellbeing Board's membership is:

- The Strategic Director of Place, CBMDC
- The Group Chief Executive, InCommunities Group Ltd
- The Chief Superintendent Bradford District, West Yorkshire Police
- The District Commander West Yorkshire Fire and Rescue Service

3.1.3 As Bradford District's senior strategic board/ partnership there are a number of sub

boards (See Diagram below) which reports to the Bradford and Airedale Health and Wellbeing Board on a regular basis and this is further discussed in section 3.2

Diagram 1 – BDP Governance structure



The increased membership of the Board allows for a whole system discussion to take place on items presented to the Board. Examples of these are highlighted in section 3.6

3.2 Relationships with other boards

3.2.1 The Bradford and Airedale Health and Wellbeing Board has picked up extra responsibilities; one of those is to oversee the development and delivery of the outcomes within the Bradford District Plan 2016 – 2020, via the Districts strategic delivery partnerships;

Strategic Delivery Partnerships	Ownership of Outcomes
Health and Wellbeing Board	• Better health better lives
Economic Partnership Board	• Better skills, more good jobs, and a growing economy • Decent homes that people can afford to live in

Safer Stronger Communities Board	• Safe, clean and active communities
Childrens Trust Board	• A great start and good schools for all our children

3.2.2 The strategic delivery partnerships (Economic Partnership, Children's Trust, and Safer Stronger Communities) will take direction from and are responsible to the Health and Wellbeing Board for delivering the District Plan outcomes and other strategic priorities. They will be expected to report their progress against these outcomes to the Health and Wellbeing Board on an annual basis through the Bradford District Plan. Please see appendix 2 for the draft Better Health Better Lives section of the Plan.

3.2.3 Also the Health and Wellbeing board receives report for sign from:

- Annual Safeguarding reports
- Bradford Council's SEND local offer
- Future in Mind strategy
- Bradford District Plan and annual progress reports
- Pharmaceuticals Needs Assessment

3.2.4 Sub groups reporting to the Board regularly are the Executive Commissioning Board (ECB) and the Integration and Change Board (ICB). The ECB oversees and assures the joint commissioning arrangements that are in place for health and social care between CBMDC and local NHS CCG, and that joint commissioning responsibilities are addressing needs and reducing inequalities. A summary of the ECBs activity is as follows:

3.2.4.1 The purpose of the Executive Commissioning Board is to provides system leadership, clinical oversight and strategic direction to the integration and alignment of commissioning arrangements so that our vision for integrated health and care is delivered. This arrangement is between Airedale, Wharfedale and Craven Clinical Commissioning Group, Bradford City Clinical Commissioning Group, Bradford Districts Clinical Commissioning Group and Bradford Metropolitan District Council.

3.2.4.2 The Board has oversight of all joint commissioning activities between the Council and CCGs, across all user groups. In addition, the Board oversees the joint commissioning activity as part of the Better Care Fund Plan. A finance subgroup has now been established to review BCF spend across the system, prior to the production of the next BCF plan for 2019/20.

3.2.4.3 The Executive Commissioning Board has now been established for 12 months and following best practice, the Chair and Vice Chair carried out an annual review of effectiveness of the board. In order to improve the Boards effectiveness, the Board's effectiveness would be reviewed again in July 2019.

3.2.5 The Integration and Change Board holds the health and social care system leaders to account to ensure the Local Place Based Plan for Bradford District and Craven and the West Yorkshire and Harrogate Health and Care Plan (as it relates to Bradford District) are delivered. A summary of it's activity is as follows:

3.2.5.1 Refresh of place based plan – 'Happy Healthy at Home': In December 2017 ICB completed an update of our earlier (2016) health and care plan. Changes were

made to reflect the 'Our Say Counts' public engagement exercise undertaken by Healthwatch during 2017, to reflect the priorities set out in our latest Joint Health and Wellbeing Strategy 'Connecting People and Place', and to reflect the progress of the West Yorkshire and Harrogate Health and Care Partnership.

3.2.5.2 System Development events – ICB sponsors a number of whole system learning and innovation events each year, as part of its system leadership role. The events aim to build a shared culture and promote integration and innovation. In February an event was held which focused on children and young people's health and wellbeing, and in September an event is to be held which will focus on the needs of key decision makers as the system strengthens its approach to operating and making decisions as a partnership.

3.2.5.3 CQC local system review – between January and June 2018 ICB oversaw the successful completion of a 'local system review' by the Care Quality Commission (CQC). The review was positive and concluded that "*There was a clear shared and agreed purpose, vision and strategy described in the Happy Healthy at Home plan which had been developed by the system. This was articulated throughout the system"* and *"There was a defined system-wide governance arrangement that pulled the system together and a clear architecture for development and roll out of the transformation of services in line with the plan".* Subsequently ICB oversaw the creation of an action plan that responds to the Review, and will continue to monitor the delivery of the action plan over the next year.

3.2.3.4 Terms of Reference and membership changes – between June and August 2018 ICB reviewed its purpose and focus leading to revised Terms of Reference and changes to membership. ICB now includes members from the Voluntary and Community sector and from the independent care home provider sector. in the year ahead it is anticipated that primary care provider representation from the Airedale Wharfedale Craven area will also be strengthened in line with equivalents in Bradford. The revised Terms of Reference were adopted in August to clarify the connection between ICB and the two local health and care partnership boards, and to formalise the link role of ICB between our local system and the wider West Yorkshire and Harrogate system (see 3.2.6 below).

3.2.3.5 Development of enablers (digital, workforce, system development, estates, self care) – during the last year ICB has focused on strengthening the cross organisational enablers of transformation (listed above). This has included widening membership and participation, establishing a new 'System Development' network, strengthening communication and alignment between enablers and with Health and Care Partnership Boards, ICB partners agreeing and providing additional resources to enablers (e.g. Workforce – ICE, and Digital – Information Governance and Business Intelligence) .

3.2.6 The Health and Wellbeing Board has recently endorse the signing of the West Yorkshire and Harrogate Memorandum of Understanding (MOU) by member organisations. The MoU is an agreement to work in partnership with other neighbouring Health and Care systems. Therefore allowing increased involvement in the decision making process within the West Yorkshire and Harrogate Integrated Care System (ICS). 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 is due to the strength of local partnership work being recognised nationally. The WY&H ICS is now strengthening the democratic oversight of its work by establishing a Partnership Board which will include membership by elected members of each local authority, including members of Bradford Council. Bradford is currently reaping the benefits of being a part of the ICS by sharing in new investment into West Yorkshire and Harrogate such as, 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 and 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.

3.3 Finance – looking at efficiency plans

As of February 2018 the Board is keen to keep well-informed of how the Health and Care systems efficiency plans are progressing. It has been agreed that an update on the plans will be presented to the Board bi-annually. These are efficiency plans consisting of the whole health and care sector. Each partner within the health and care sector has efficiency plans and targets that they need to save each financial year. The Health and Care system financial plan adds these together and measures progress against delivering the system efficiency plan/financial gap.

3.4 JHWS strategy and logic models

3.4.1 The ‘ Connecting People and Place’ the new Joint Health and Wellbeing strategy (JHWS) was approved by the Board in December 2017, its aim is to help the Health and Wellbeing Board to meet its duties to improve health and wellbeing, reduce health inequalities, and provide a shared, public agreement about the focus and direction of the Health and Wellbeing Board as it leads this work. (See Appendix 3)

3.4.2 The Health and Social Care Overview and Scrutiny committee received and commented on the first draft of the strategy at their October 2017 meeting as part of a stakeholder consultation. It was then approved by the Health and Wellbeing Board in December 2017.

3.4.2 The key to the success of the strategy is to work with other Council departments and partnering health and care organisations collaborate on matters. The strategy focuses on the wider determinants of health and this is now reflected in the membership of the Board.

3.4.3 In order to measure the success of the strategy, a set of logic models have been created. These are soon to be signed off as a performance measure approach by the Board in November 2018. There are no new measures or strategies to report progress against within the JHWS, these are pre existing and no additional work is required. In order to see statistical change it will take 3 years work to see 1 years change therefore evaluation and review will take place regularly to determine whether measures are creating an impacting or not. Updates will be provided to the Board quarterly. See Appendices 3& 4 for the

approved strategy and draft logic models.

3.4.4 There are 4 outcomes within the logic model and there is an assigned Public health Consultant to each outcome. Outcome 1 – Our children have a great start in life, Outcome 3 - People in all parts of the District are living well and ageing well and Outcome 4 – Bradford District is a healthy place to live, learn and work, currently have lots of on – going activity. Public health is looking to add value to current activity, a chance to seek new opportunity and build relationships.

3.4.5 Outcome 2 is mental wellbeing and good progress has taken place, particularly on the work of our children' and young people's mental health transformation plan. NHS England has recently rated the progress as "Excellent – fully confident" with particular reference to the excellent system wide partnership approach to our work. We are making good progress on our strategy implementation and will be sharing detailed progress at a system wide event on the 30th of January 2019.

3.5 CQC review

3.5.1 In December 2017, the Health and Wellbeing Board Chair was informed by the Care Quality Commission (CQC) to conduct a Local System Review of our health and care system in Bradford in January and February 2018. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services for the over 65s. The review looked into the commissioning arrangements of services and how a person centred service is coordinated. The review included a range of interviews with system leaders, a variety of focus groups and site visits from across the whole health and care system. The selection of the CQC reviews is driven partly by the set of metrics which is now known as The Health and Social Care Interface Dashboard. The latest publication of the Dashboard (Sept 18) shows Bradford is still 5th out of 150 local authorities against these measures – a position that has been sustained for 12 months now. A final report has now been published. The report of the Bradford Local System Review was positive and can be found on the CQC website at: https://www.cqc.org.uk/local-systems-review

3.5.2 Following on from the CQC report an action plan has been produced and updates will be provided through the Integration and Change Board to the Health and Wellbeing Board bi – annually. Progress of the action plan is on track. See Appendix 5 for the CQC action plan.

3.6 System working –

3.6.1 Early help and prevention

As of 2018 pieces of work which have been positively encouraged by the Board is the work to integrate the Primary Care homes model and the Early help, prevention and Localities work together creating a stronger partnership between the Local Authority and services provided by Board member organisations. This work has hugely benefitted from a whole system approach and work is reported to the Early help, prevention and localities Board comprising of strategic leaders across the Health and Care sector. Council Members have received the data profiles for their Primary Care Home locality and an awareness session is due to take place in November explaining

the information in further detail and a chance to hear more information on how services will change in their ward. The nationally branded Primary Care home model within Bradford has recently rebranded itself to Community Partnerships to allow for consistent language with the equivalent local partnership arrangements in Airedale Wharfedale and Craven..

3.6.2 The Workforce programme

As reported to the Board on 4th September Bradford District has been successful in attracting over £1million from the Leeds City Region Business Rates Pool to increase skill levels and employment for local residents, while also addressing capacity and competency needs of the local health and care sector. For example local community partnerships will need people to engage local communities in their health and to help health and care teams make the most of strengths and assets. One Workforce will also help people progress their careers e.g. by developing those in care giving roles. Again a whole system approach has been provided to this piece of work through looking at recruitment and retention matters across the system, sharing of good practice across the system and navigate staff between organisations within the system.

3.6.3 The developemenrt sessions have allowed for a single item to be viewed as a system. The sessions allow for connections to be made and views points from organisations that traditionally wouldn't have a chance to be involved. The sessions are informal and allow for good flow of discussion, encouragement and suggestion.

3.7 Future activity

3.7.1 Smoking – there is a smoking event/ network in the making which will bring together all that are working in smoking cessation across the District to discuss whether their work is aligned to key strategies and to map where services are taking place across the District.

3.7.2 The ICB showcase event is a chance for those in Executive Directors and Non Executive Director roles to join in discussion on the challenges and opportunities to the Bradford district and Craven health and Care systems. This will provide opportunity for attendees to understand decision making from other organisations and from a system perspective. This event is taking place on Friday 21st September. The findings of this event will be reported back to the Health and Social Care Overview and Scrutiny Committee.

4. FINANCIAL & RESOURCE APPRAISAL

Finance has been consulted on this paper. No financial implications are expected based on this report

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

If there are no significant risks arising out of the implementation of the proposed recommendations it should be stated but only on advice of the Assistant Director Finance and Procurement and the City Solicitor.

6. LEGAL APPRAISAL

There do not appear to be any recommendations being asked for in this report. It appears to be for review and comment only, if this changes and the elected members are asked to make any decisions regarding this report a further legal appraisal may be required.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

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

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it;
- Relevant protected characteristics include age, disability, gender, sexual orientation, race, religion or belief.

7.2 SUSTAINABILITY IMPLICATIONS

None

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

None

7.4 COMMUNITY SAFETY IMPLICATIONS

None

7.5 HUMAN RIGHTS ACT

None

7.6 TRADE UNION

None

7.7 WARD IMPLICATIONS

No direct impacts from this report

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 ASSESEMENT

None

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

No options are provided

10. RECOMMENDATIONS

The committee to note the activity and provide comment on the Annual Report of the Bradford and Airedale Health and Wellbeing Board

11. APPENDICES

1. Terms of Reference 2018 (pages 11 – 14)
2. Draft Better Health Better Lives report (pages 15 – 20)
3. Joint Health and Wellbeing Strategy 2017- 21 (pages 21 – 34)
4. Draft logic models for the Joint Health and Wellbeing Strategy 2017-21 (pages 35 – 50)
5. CQC action plan (page 51)

12. BACKGROUND DOCUMENTS

- CQC local system review to the Health and Social care scrutiny committee – Thursday 12th July 2018.

Bradford and Airedale Health and Wellbeing Board
Terms of Reference – March 2018

1. Name

The name of the Partnership will be "Bradford and Airedale Health and Wellbeing Board", referred to as The Board.

2. Principal Purpose

The Board has a dual purpose.

Firstly to perform the statutory functions of a Health and Wellbeing Board as defined in the Health and Social Care Act 2012. Principally to improve the health and wellbeing of the people in their area; reduce health inequalities; and, promote the integration of services. In so doing, the strategy of the Board is to focus on the wider determinants of health and wellbeing.

Secondly the Board is the senior strategic partnership in Bradford District, leading the family of linked strategic partnerships through which we collectively deliver the five outcomes of the Bradford District Plan.

3. Principal Duties

3.1 To provide local democratic accountability for the use of public resources to improve health and wellbeing and reduce health and social inequalities

3.2 To promote integration in the commissioning and provision of health and social care services across the District.

3.3 To oversee and be assured that joint commissioning arrangements are in place for health and social care through the Executive Commissioning Board, and that joint commissioning responsibilities are being effectively discharged to address needs and reduce inequalities.

3.4 To oversee the production of the Joint Strategic Needs Assessment and the Pharmaceutical Needs Assessment

3.5 To oversee the production of the Joint Health and Wellbeing Strategy

3.6 To provide system leadership and a local interface for both planning and governance through engagement with NHS England, Public Health England, Local Partnerships and providers, including the Voluntary, Community and Faith Sector, and to undertake all statutory duties.

3.7 To hold health and social care system leaders to account through the Integration and Change Board to ensure the Local Place Based Plan for Bradford District and Craven and the West Yorkshire and Harrogate Health and Care Plan (as it relates to Bradford District) are delivered.

3.8 To oversee the development and delivery of the outcomes within the Bradford District Plan 2016 – 2020, via the Districts strategic delivery partnerships;

Strategic Delivery Partnerships	Ownership of Outcomes
Health and Wellbeing Board	• Better health better lives
Economic Partnership Board	• Better skills, more good jobs, and a growing economy • Decent homes that people can afford to live in
Safer Stronger Communities Board	• Safe, clean and active communities
Childrens Trust Board	• A great start and good schools for all our children

3.9 To support delivery of the District Plan by;

- Drawing on the expertise of the private, public and voluntary sector to coordinate joint working to improve service delivery, and achieve efficiencies while improving the quality of life for people
- Encouraging joint working, reducing duplication and improving coordination of service commissioning and delivery between partners
- Aligning partnership activity to deliver the District Plan, as well as ensuring delivery against statutory priorities assigned to the strategic delivery partnerships
- Promoting and overseeing the delivery and performance management of the aims and outcomes set out in the District Plan
- Monitoring and promoting the overall achievements against the delivery of the District Plan outcomes and being accountable to the wider community and key stakeholders

3.10 The Strategic Delivery Partnerships will;

- Take responsibility for the delivery of outcomes as set out in the District Plan and for pursuing specific pieces of work on behalf of the Health and Wellbeing Board acting as the senior strategic partnership.
- Be expected to carry out regular reviews to ensure that the set of established delivery groups are the most appropriate for delivering these outcomes, and that as such they are fit for purpose
- Determine the need for, and the work programme of, any delivery groups that report to them and will actively monitor and manage these work programmes.

4. Membership

4.1. The Board shall consist of:

a) The Leader of the Council, CBMDC

b) The Elected Member portfolio holder for Health and Wellbeing, CBMDC

c) One opposition Elected Member, CBMDC

d) The Chief Executive of the Council, CBMDC

e) The Director of Public Health, CBMDC

f) The Strategic Director of Health and Wellbeing, CBMDC.

g) The Strategic Director of Children's Services, CBMDC.

h) The Strategic Director of Place, CBMDC

i) The Accountable Officer for the District's Clinical Commissioning Groups and a clinician from each of Airedale, Wharfedale, Craven CCG, Bradford City CCG and Bradford District CCG if the Accountable Officer is not a clinician

j) One member from the NHS England Area Team

k) The Chief Executive of Bradford Teaching Hospitals NHS Foundation Trust

l) The Chief Executive of Airedale NHS Foundation Trust

m) The Chief Executive of Bradford District Care NHS Foundation Trust

n) The Group Chief Executive, InCommunities Group Ltd

o) The Chief Superintendent Bradford District, West Yorkshire Police

p) The District Commander West Yorkshire Fire and Rescue Service

q) One member from Bradford HealthWatch

r) One member from the Voluntary, Community and Faith Sector, elected through Bradford Assembly.

s) One member from the GP community

4.2 The Board will be able to co-opt further members, as required.

4.3 Named alternates can be provided for the members of the Health and Wellbeing Board.

5. Meetings of the Board

5.1 The Board will have a chair who is the leader of Bradford Council

5.2 Provision will be made for a Deputy Chair who will be appointed from the NHS CCG membership on the Board

5.3 Meetings will be held in public

5.4 Meetings will take place bi-monthly

5.5 Each Member of The Board will have a vote though agreement on matters considered by The Board will generally be by consensus. Further persons co-opted by The Board will be non-voting unless the terms of reference are amended by Council.

6. Quorum

6.1 One third of Board members will form a quorum, with at least two Elected Member representatives from the Council, one Council Officer, and one representative from Clinical Commissioning Groups.

7. Governance

7.1 The work of the Board shall be reviewed by the Health and Social Care Overview and Scrutiny Committee.

7.2 Sub-groups that report directly to the Board shall include the Executive Commissioning Board and the Integration and Change Board, with further direct reporting Task and Finish groups to be appointed, as needed, to progress Board priorities.

7.3 Clear reporting arrangements shall be put in place for each sub-group that reports directly or indirectly to the Board.

7.4 The strategic delivery partnerships (Economic Partnership, Childrens Trust, Safer Stronger Communities) will take direction from and are responsible to the Health and Wellbeing Board for delivering the District Plan outcomes and other strategic priorities. They will be expected to report their progress against these outcomes to the Health and Wellbeing Board on an annual basis.

7.5 The working arrangements between the strategic delivery partnerships (including Health and Wellbeing Board) are to include;

- Annual conference – to support alignment, review delivery of outcomes and agree and align forward plans
- Twice yearly meeting of the chairs of the strategic delivery partnerships for horizon scanning and placement of cross-cutting themes
- Quarterly meetings of the lead support officers of each strategic delivery partnership to generate an integrated progress report and coordinate forward plans
- The agendas of the Health and Wellbeing Board to include a quarterly focus on one of the outcomes in the District Plan (Better Health Better Lives included in every meeting).

7.6 The Board will receive the annual reports of the Safeguarding Adults Board and the Safeguarding Children Board

8. Review

8.1 The Board is recommended to review these Terms of Reference on a 12 monthly basis

6. Better health, better lives

Ambition

We want all of our population to be healthy, well and able to live independently for as long as possible – with the right healthcare or support for each person, available at the right time. Our ambition is to help everyone take more control of their own health and wellbeing, to see more people taking good care of their health and fitness and to see people supporting each other to make positive changes.

Getting and staying healthy can be harder for people living on low income, in poor-quality housing or leading insecure, stressful lives. Our challenge is to ensure everyone is able to enjoy the best health they can and to have a good quality of life whatever age they are and wherever they live.

Progress on our success measures for 2020

District Plan 2020 target	Short name	Latest value	Trajectory to 2020 target
4a) Increase healthy life expectancy	Healthy life expectancy at birth (Female)	61.1	
4a) Increase healthy life expectancy	Healthy life expectancy at birth (Male)	61.8	
4b) Reduce the gap in life expectancy between the most and least deprived areas	Difference in life expectancy at birth between the most and least deprived parts of the district (Females)	7.5	
4b) Reduce the gap in life expectancy between the most and least deprived areas	Difference in life expectancy at birth between the most and least deprived parts of the district (Males)	8.8	
4c) Significantly reduce the proportion of children overweight or obese at age 10 to 11	Excess weight in 10-11 year olds	37.9%	
4d) Improve mental wellbeing and reduce high anxiety to below the England average	Self-reported wellbeing - people with a high anxiety score	23.1%	
4e) Build on success at tackling loneliness and	Proportion of people who use services who	50.3%	

social isolation	reported that they had as much social contact as they would like		
4f) Significantly reduce causes of preventable deaths – smoking, being overweight and obesity – and increase physical activity and healthy eating	Percentage of inactive adults	23.3%	New measure so no trajectory possible
4f) Significantly reduce causes of preventable deaths – smoking, being overweight and obesity – and increase physical activity and healthy eating	Smoking prevalence - adults (over 18s)	22.2%	🔴

▶ On track to meet target by 2020
⚠ Some concerns/possible delays
🔴 Not expected to be achieved

Overall life expectancy has not changed. Healthy life expectancy tells us the age that people remain in good general health on average. For males in 2014-16, that age decreased by 1.1 years compared to 2013-15, whilst for females it increased by 0.6 years over the same period. On average women reported 0.7 fewer years of healthy life than men in 2014-16. Though overall life expectancy has not changed there is an increasing number of people with chronic illnesses which continues to create demand on the district's services. It also impacts on the economic contributions that can be made by the working age population.

Two of the main factors causing preventable deaths in adulthood show a slight increase. These are smoking prevalence (the percentage of adults who are current smokers), and excess weight in 10-11 year olds. Both of these are concerning as they undermine people's health and wellbeing. Although we already have programmes in place, we will need to rethink how we work with and alongside people to support them to improve their health and wellbeing. It is important to note that health and care outcomes are difficult to evidence and show improvements or declines as behaviour change impacts take place over very long periods of time.

Good things are happening here

Keep it Out: Preventing people from starting to smoke and helping them to quit is the single most effective way of improving health outcomes for individuals. 'Keep it Out' is a programme to combat the damage illegal tobacco does to our communities. The Keep it Out partnership between health and West Yorkshire trading standards is committed to reducing both the supply of and the demand for illicit tobacco to increase intelligence reporting and change behaviours.

Bradford Beating Diabetes (BBD): This programme has focussed its attention on supporting people who are at high risk of developing Type 2 diabetes to delay or prevent the onset of the disease and is supported by Bradford becoming a demonstrator site for the National Diabetes Prevention Programme. We found over 1,000 new diabetics within the first year and since starting the programme prevalence has increased from 5% to 10%. This isn't more people getting diabetes, this is people who were unaware they had diabetes and were therefore not receiving treatment. The programme has also focused on prevention of diabetes as well and has targeted over 27,000 people with interventions.

Bradford Social work: Bradford has been awarded over £600,000 to become a Teaching Partnership (with Bradford University, Bradford College Children's and Adults). To help improve the overall quality of practice, learning and Continuing Professional Development amongst trainee and practicing social workers who work with both children and adults. We are the only standalone Teaching Partnership in the country.

Our achievements over the last 12 months

The Health and Wellbeing Board is leading on the delivery of the Joint Health and Wellbeing Strategy and the Health and Care Plan for Bradford and Craven with an additional focus on the wider determinants of health.

Over the last 12 months the following has been achieved:

- The recent CQC - Local System Review stated all within the Bradford's system understood the vision and is owned across the system. The CQC remarked on the breadth and strength of partnership here and the commitment from all towards our common ambition of keeping people happy, healthy at home.
- Bradford was awarded £3.2 million from the DfE Innovation Fund. We have created our B Positive Pathways Programme to:
    - Reduce the number of teenager's children in care through stronger edge of care work.
    - Improve our ability to provide high levels of care within our residential homes through embedding a therapeutic approach.
    - Set up two 'Mockingbird' hubs to provide support to foster carers working with children with more complex needs.
    - Our work has been recognised nationally and we were shortlisted for the prestigious MJ Award for innovation
- Retrofitting of 25 service buses and 165 school buses in the city with cleaner engine technology, provision of over 5000 electric vehicle charging points on new developments, introduction of low emission vehicles into the council fleet, setting up of fleet recognition scheme (ECO-stars) and grants for the development of electric taxi infrastructure.
- Additional investment into the prevention and early treatment of lung cancer into the Bradford's Healthy Hearts programme, and national capital investment was secured into specialist children's mental health services that will enable more young people to receive care closer to home.
- 37 primary school are involved in the Daily Mile, in June 2018, Sir Andy Murray announced a partnership with the NHS to promote the benefits of exercise to improve physical and mental health and wellbeing

- Although our care population is rising, we continue to out-perform our statistical neighbours. Our rate of Looked After Children is 66/10,000 against a statistical neighbour rate of 82. Our rate of Child Protection is 43/10,000 against a statistical neighbour rate of 53.
- We were hand picked as one of 12 Authorities to pilot the National Accreditation Scheme for Social Workers, with this comes nearly £250,000 of workforce development investment.
- Council has agreed for Children services to recruit an additional 8 Social Workers with an investment of £450k
- A successful bid by the local authority, Active Bradford and Yorkshire Sports resulted in receiving funding of £13m from Sport England for four years to transform physical activity levels in 5-14 year olds in under represented groups as one of 12 local delivery pilots. This will make a positive contribution to improving health, mental wellbeing, academic achievement, social development, quality of life and reducing obesity.
- The West Yorkshire Cancer Alliance's emphasis is being placed on prevention by tackling lifestyle choices which can impact on cancer. This also extends to investing in earlier diagnosis, new treatments and better support to help people live well beyond their cancer diagnosis. An additional investment of £750k for Bradford and Wakefield will enable the Bradford Lung Cancer Programme to enhance smoking cessation and allow for early identification and treatment of lung cancer.
- Bradford has been held up by West Yorkshire Police as an exemplar of good practice for our Missing Policies and Procedures. We are re-vamping our Emergency Duty Team (EDT) working hours to ensure we provide an even better service by matching shift patterns to the peak hours that vulnerable children go missing
- Multi-disciplinary teams are in place to facilitate quick and effective discharges from hospital and minimise delays to patients. Additional community beds have also been commissioned during times of high pressure. As a result the district continues to have one of the lowest rates of delayed transfers of care (DTOC) nationally and continues to minimise the use of hospital beds following emergency admission. The area was ranked 5th nationally at quarter 2 for performance against the new Better Care Fund composite measure (DTOC, non-elective (NEL) length of stay, access to and effectiveness of reablement/rehabilitation, weekend discharges and NEL admissions).
- Bradford has received national attention for its Children's Home Strategy, including its specialist homes. '*9 out of 10 Children's Homes have been rated as Good or Outstanding'*
- The Bradford Crisis Care Partnership and first response services have been established which have received national recognition. Partners from the NHS, local authority, police and community organisations work together under the crisis care concordat to ensure that people who experience a mental health crisis receive the care they need from the service best placed to provide it, 24 hours a day, seven days a week.
- We are part of the West Yorkshire National pilot of Problem Solving Courts. We now have 6 families in the Problem Solving Court, more than any other West Yorkshire authority. The judiciary were very complimentary about our progress and there is a strong chance of reunification with some families.

The challenges facing us over the next 12 months

A range of heath conditions accompanied with an ageing population in Bradford continue to add pressure and challenge to the health and care system, despite a varied approach to tackling such issues. Across the Health and Care Partnership these pressures will continue to be a priority and a focus for commissioned services across the district. The Universal Credit scheme has now arrived in Bradford. Other Local Authorities that have rolled out Universal Credit have seen an increased demand for Early Help and Social Work services. Bradford council will monitor the demand for services in Bradford.

We need to ensure the environment in which people are living, learning and playing is the best it can be. Areas of poor air quality are often linked to the highest areas of deprivation, adding an additional challenge to health improvement in these areas. A range of ambitious and far reaching air quality improvement measures will be needed to further improve air quality in these areas. Deciding on what these should be and how they can be funded and implemented will be key challenges for the Council.

Addressing the high level of health inequality between different areas of the district and between different people remains a priority. There are encouraging signs for the local economy but resources are shrinking and demand is likely to continue to grow, such as, we want children to remain with their birth families, with extended families if this is not possible and in family foster care in preference to residential care when family are not available.

Our aim is to support people to stay well so that more resources can be used for maintaining health rather than treating illness. To support this approach the Board will lead the work to enable more people to be supported in their homes and communities for as much of the time as possible, and at the appropriate level of care. Developing a sustainable, integrated approach to health and wellbeing is likely to remain a challenge for the next few years.

Our focus for the next 12 months

Consolidating the Prevention and Early Help offer to provide the right service at the right time to children and families in partnership with other agencies and our communities is a priority. Bradford recruited 72 new foster carers in 2017/18, however, with numbers rising; we still need to recruit around 100 further foster carers. This will place increased demand on services unless we can improve people's health and wellbeing by keeping more people healthy for longer and intervening earlier when people do become ill. For example, a review of services for children with disabilities: a report has been compiled to provide options to identify the required savings of £400k.

Practice support from the Ministry of Housing, Communities and Local Government on the Families First work was very complimentary about the Families First work that they saw in June 2018. However, have asked Bradford to continue to identify and support more families who would benefit from this focussed work.

The Bradford LES will determine the next steps to be taken to improve air quality on the most polluted roads in the city and updating the Bradford LES to ensure continual improvement in air quality across the wider district.

Developing a sustainable, integrated approach to health and wellbeing is likely to remain a challenge for the next few years. Resources are shrinking and demand is likely to continue to grow. This will place increased demand on services unless we can improve people's health and wellbeing by keeping more people healthy for longer and intervening earlier when people do become ill.

The Bradford and Airedale Health and Wellbeing Board have collectively agreed to focus on the wider determinants of health recognising that health conditions are not single issues. The Board will lead the work to enable more people to be supported in their homes and communities for as much of the time as possible, and at the appropriate level of care.

Connecting people and place for better health and wellbeing

A Joint Health and Wellbeing Strategy for Bradford and Airedale

2018 – 2023

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Leadership, development and links to other strategies and plans

Who will lead the joint Strategy?

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

How the strategy was developed

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

Links to other strategies and plans

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

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

Foreword

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

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

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

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

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

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

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

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

Guiding Principles

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

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

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

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

Context: Our wellbeing challenge and ambition

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

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

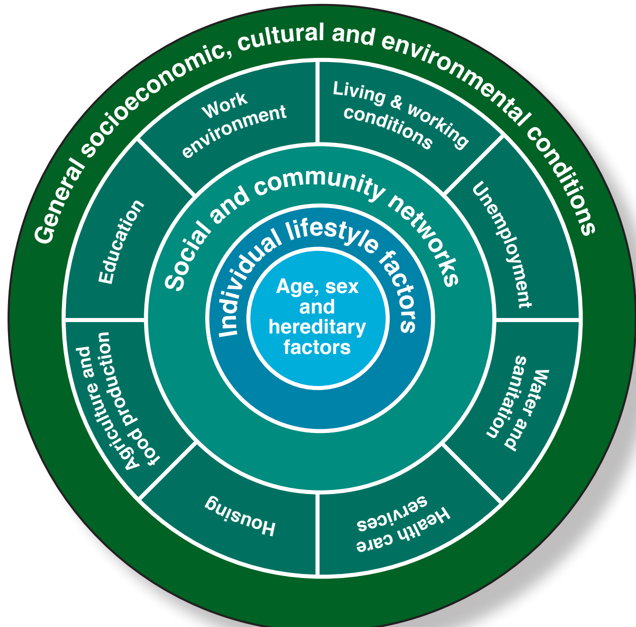
These challenges contribute to lower life expectancy at birth, almost 3 years lower than the national average for men, and 2 years lower for women. Shorter life expectancy is largely due to conditions that can be prevented: heart and lung disease, type 2 diabetes and some common types of cancer. Many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

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

What influences our health and wellbeing?

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

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



The Determinants of Health (1992)

Dahigren and Whitehead

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

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

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

Strategy: Connecting people and place for better health and wellbeing

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

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

A shared vision and outcomes

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

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

4 Four outcomes describe our aspirations for the district:

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

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

For each outcome we:

Outcome 1 Our children have a great start in life

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

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

How are we doing?

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

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

Percentage of children and young people
30
20
10
0
Bradford
England average
2014

Our ambitions for a great start in life are:

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

Lead responsibility

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

Outcome 2 People in Bradford District have good mental wellbeing

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

How are we doing?

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

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

Our ambitions for good mental wellbeing are:

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

Delivering outcome 2

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

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

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

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

Our ambitions for living well and ageing well are:

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

How are we doing?

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

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

Lead responsibility

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

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

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

How are we doing?

16%

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

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

Our ambitions for a healthy place are:

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

Lead responsibility

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

6 Implementing the strategy

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

We will make the difference by:

Creating a health-promoting place to live

Promoting wellbeing and preventing ill health

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

1. A health promoting place to live

Why is this important?

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

What can we do?

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

2. Promoting wellbeing, preventing ill-health

Why is this important?

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

What can we do?

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

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

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

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

3. Getting help earlier and self-care

Why is this important?

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

What can we do?

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

Support everyone to self-care by:

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

Tracking progress

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

Putting our principles into practice

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

Measuring Progress on the Joint Health and Wellbeing Strategy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Connecting People and Place for Better Health and Wellbeing

How will we know that we have made a difference?

Background/purpose (1)

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

Background/purpose (2)

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

Background/purpose (3)

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

Overarching outcomes

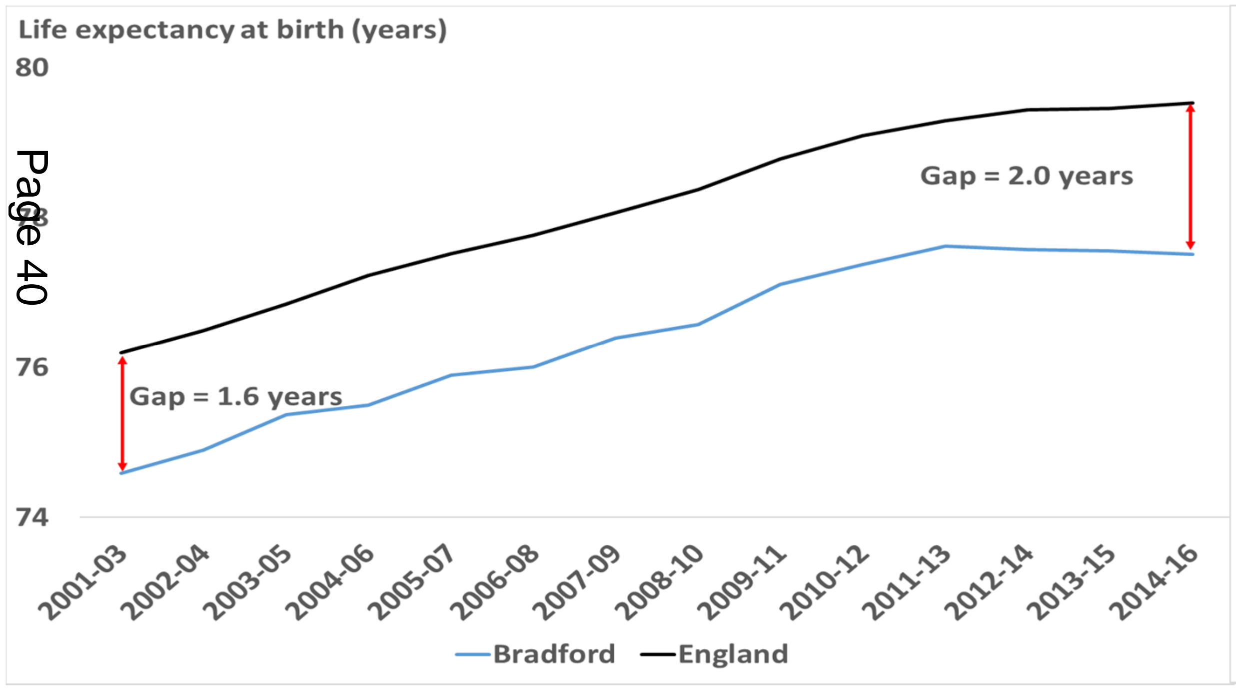
- **Life expectancy at birth (males & females).**
- **Gap in life expectancy between most and least deprived areas.**
- **Healthy life expectancy (males & females)**
- **Gap between healthy life expectancy and life expectancy.**

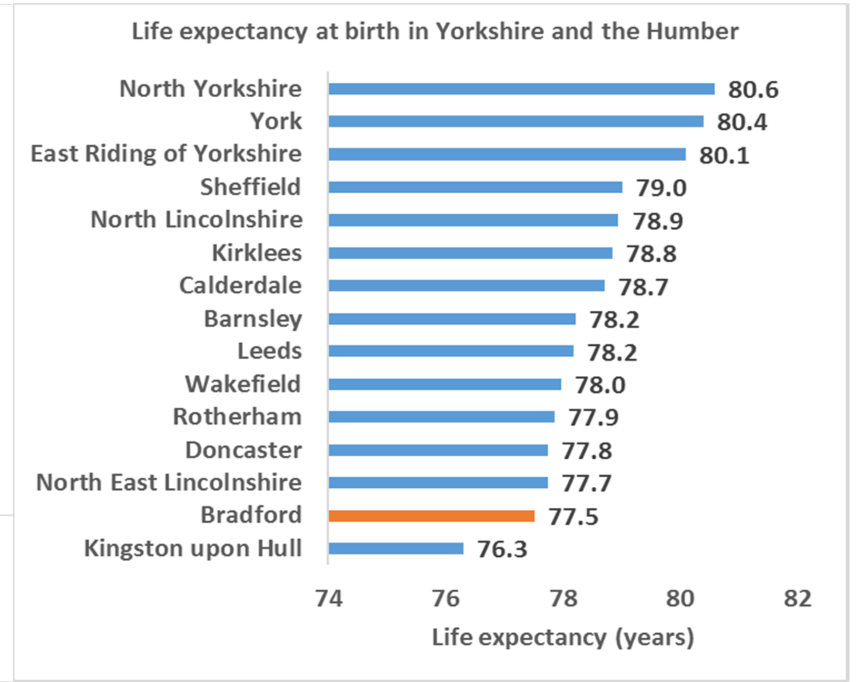
Life expectancy at birth– males The average number of years a person can expect to live based on contemporary mortality rates

Most deprived quintile in Bradford
73.6 years

Least deprived quintile in Bradford
80.7 years

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





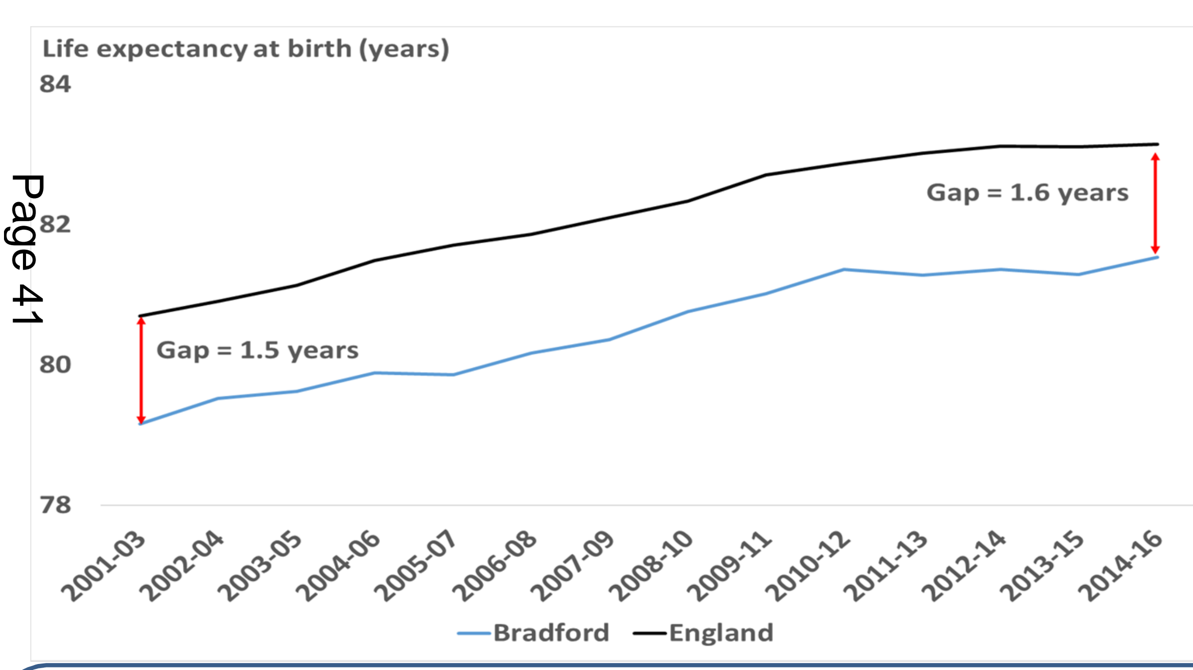
Life expectancy at birth for males in Bradford District has followed an upward trend; however since 2012-14 life expectancy has shown signs of levelling out and the gap between Bradford District and the average for England has widened. Bradford District has the second lowest life expectancy in the region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

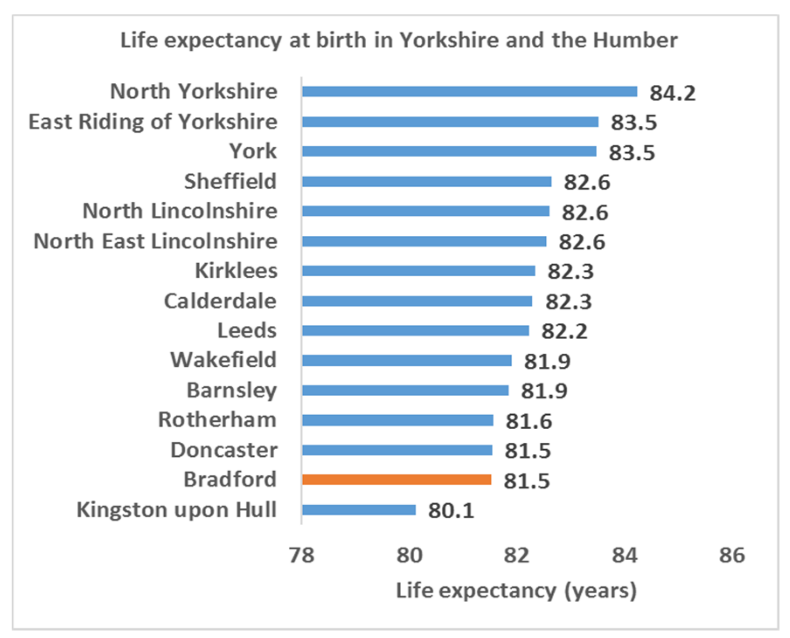
Life expectancy at birth– females

The average number of years a person can expect to live based on contemporary mortality rates

Least deprived quintile in Bradford
84.9 years

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

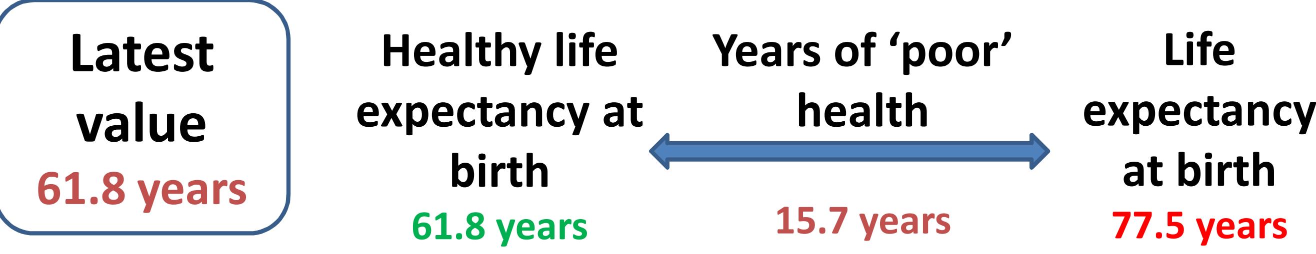




After a period of levelling off between 2012-12 and 2013-15, life expectancy at birth for females in Bradford District has risen in recent years. However the gap between Bradford District and the average for England has widened slightly. Bradford District has the second lowest life expectancy in the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

Healthy life expectancy at birth – males

The average number of years a person can expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health.



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

Healthy life expectancy at birth (years)

64

Gap = 1.5 years

Gap = 2.2 years

60

2009-11 2010-12 2011-13 2012-14 2013-15 2014-16

Bradford England

Healthy life expectancy at birth in Yorkshire and the Humber

Area	Healthy life expectancy (years)
North Yorkshire	66.8
York	66.3
Calderdale	63.5
East Riding of Yorkshire	61.9
Bradford	61.8
Kirklees	61.6
Sheffield	60.4
Leeds	60.3
North East Lincolnshire	59.9
Rotherham	59.8
Doncaster	59.6
North Lincolnshire	59.5
Barnsley	58.6
Wakefield	57.4
Kingston upon Hull	56.5

0 20 40 60 80

Healthy life expectancy (years)

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

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

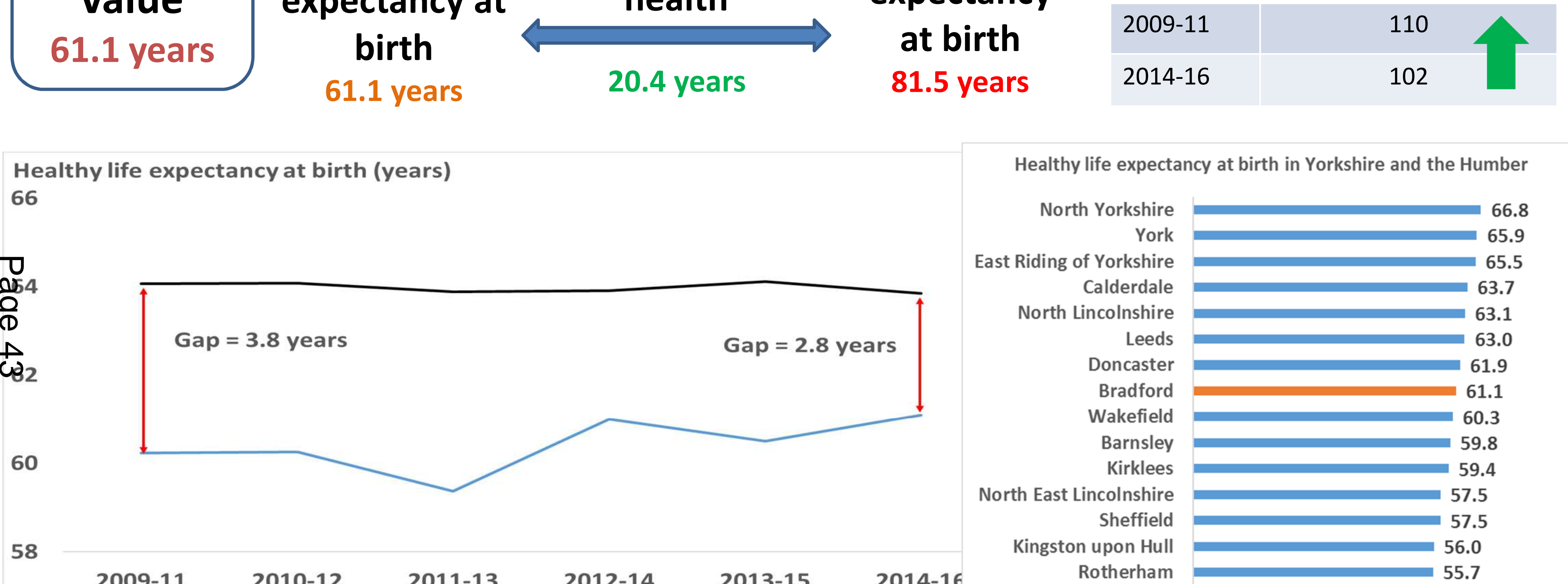
Latest value
61.1 years

Healthy life expectancy at birth
61.1 years

Years of 'poor' health
20.4 years

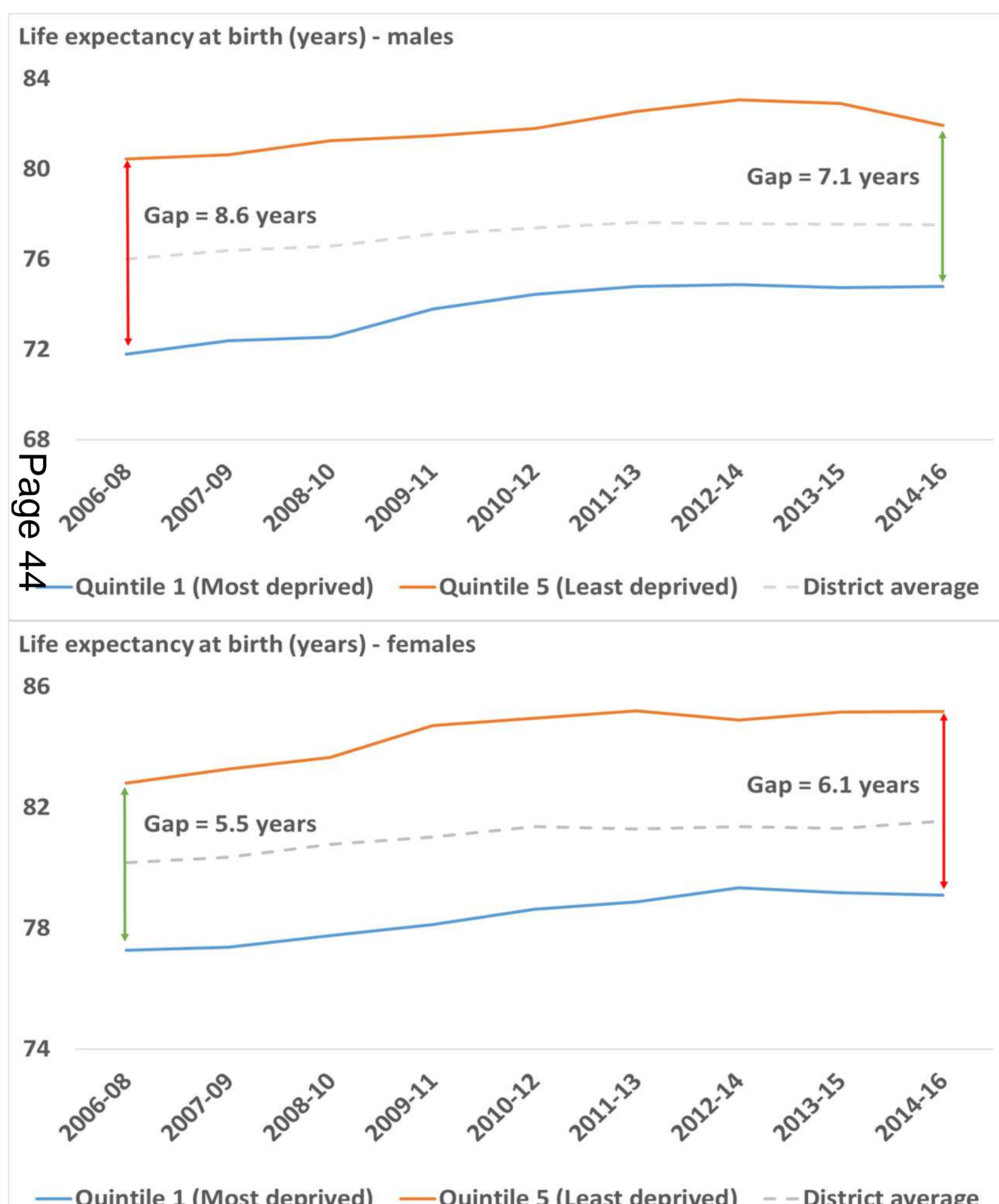
Life expectancy at birth
81.5 years

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



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

Health inequalities – Life expectancy at birth



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

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

Health inequalities – Healthy life expectancy and life expectancy

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

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

Outcome 1: Our children have a great start in life

<table>
<tr><th>KEY OBJECTIVES</th><th>WHAT WE WILL DO</th><th>HOW WE WILL DO IT</th><th>HOW WE WILL KNOW WE HAVE DONE IT</th><th>HOW WE WILL KNOW THAT WE HAVE MADE A DIFFERENCE</th><th>HOW WE WILL KNOW THAT WE HAVE IMPROVED PEOPLE'S HEALTH & WELLBEING</th></tr>
<tr><td>CHILDREN ARE SCHOOL READY & ACHIEVE A GOOD LEVEL OF ATTAINMENT</td><td>Promoting integrated working across the early years workforce; helping parents to develop their knowledge & skills around parenting; rolling out learning from Better Start; Bradford Education Covenant; development of Education Hub; creation of new secondary school places; working with partners to raise aspirations.</td><td rowspan="4">• Children, Families & Young People's Plan
• SEND Strategy
• Integrated Early Years Strategy
• PH 0-19 service (school nursing & health visiting commissioning)
• Active Bradford
• Healthy Bradford
• Future in Mind
• Better Start Bradford
• Oral Health Improvement Action Plan
• Every Baby Matters
• Sport England LDP
• Maternity, Children and Young People's Partnership Board
• Economic Growth Strategy
• Better Births (STP)
• Saving Babies' Lives Bundle
• Future in Mind
• Innovation Plan Integrated Early Years Strategy
• Journey to Excellence Transformation Plan
• Ofsted School Improvement Action Plan
• Anti-Poverty Strategy
• Bradford Safeguarding Children Board</td><td>Number of unauthorised primary & secondary school absences; number of children missing from education in Bradford; number of looked after children who had a missing or absence incident; % of schools rated good or better</td><td>% of children achieving a good level of development at the end of reception

Average Attainment 8 score for all pupils

% achieving 5 A*-C GCSEs</td><td rowspan="4">NARRATIVE HERE

Still births: Rate of stillbirths (fetal deaths occurring after 24 weeks of gestation) per 1,000 births.

Infant mortality: rate of deaths in infants aged under 1 years per 1,000 live birth

% of all live births at term with low birth weight

% of 5 year olds who are free from obvious dental decay

Hospital admissions caused by unintentional and deliberate injuries

Teenage pregnancy: rate of conceptions per 1,000 females aged 15-17</td></tr>
<tr><td>CHILDREN & YOUNG PEOPLE ARE READY FOR LIFE & WORK</td><td>Work with businesses to prepare young people for working lives; develop the Bradford Pathways approach to support career progression; deliver a transition service which focuses on the most vulnerable; work with businesses and training providers to increase the number of apprenticeships; encourage participation of young people that enhance core skills.</td><td>Number of apprenticeships; % of schools with Bradford Pathways Programme; % of sixth form establishments rated good or outstanding% of young people participating up to age of 18.</td><td>% of 16-17 year olds NEET

% first time entrants into youth justice</td></tr>
<tr><td>SAFEGUARDING MOST VULNERABLE & PROVIDING EARLY SUPPORT</td><td>Implementation of Signs of Safety Model, working with social investors, establishment of a joint transitions team; reimagining how we structure and run residential units; supporting young people to access direct payments; development of a local approach to adverse childhood experiences.</td><td>Number of contacts to social care; number of children in care and child protection system; number of DV incidents where child present; number of young people accessing direct payments.</td><td></td></tr>
<tr><td>REDUCING HEALTH & SOCIAL INEQUALITIES</td><td>See OUTCOME 3 – living well
Maternity & CYP Partnership – actions to be inserted here when plan refreshed.
Every Baby Matters – driving down infant morality and evidence based risk factors.</td><td>See Outcome 3 – living well measures; % of antenatal assessments occurring before 13 weeks;</td><td>% of all infants that are breastfed at 6-8 weeks; % of children in reception/Year 6 who are overweight/obese; % of women smoking at time of delivery; % uptake of childhood immunisations</td></tr>
</table>

Outcome 2: People in Bradford District have good mental wellbeing

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

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

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

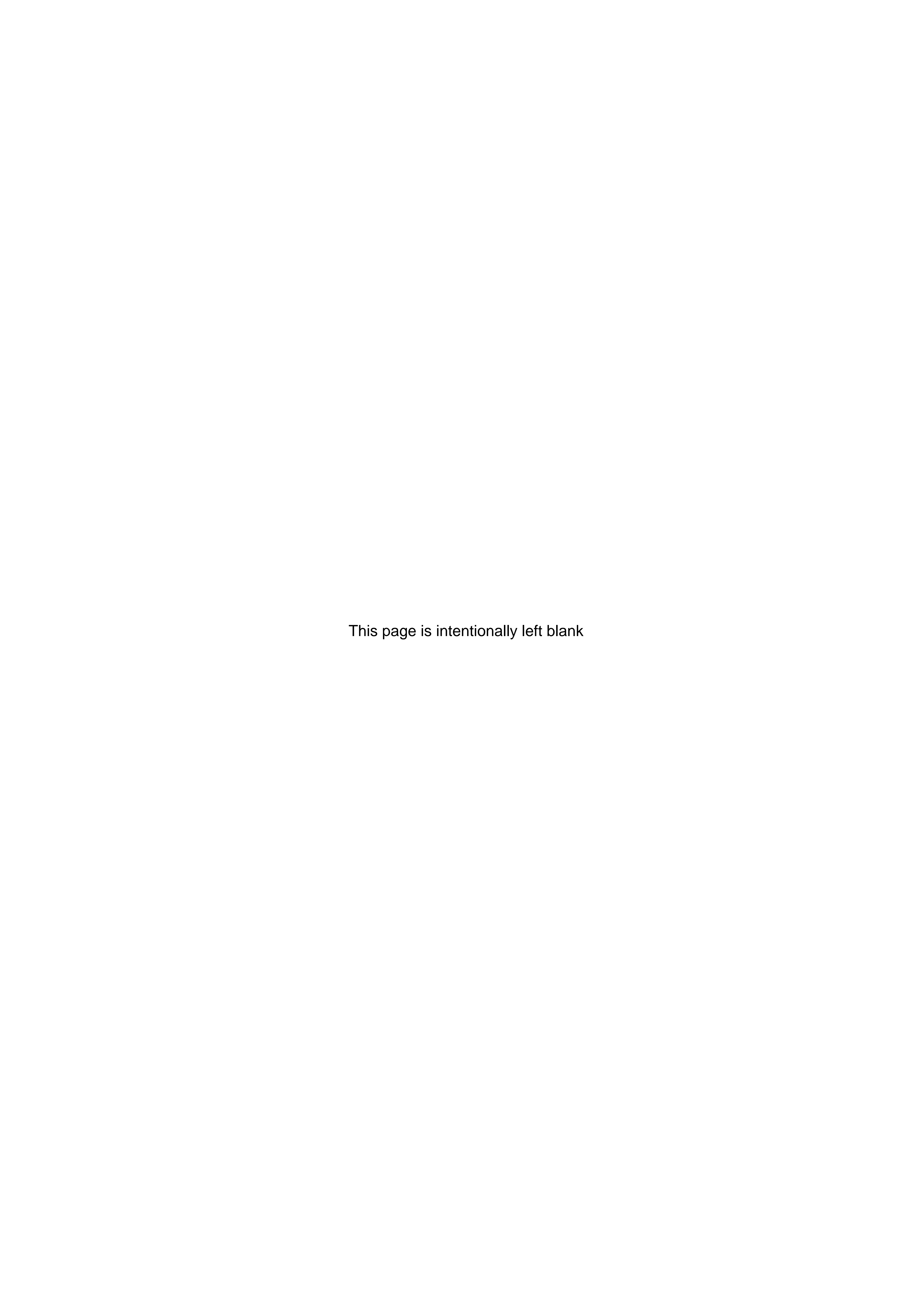
Outcome 4: Bradford District is a healthy place to live, learn and work (1)

KEY OBJECTIVES	WHAT WE WILL DO	HOW WE WILL DO IT	HOW WE WILL KNOW WE HAVE DONE IT	HOW WE WILL KNOW THAT WE HAVE MADE A DIFFERENCE	HOW WE WILL KNOW THAT WE HAVE IMPROVED PEOPLE'S HEALTH & WELLBEING
AIR QUALITY IMPROVES	Specific actions are still to be determined, but will be listed here when agreed.	• West Yorkshire Low Emissions Strategy • Feasibility Studies	This will be determined based on 'what we will do'	Reduction in the annual mean concentration of NO_2 in air quality management areas and areas of concern.	The communities we are born, live, work and socialise in have a significant influence on our health and wellbeing. The wider determinants or social determinants of health determine the extent to which people have the physical, social and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances. By creating healthy places to live, learn & work fewer people will develop long term conditions and poor mental wellbeing. As a result people will live longer lives with more years of good health. **Under 75 mortality rate from CVD, cancer, liver disease & respiratory disease.** **Excess winter deaths index.** **Excess under 75 mortality rate in persons with serious mental illness** **Health related quality of life for people with LTCs**
PEOPLE HAVE ACCESS TO GREEN SPACE & PLACES TO PLAY	Improvement of existing green spaces and play areas, and the creation of new green spaces and play areas through new developments, the area action plans, and grant funding. Increase access and engagement through awareness raising & social prescriptions and making every contact count.	• Core Strategy • Area Action Plans • Planning for a Healthy & Happy Bradford Framework • Healthy Bradford • Active Bradford inc. LDP. • Better Start Bradford	The number of new play areas created; the number of play areas that have been improved; the number of new green spaces created; the number of green spaces that have been improved; the number of street closures for play approved; referrals to outdoors activities.	% of the District meeting the Accessible Green Spaces Standard % of people using outdoor spaces for exercise or health reasons.	
PEOPLE HAVE DECENT JOBS AND FINANCIAL SECURITY	Increase opportunities to support people into paid employment, maximise people's incomes via welfare advice. As set out in the Economic Growth Strategy we will grow our economy by increasing the number of productive businesses and supporting young and enterprising people to innovate, invest and build fulfilling lives in the district. Also see outcome 1 - children and young people are ready for life and work.	• Economic Growth Strategy • Welfare Advice Services • REED in Partnership • Commissioned Services • Anti-Poverty Strategy • Children, Families & Young People's Plan • Opportunity Area Programme	POPULATE BASED ON ECONOMIC GROWTH STRATEGY	% of children living in low income family; % of people aged 16-64 in employment; average weekly earnings; % of working age people qualified to NVQ level 3 or equivalent.	
THE DISTRICT HAS A HEALTHY WORKFORCE	Introduce a charter for employers outlining the steps that they can take to improve the health and wellbeing of their workforce	Healthy Bradford NHS health & wellbeing CQUIN	The number of employers who have signed up to the Healthy Bradford Charter; % achievement CQUIN	% of working days lost to sickness absence; % of employees who had at least 1 day off in previous week.	

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

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

Ref.	Action	Owner	Status	Due	action verified by owners
1. System leaders need to address issues around quality in the independent social care market with a more proactive approach to contract management and oversight					
1.1	Engage all adult social care regulated services as quality improvement partners - Electronic survey to be completed to engage providers across the whole CQC regulated services across the District, providing space for providers to advise on their top risks in keeping with the top issues identified in the House of Lords review.	ECB	open	31/03/19	
1.2	Establish Service Improvement Boards for home care and care homes, and an over-arching quality forum to coproduce a single market position statement which shifts from reactive annual activity towards a population focus defining the size and desired consitution of the future market shape.	ECB	open	30/11/18	
1.3	Undertake fair cost of care modelling exercise with providers drawing on CIPFA (Chartered Institute of Public Finance and Accountancy) Guidance and use to inform re-commissioning of the frameworks for regulated services - enabling a shift from annual fee setting processes to a long term settlement.	ECB	open	30/11/18	
1.4	Share the findings from the Cordis Bright tool market risk analysis with providers and co-produce themes arising from this work to inform a new Quality Framework and peer to peer approach to ensuring good quality person-centred care and support for all.	ECB	open	31/08/18	
1.5	Examine potential to embed principles and meet the cost of implementing the living wage and Unison Ethical Care Charter within reviews of frameworks for care homes, home care and supported living.	ECB	open	31/08/18	
1.6	modelling to be undertaken on the current state and potential future state given changes in micro-commissioning trends	ECB	open	30/09/18	
1.7	Share intelligence coordinated by Public Health to enable modelling to be undertaken of the long term shifts in the profile of people who need care and support	ECB	open	31/08/18	
1.8	Consider proposal of care home home providers to integrate with locality working arrangements through primary care home/ community model, and to establish a joint service improvement team	ECB	open	31/08/18	
1.9	Explore opportunities to introduce a common framework of competences (skills) and competencies (attributes) for integrated working across health and social care across all provider settings.	IWPB/Health and Social Care Academy Leadership Group	open	31/10/18	
2. Building on good relationships that exist between stakeholders such as VCSE organisations and GP alliances, this needs to be extended to the independent care sector					
2.1	Work with independent care sector to review participation in local partnership, governance and programme delivery arrangements. To include (but not limited to): ICB, Health and Care Partnership Boards, Provider Alliances, Out of Hospital programme board	ICB (to coordinate)	open	31/08/18	
2.2	Programme Management Offices/ support for local partnership arrangements to consider how to operate with greater flexibility to enable participation by wider range of stakeholders without relying on meeting attendance	ICB (to coordinate)	open	30/09/18	
2.3	Work with the independent care sector to be actively involved in shaping how as a system we attract, recruit, develop and retain a high quality workforce across the wider health and care system	IWPB/Health and Social Care Academy Leadership Group	open	31/03/19	
3. Leaders need to ensure that outcomes are person centred and caring in line with the vision and strategy					
3.1	Develop an agreed approach to system development to support delivery of strategy and vision	OD Network	open	30/09/18	
3.2	Roll out the agreed common set of values/principles for integrated working across all organisations, to help foster a culture of being part of one system with a common purpose	IWPB	open	31/12/18	
3.3	Develop a system-wide programme of staff engagement, using personal narrative to reflect person centred approaches in various care settings, to ensure that Happy, Healthy at Home is owned by staff at all levels in all parts of the system.	Comms and Engagement Network	open	30/09/18	
3.4	In recognition of the challenges posed by differing national requirements placed on organisations that are trying to work together; develop a common framework for the next level of collaboration, addressing shared decision making and integrated commissioning and delivery.	Health and Care Partnership Boards	open	30/11/18	
3.5	Establish learning and improvement processes through which the system will support providers with common themes and systemic issues emerging from CQC (and other quality) inspections.	ICB (to coordinate)	open	30/09/18	
3.6	CQC consider best practice is the ethos of not moving frail people between wards in the hospital where possible – however they observed occasions where this didn't happen in practice during the review. The system to stress test how embedded this approach is in practice, and develop a method of assurance through which partners hold each other into account to hold true to the principles during periods of stress within the system such as winter peak flow.	A&E Delivery Board	open	30/09/18	
4. NICE guidance recommends that, apart from some exceptions, domiciliary care visits should not be shorter than half an hour. The commissioning of 15 minute domiciliary care visits needs to be reconsidered as concerns had been raised about the provision of care being task focused rather than person centred and leading to an increased risk of medicines errors.					
4.1	review current commissioning policies and move towards outcome based contracting arrangements, rather than time/ task focused commissioning	CBMDC	open	30/09/18	
5. There needs to be clearer signposting systems to help people find the support they need, particularly for people who fund their own care.					
5.1	Review current arrangements with the aim of implementing an integrated/ aligned single point of access, which allows for easy access, smoother customer journey, and enhanced communication between services	Out of Hospital Programme Board	open	31/12/18	
5.2	Review current information available to people and their families to help them make informed decisions on care options (particularly re long term care options)	CBMDC	open	31/12/18	
6. Although good work was in place with the local authority MCA and best interest assessment team, system leaders need to ensure that staff in health services and independent social care provider services have a better understanding of peoples rights and are able to understand the lifestyle choices that people make. System leaders need to address the fact that some peoples experience is not consistently good and person-centred.					
6.1	Continue roll out of Mental Capacity in Practice training to strengthen understanding of how to capture and uphold people's wishes, feelings and beliefs within care and support planning and delivery and refresh the offer in keeping with the new Multi-Agency Safeguarding Adults Procedures implementation programme.	Safeguarding Adults Board	open	31/03/19	
6.2	Safeguarding Adults Board to seek assurance from all local partner organisations on the compliance and effectiveness of their MCA training arrangements	Safeguarding Adults Board	open	31/03/19	
6.3	MCA teams across local partners to review opportunities for whole system collaboration, with the aim of enhancing adherence in all providers (health and care)	MCA teams	open	30/11/18	
7. There is potential to build primary care capacity and to maximise the impact of the primary care home model; the commissioning approach to primary care needs to maximise the outcomes from the two at-scale GP models emerging in Bradford.					
7.1	Develop plans to align approaches to locality working (primary care homes, ward teams etc)	Health and Care Partnership Boards	open	31/10/18	
7.2	Keep looking outwards and bringing more people together.Test how effectively current partnerships are fully inclusive of diverse and differentiated viewpoints and agendas. (e.g. community pharmacy, dentistry, optometry, VCS organisations large and small, faith organisations, housing organisations, tenants and residents associations)	Health and Care Partnership Boards	open	31/03/19	
7.3	Build on strength of community anchor involvement in communities/ locality working, to maximise VCS engagement	Health and Care Partnership Boards	open	31/03/19	
8. Although information sharing and governance was well-developed, system leaders need to consider how to streamline processes when people are discharged from hospital with less reliance on paper based systems.					
8.1	Investigate and eliminate the use of fax machines, with all partners committing to support a consistent approach	Digital 2020	open	30/09/18	
8.2	Subject to feedback from the pilot, roll out the new SystmOne EDSM (Enhanced Data Sharing Module) across the District.	Digital 2020	open	31/12/18	
8.3	Review current data sharing and information governance procedures across the heallth and care system with a view to developing an approach that addresses barriers and supports integration.	Digital 2020	open	31/03/19	
9. Medicines management when people have left hospital needs to be improved to reduce the time people have to wait for their medicines and to ensure that social care providers and people returning to their own homes have a clear understanding of the medicines they have been prescribed					
9.1	CQC observed low levels of self administration on wards – noted that this helps people to retain/ regain independence and should be promoted. Consider how to strengthen this	A&E Delivery Board	open	31/10/18	
9.2	Review medicines supply and usage along pathways including home, hospital and residential/ nursing care settings, applying best practice - including Red Bag scheme; ensuring people and their carers have a clear understanding	A&E Delivery Board	open	31/03/19	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Report of the Strategic Director of Health and Wellbeing to the meeting of the Health and Social Care Overview and Scrutiny Committee to be held on 4th October 2018

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Subject:

Reimagining Days

Summary statement:

This report gives an update on the work taking place to re-think the Department's approach to daytime activities.

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Portfolio:
Healthy People and Places

Overview & Scrutiny Area:
Health & Social Care

1. SUMMARY

1.1 The following report summarised the work that has been undertaken in the last year on the different elements of the Reimagining Days project.

2. BACKGROUND

2.1 A report on Reimagining Days came to Overview and Scrutiny committee on the 7th December 2017 and was asked to return to provide a further report.

2.2 This forms part of the overall departmental transformation work. Community Led Support is a model for social work that is about working collaboratively with communities to redesign services that work for everyone, that evolve and are continually refined, based on learning. The Community Led Support principles are:

- Coproduction brings people and organisations together around a shared vision
- There has to be a culture based on trust and empowerment
- There is a focus on communities and each will be different
- People are treated as equals, their strengths and gifts built on
- Bureaucracy is the absolute minimum it has to be
- People get good advice and information that helps avoid crises
- The system is responsive, proportionate and delivers good outcomes

2.3 Reimagining Days is an area of work that is about re-thinking the aspirations for people we support, exploring new partnerships with communities, thinking about how funding is most effectively used, planning new services and alternative types of support and reflecting on what actually works. This includes a focus on employment, community connecting, market development and individual service funds/self-directed support.

2.4 Work is underway to ask people with learning disabilities what a good day would look like and this will continue to influence the development of this area of work.

2.5 A light touch grant process was run and concluded by 31st March 2018. The experience of this project led us to believe that a procurement process would not lead to the provision of grass roots community projects that we need in line with the Community Led Support approach the department is developing and with the appropriate approvals we have proceeded with a grants process.

3. OTHER CONSIDERATIONS

3.1 Employment: There are real opportunities to promote access to Council apprenticeships for young people with learning disabilities as well as the Council taking a more prominent role within Project Search in partnership with the provider Hft.

3.2 Project Search is a pre-employment program based at Bradford Teaching Hospitals NHS Foundation Trust initially, but now working with other employers, which helps

young people with learning disabilities gain the skills they need to get meaningful paid jobs. Interns are supported with training as well as each term undertaking a work placement. During each placement people participating will have a mentor as well as support from an Hft job coach. As part of the scheme there is a Business Advisory Committee comprised of business people who advise on skill shortages and hard to fill entry level jobs as well as providing interview experience for interns and some employers may offer rotations for an intern.

3.3 Work with colleagues in Public Health is also underway to bring together all Supported Employment providers to develop a more joined up approach to offer employment opportunities to as great a number of people as possible.

3.4 Individual Service Funds (ISFs): We have been developing this option for people and by the 1st October we anticipate 40 people with 6 providers will be using these. Piloting of the Connect to Support virtual wallet is being developed as part of this work.

3.5 An ISF is where the persons social care budget is held by a care provider but the service user can choose how it is spent. It can therefore be used flexibly to tailor services to meet people's needs and help them achieve their outcomes. The ISF holder will be an organisation the person chooses, who will then manage the money on their behalf, arranging the care and support services they choose.

3.6 We are actively working with Hft to manage the end of the existing block contract by:

- Supporting people to transfer their existing funding arrangements to individual service funds
- Working in partnership with Asset Management and Hft, to ensure buildings are fit for purpose
- Through prioritised assessments and reviews and implementation of the principles of Community Led Support and reimagining days to offer alternatives
- Supporting the re-structuring of the service currently being delivered

3.7 To support the changes we are developing we have awarded the Gig Buddies contract to MENCAP. Gig Buddies matches adults who have a learning disability to a volunteer who has similar interests, to go to events together that they both enjoy. This will help us support people to get involved in community activities with friends rather than paid support.

3.8 A number of developments in relation to developing other options for people are underway. We have had initial discussions with colleagues in Sports and Recreation to work with them on an inclusive sport project they are developing. Colleagues in Culture have supported us with Gig Buddies and we hope to develop this relationship further as new music and theatre venues are developed in Bradford. We have also been in touch with anchor organisations such as the Science and Media Museum and Kala Sangam to work more closely.

3.9 We are in the process of evaluating grant applications for community activities. This will mean we will only be funding those organisations which are working within the ethos of Community Led Support. This will be concluded before the end of this calendar year and new grant agreements will commence from 1st April 2019.

3.10 We will commence work on developing a daycare framework in winter 2018. The Care Act specifies that people should be able to access managed services should they choose to do so and a framework would be the ideal way to ensure we can offer this to people but for them to still have a personalised option. A framework would also allow us ensure we have consistent terms and conditions and costs across the sector.

4. FINANCIAL & RESOURCE APPRAISAL

4.1 The grants process will deliver savings of £400,000. We will work to deliver this whilst minimising the impact on people using daytime activities.

4.2 The daycare framework will also deliver savings by establishing clearer costs.

4.3 These savings are included in previous year's savings plans and will assist in achieving the overall target reductions.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

5.1 This project is required to regularly report to the Departmental Procurement Assurance Board and the Departmental Transformation Programme Board

6. LEGAL APPRAISAL

6.1 The Care Act 2014 contains provisions relating to adult care and support and health The Care and Support Statutory Guidance suggests that councils may seek to use ISFs:

- To promote flexible support;
- To offer people choice over who provides them with support
- As a legitimate method for managing a personal budget

6.2 Legal services have been actively engaged with work on Individual Service Funds and ending the Learning Disability block contract with Hft.

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

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

7.1.1 As part of all commissioning processes equality impact assessments will be completed to ascertain any possible impacts.

7.2 SUSTAINABILITY IMPLICATIONS

7.2.1 None

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

7.3.1 None

7.4 COMMUNITY SAFETY IMPLICATIONS

7.4.1 None

7.5 HUMAN RIGHTS ACT

7.5.1 The implementation of the Council's duties under the Care Act 2014 must be discharged in keeping with the positive obligations on the Council to uphold and safeguard people's human rights in keeping with the European Convention on Human Rights.

7.5.2 ISFs help people with care needs to have flexible, personalised support, tailored to individual preferences without having to manage cash direct payments. This means people and families can choose to live in their own homes, with their own support and using their own budgets, while the councils that commission those services work differently with community organisations and providers of services to improve outcomes for people they serve and reduce costs

7.6 TRADE UNION

7.6.1 None

7.7 WARD IMPLICATIONS

7.7.1 Neighbourhood staff have been working with us in relation to Community Led Support and Ward officers are supporting the grant application evaluations.

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

7.8.1 As above

7.9 IMPLICATIONS FOR CORPORATE PARENTING

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

7.10 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

7.10.1There may be a need for partner agencies to share data this would only be with the express permission of the service user in the full knowledge of why and what it would used for. General Data Protection Regulation (GDPR) principles relating to any individuals data and rights under the Data Protection Act 2018 will be respected.

8. NOT FOR PUBLICATION DOCUMENTS

8.1 None

9. OPTIONS

9.1 None

10. RECOMMENDATIONS

10.1 Recommended:

1. That the contents of this report be noted.
2. That the Committee support the overall direction of travel of Reimaging Days.
3. That the Committee consider the option for the Council to support apprenticeships for people with a learning disability and take a more active part in Project Search.

11. APPENDICES

11.1 None

12. BACKGROUND DOCUMENTS

12.1 Report to the Health and Social Care Overview and Scrutiny Committee on 7 December 2017, Document “U”.

Report of Bradford City, Bradford Districts and Airedale, Wharfedale and Craven Clinical Commissioning Groups to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 4th October 2018

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Subject: Clinical Commissioning Groups' Annual Performance Report

Summary statement: This report presents performance against the NHS England Clinical Commissioning Group Improvement and Assessment Framework for 2017/18 for Bradford City (BCCCG), Bradford Districts (BDCCG) and Airedale, Wharfedale and Craven (AWCCCG) Clinical Commissioning Groups.

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Portfolio:

Healthy People and Places

1. Summary

This report presents performance against the NHS England Clinical Commissioning Group Improvement and Assessment Framework for 2017/18 for Bradford City (BCCCG), Bradford Districts (BDCCG) and Airedale, Wharfedale and Craven (AWCCCG) Clinical Commissioning Groups.

2. Background

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

NHS England has a statutory duty (under the Health and Social Care Act 2012) to conduct an annual assessment of every CCG. The CCG Improvement and Assessment Framework (IAF) draws together the NHS Constitution, performance and finance metrics and transformational challenges and plays an important part in the delivery of the NHS Five Year Forward View.

3. Report issues

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

3.1 Overall IAF Performance

The CCGs have demonstrated improvement in a number of performance areas and this has resulted in an improved overall rating of 'OUTSTANDING' for Airedale, Wharfedale & Craven CCG (AWCCCG) and Bradford City CCG (BCCCG). Bradford Districts CCG (BDCCG) has maintained its overall rating of "GOOD".

These ratings compare to a national position as presented in the table below:

CCGs rating	**2017/18**		**2016/17**		**2015/16**	
	No.	%	No.	%	No.	%
Outstanding	20	9.7%	21	10.0%	10	4.8%
Good	100	48.3%	99	47.4%	82	39.2%
Requires improvement	69	33.3%	66	31.6%	91	43.5%
Inadequate	18	8.7%	23	11.0%	26	12.4%

Fifty percentage of the overall rating was based on performance against a range of indicators across the two domains of Better Health and Better Care, 25% is based upon financial performance and the remaining 25% is allocated to the quality of leadership assessment. Key points to note are:

- AWCCG - Particular areas that are performing well include, the levels of childhood obesity; antibiotic prescribing; CQC high quality care ratings for GP practices; and minimising admission rates for people at their end of life.

  The CCG has no indicators amongst the bottom 10 CCGs in England, although there are some areas where performance could be improved including: reducing health

inequalities; extended access to GPs; and patient and community engagement.

- BCCCG - Delivery of the Better Care and Better Health indicators remains more challenging. Whilst there has been improvement in 20 indicators including reducing injury from falls, antibiotic prescribing, early cancer diagnosis and maternity experience and choice, 14 indicators appear amongst the 22 worst performing CCGs in England.

  Areas in greatest need of improvement are: improving the quality of life for carers; one year cancer survival rates; reducing hospital admission rates for people at their end of life; hospital waiting times; access to psychological therapy services (IAPT) and associated recovery rates; the level of childhood obesity; health inequalities; and neonatal mortality and stillbirths.

  Patient experience of GP services has improved from 56.1% in 2016 up to 73.8% in 2017, although BCCCG is still below the England average. Our Enhanced Primary Care work stream is focussing on a number of key areas for 2018/19 including: Roll out of extended access to 100% of the population by October 2018; successful recruitment of international GPs; and the roll out of online consultation systems.

- BDCCG - Performance against both the Better Care and Better Health indicators is rated as AMBER. Over the year there have been improvements for 18 indicators with areas of good performance including antibiotic prescribing, one-year survival from all cancers, ensuring patients who require a mental health bed can remain local, reducing the reliance on specialist learning disability (LD) inpatient beds (allowing patients to remain in the community) and increasing the number of LD physical health checks conducted in primary care.

  Areas in need of improvement include, reducing childhood obesity levels; reducing health inequalities; improving quality of life for carers; IAPT access; experience of GP services; and extending access to GP services in the evenings and at weekend.

- The rate of unnecessary delays for discharge from hospital remains low. Funded via our Better Care Fund (BCF), we have multi-disciplinary teams in place to facilitate quick and effective discharges from hospital and minimise delays to patients and additional community beds have been commissioned during times of high pressure. As a result we continue to have one of the lowest rates of delayed transfers of care nationally and continue to minimise the use of hospital beds following emergency admission. We will continue to work with the local authority to fund and develop services which help people manage their own health and wellbeing, and live independently in their communities for as long as possible.

- However, inspection of the adult social care sector remains a cause for concern. As part of our BCF work, in order to stabilise and improve the quality of care in the care homes sector, targeted support has been offered by the system including training, support with CQC inspection processes, specialist equipment provision and use of technology.

- The number of referrals for hospital treatment, which were made electronically, remained below national averages in 2017/18 for all 3 CCGs. The national ambition is for all referrals to be made using the national e-referrals service from 1st of October 2018 as a key element in the move to a paperless NHS. Following Airedale Hospital Foundation Trust (AHFT's) & Bradford Teaching Hospitals Foundation Trust (BTHFT's) move to 'paperless' in March and June 2018 respectively, we are now

seeing a steady increase in the % of electronic referrals. Electronic referrals help patients to have more choice and control over their healthcare, the quality of referral information is improved and Trusts' benefit through reducing 'did not attend' (DNA) rates and improving administrative efficiencies.

- All three of our CCGs have been rated highly for Quality of Leadership with a GREEN STAR placing our 3 CCGs within the top 26 CCGs awarded this rating for 2017/18.

  The CCGs are part of the Bradford district and Craven (BdC) health and care system and collectively we have much to be proud of in pursuit of our shared ambition of keeping people Happy, Healthy at Home. The extent to which this vision is understood and owned across the system has been tested in the recent Care Quality Commission (CQC) review. The CQC remarked on the breadth and strength of partnership here and the commitment from all towards our common ambition of keeping people happy, healthy at home.

- All three CCGs delivered their statutory financial targets in 2017/18.

The ratings for five of the six national clinical priorities have also been published and CCG performance is shown in the table below:

	AWCCCG		BCCCG		BDCCG	
	Baseline rating	Latest Rating	Baseline rating	Rating 2017/18	Baseline rating	Rating 2017/18
Cancer[2]	Good	Good	Inadequate	Requires improvement	Good	Requires improvement
Mental Health[1]	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Good
Dementia[1]	Outstanding	Good	Outstanding	Outstanding	Outstanding	Good
Diabetes[2]	Requires improvement	Requires improvement	Inadequate	Inadequate	Requires improvement	Requires improvement
Maternity[2]	Requires improvement	Good	Requires improvement	Requires improvement	Inadequate	Requires improvement
Learning Disability	Requires improvement	Not yet published	Requires improvement	Not yet published	Requires improvement	Not yet published

[1] *Latest rating is 2016/17* [2] *Latest rating is 2017/18*

Key points to note are:

Cancer

Half of people are diagnosed at stage 1 or 2 in AWCCCG and BCCCG against a national ambition of 62% by 2010/21. This is less in BDCCG, but has improved from 38.3% to 48.8%. Whilst diagnosis at an early stage is also improving and all 3 CCGs have seen improvement in one-year survival rates, performance against the national cancer waiting times standards can sometimes be challenging and BCCCG and BDCCG rank poorly nationally in terms of patient experience.

It is recognised that cancer treatment pathways can be specialised and cross numerous providers. Work is ongoing to improve engagement with the national screening programmes for bowel, cervical and breast cancer and the CCG has partnered with several charitable organisations such as Cancer Research UK and Yorkshire Cancer Research to promote knowledge of cancer symptoms within our population as well as practical steps to reduce the risk of cancer. The West Yorkshire Cancer Alliance has provided additional money to develop and implement an education programme for Lung Cancer to raise awareness of early signs and symptoms to help detect cancers earlier;

Mental Health
There is strong evidence that tackling mental ill health early improves lives and around 1 in every 6 adults in England suffers from common mental health problems such as depression or anxiety disorder. The Mental Wellbeing in Bradford District and Craven: A Strategy 2016 – 2021, was launched in January 2017 to improve the wellbeing for the people of BdC. The strategy outlines three key strategic priorities:

- our wellbeing: building resilience, promoting mental wellbeing and delivering early intervention;
- our mental and physical health: developing and delivering care through the integration of mental and physical health and care; and,
- care when we need it: ensuring that when people experience mental ill health they can access high quality, evidence-based care.

However, our ratings suggest that there is still work to do to improve access to mental health service. Locally we have established the Bradford crisis care partnership and first response services which has received national recognition. We have had no out of area placements for people needing an acute mental health bed in over a year and we have established services in A&E and acute hospital wards to manage crisis care. Partners from the NHS, local authority, police and voluntary and community sector (VCS) organisations work together under the crisis care concordat to ensure that people who experience a mental health crisis receive the care they need from the service best placed to provide it, 24 hours a day, seven days a week. We also commission 'safe havens' (The Sanctuary, The Haven) and a safe space for children and young people from the VCS. These offer a warm and supportive place to stay for people experiencing a crisis but who do not need to be admitted to hospital, providing care in the least restrictive environment possible.

Our work across West Yorkshire and Harrogate Health and Care Partnership includes developing a local service framework for mental health and strong partnership working on child and adolescent mental health services, low, medium and secure forensic services, autism and suicide prevention.

Dementia
Dementia diagnosis and post diagnosis care for all 3 CCGs remains amongst the best in England. There are four key elements of post-diagnostic support: Access to a Dementia Adviser 2 weeks after referral; a Nurse review 3 months after diagnosis, of individuals physical and mental health and social care needs; a GP review every 12-15 months; and Dementia Friendly communities, businesses and services.

Working closely with local partners, including VCS organisations such as Carer's Resource and the Alzheimer's Society, our work across BdC has included:

- Improving access and waiting times to Memory Clinics;
- Caring and Sharing - relationship counselling for people with dementia and/or their partners;
- 23 Memory Cafes across Bradford for vulnerable people over 55, including 4 specifically for people with Dementia;
- Airedale Hospital has held a Living with Dementia Awareness Week and implemented dementia awareness training for all staff together with bespoke training to targeted areas and their Dignity Room provides provisions/clothes/toiletries etc. for patients and carers; and

- Diagnosis rates in Bradford District Care Foundation Trust's (BDCFT) Memory Assessment Clinics are now one of the highest in the region and their Daisy Hill Dementia Assessment Unit has received a Gold Award from Stirling University.

Stroke Services
The Sentinel Stroke National Audit Programme (SSNP) data has recently indicated there has been an overall deterioration in the quality of stroke services across the district. Work continues to establish the service as a single service across both acute hospital trusts, supported by the Head of Collaboration for Stroke. Some challenges persist in recruitment across all clinical teams and bed capacity, which the teams are actively working towards resolving. Pathway reviews are under way and the teams are also working towards a joint action plan to aid collaborative working.

As of 29th August 2018, BTHFT SSNAP data is showing an improvement which provides some assurance on all the focused work the trust is undertaking, and the team score (all patients whose full pathway is within the Trust service) increased to a level B (the highest score ever achieved for the Trust).

Diabetes
This national clinical priority is in place to incentivise CCGs to improve implementation of the NICE-recommended treatments (e.g. management of blood pressure, glucose (sugar) and cholesterol levels) and increase the number of patients attending structured education. Better management of diabetes can play an important role in the reduction of risk and complications of diabetes e.g. eye disease, kidney failure, stroke, heart disease, foot ulcers and amputation.

Across England 40% of people are within NICE recommended treatment levels, this is a low result and means that only 2 out of 5 people with diabetes are managed within recommended levels. For BdC, of the 35,545 people on GP practice registers, 13,650 were within all three NICE recommended treatment levels, the same result as England. While our focus via *Bradford Beating Diabetes* is on prevention and self-care, more work needs to be done on supporting those who have been diagnosed with the disease to make sure that people with the condition have the best outcomes.

Across England just 7.3% of diabetics completed structured education within the first twelve months of their diagnosis. This low result is thought to be in some part due to people not taking up the offer of education and in part due to methods of recording attendance. For BdC, of the 2,535 people who received a diagnosis during 2015, only 105 were recorded as completing 6 sessions of structured education within the first twelve months of their diagnosis, that's just 4%. We are working hard with our local hospitals, GPs and patients to make improvements in the way we provide structured education courses to encourage more people to take up the offer of life changing health and lifestyle advice, enabling people to attend them closer to home, in a suitable language and in a familiar environment, and we were awarded £702k to improve structured education in 2017/18.

We are planning to provide more education sessions within GP surgeries and community centres, in different languages, women only sessions and at different times including weekends so that people have more choice and can attend the structured education programme closer to home and in familiar environment.

Maternity
There has been an improvement in smoking rates during pregnancy for AWCCCG and BDCCG but an increase in BCCCG. Working in partnership with Public Health we will utilise the learning from the work undertaken by the Women's Health Network to

understand why women from some our communities don't access smoking cessation services to improve our local service offer. In addition, we will utilise the leaning from the Better Start Bradford case loading midwifery pilot to reduce our rates for smoking at time of delivery and at 6 weeks baby check appointment.

The neonatal mortality and still births rates have increased in AWCCCG and BCCCG, but reduced for BDCCG. We are working in partnership with colleagues across the health and care economy to reduce stillbirth, neonatal and infant mortality rates. This work recognises a number of factors including the impact of poverty, access to a range of services and the need to offer high quality maternity provision.

In general women's reported satisfaction with maternity services is good. We are continuing to develop our understanding of the needs of the local population through the development of BdC Maternity Voices Partnership and our work with the Women's Health Network. In addition, we will utilise the learning from the Better Start Bradford case loading midwifery pilot where 100% of women advised they would recommend the service they received. The CCGs commission the full range of maternity choices for local women and therefore future work will focus on how these choices are offered along the care pathway to ensure all women feel they have access to the full range of services available to them.

Our CCG wide Maternity, Children and Young People's Programme Board will oversee the implementation of the recommendations of the five year forward view for maternity services. Led by a senior clinician we have identified our local priorities, developed an action plan and will engage with senior management from across the local health and care system to achieve delivery. Locating maternity alongside the children and young people's developments allows us to maximise the opportunities for improving both maternal and child health outcomes.

Over 2016 and into 2017 the maternity services at BTHFT saw an increase in the level of serious incidents reported, alongside a range of other ongoing concerns. The CCG raised concerns and via our Joint Clinical Board (JCB) and Joint Quality Committee (JQC) a number of maternity themed discussions took place. Prevention of stillbirths has remained a major priority during 2017/18, and data for the trust indicates a significant reduction in stillbirths for this period. 2017/18 has therefore been a challenging year for the Maternity Services at BTHFT, as the unit has worked hard to complete and embed the Maternity Improvement Plan (MIP), which were the combined recommendations from the 2016 Maternity Quality Summit, the CQC and the Royal College of Obstetricians and Gynaecologist (RCOG) review, held in April 2017.

Learning Disability

The number of people with a learning disability and/or autism in specialist inpatient care has increased over time and nationally there is a drive to reduce reliance on inpatient care, and provide better community based care. Our system wide Transforming Care Partnership has plans in place to:

- Engage with and support providers who are new to Bradford but have experience of supporting people with very complex presentations;
- Develop community housing provision at 8 sites across Bradford and Keighley to offer people different housing options; and
- We are working with other CCG's in West Yorkshire to collaboratively commission an Assessment and Treatment service within the regional footprint.

Annual health checks are an important tool to help improve health and reduce premature death in people with a learning disability and the ambition is to improve access to health

checks for people with a learning disability over 14 years of age. To support this, BDCFT has recently re-launched easy read publicity, which has gone to GP surgeries and other public buildings, around the importance of having an annual health check.

However, the Royal College of General Practitioners (RCGP) suggest that nationally only around a third of the estimated numbers of people with a learning disability are on a GP register, meaning that appropriate adjustments to their healthcare cannot be delivered and a number of patients miss the benefits of targeted interventions such as annual health checks. We aim to increase the number of people with a learning disability on the register from the current level of 0.50% of the practice population through working with GP practices to promote the benefits of being on this register (some families and individuals are still reluctant to have their name on a register that indicates they have a learning disability). This will be supported by better sharing of information and data across health and social care.

The CCG have launched ThinkLD, a campaign which asks everyone involved in caring for people with a learning disability (across the health, social care and voluntary sector) to think about how they can make access to health services as easy and as positive as possible. The CCGs are also participating in the Learning Disabilities Mortality Review Programme, a review process for the deaths of people with a learning disability, with a view to take forward lessons learnt in the reviews to make improvements to service provision. Completion of reviews is a national challenge, and we aim to increase the number of Multiagency reviews completed. A Regional LeDeR Co-Ordinator has been recruited to facilitate this.

3.2 Constitutional Target Performance

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

18 weeks Referral to Treatment (RTT)

The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). However, delivery of the target has been challenging as a result of increased demand and capacity issues across the local system.

Whilst AHFT delivered the RTT target overall in 2017/18 they did experience pressures at a specialty level (in particular General Surgery, Urology and Orthopaedics). However, there has been consistent poor performance at BTHFT.

Issues at BTHFT have been compounded by the introduction of a new Electronic Patient Record (EPR) system in August 2017. Capacity across the Trust was reduced for a number of months during implementation and data quality has been affected. The Trust has a full recovery plan agreed with NHS Improvement for delivery of the national target by March 2019, which is focusing on a number of areas:

- <u>Patient safety & clinical harm:</u> A process is in place to clinically review all patients waiting 52+ weeks. Currently no clinical harm has been identified;
- <u>Operations & performance</u>: Backlog clearance plans have been developed and specialty level trackers are being rolled out across the Trust in order to quantify specialty level delivery against recovery trajectories. Weekly reviews are taking place and there is a monthly stocktake of demand and capacity. There is also work ongoing to improve the management of the planned and diagnostic waiting lists, outpatient

referrals, reduce elective cancellations and improve communication to GPs;

- Data quality & validation: Whilst some of the increase in the waiting list will be a result of reduced capacity during EPR 'go live', there could be some impact from how patients are coded which may be resulting in duplicate entries; and
- Training: Additional training for staff on pathway management processes will be developed and standard operating procedures (SOPs) for managing waiting lists.

We are working in partnership with our local providers to develop a more sustainable planned care delivery model through our Planned Care Programme work. This work has identified a number of opportunities including reducing unnecessary follow up appointments, standardising GP referral criteria and limiting access to procedures which have been proved to have limited clinical effectiveness.

Diagnostic 6 week wait
Delivery of the 6 week diagnostic target was also a challenge in 2017/18. At AHFT, increased demand, coupled with staffing pressures in Ultrasound, were the main issues. BTHFT's diagnostic position was also affected by the EPR implementation, with technical issues resulting in incomplete performance data (figures still exclude Endoscopy and Neurophysiology), making it difficult to manage the capacity issues experienced for Endoscopy tests.

Cancer waits
Whilst in the main AHFT has delivered the national cancer standards in 2017/18, performance at BTHFT has continued to deteriorate. There has been increased demand and ongoing capacity issues in some specialties, particularly dermatology. Extra clinical sessions have been introduced and the CCGs are working with the Trust to review demand and the potential for lower risk patients to be treated in community services.

Cross organisational work between different hospital sites has also continued, in particular with Inter Provider Transfers, to ensure patient flow is streamlined and well timed to meet the national 62 day waiting time target.

Accident & Emergency (A&E) 4 hour wait
Ensuring we have a robust urgent care system also continues to be a challenge across the health and care system with performance against the 4 hour A&E access target remaining below the national 95% standard.

We have seen increased attendances, high patient acuity and high levels of bed occupancy. Locally, working with partners as part of the BdC Urgent Care Programme, we have introduced GP streaming of patients at the front door to A&E (ensuring only appropriate patients get A&E treatment), increased the numbers of NHS 111 calls transferred for clinical advice, increased extended access to GP appointments and implemented discharge to assess to trusted assessor models. As part of the West Yorkshire and Harrogate Health and Care Partnership, we have worked with other CCGs to increase clinical contact through NHS 111 calls and expand direct booking to GP practices from NHS 111.

We continue to rethink the way urgent and emergency care is provided to ensure more options are available away from hospital, ensuring our A&Es are supported by better primary and social care and improving the flow of patients in our accident and emergency departments.

Mental Health Access
We continue to deliver the national standard to ensure patients with a first episode of

psychosis commence treatment with a NICE approved care package within two weeks of referral, and to ensure this can be further improved, additional 2018/19 funding has been agreed. We also ensure that services are assessed, planned, co-ordinated and reviewed (CPA follow up) for people with mental health problems within 7 days of discharge from inpatient care.

The majority of patients are also able to access Psychological Therapies (IAPT) services within six weeks of referral. However, it is acknowledged nationally that IAPT recovery rates are lower for areas of higher deprivation and for BME communities. BDCFT has commenced innovative work within the City IAPT Team to consider and develop appropriate service responses to cultural issues. This work is supported by Hari Sewell, a national expert in the specialist field of equalities in mental health. They expect that this will support improvements in both access and recovery rates for BME populations across the district.

Quality of Care
VTE stands for venous thromboembolism and is a condition where a blood clot forms in a vein. This is most common in a leg vein but a blood clot can form in the lungs. Hospitals are required to ensure that medical, surgical or trauma patients have their risk of VTE and bleeding assessed using a national tool as soon as possible after admission to hospital. AHFT delivered above the 95% standard in 2017/18, but performance at BTHFT was on average around 90%. Whilst implementation of the new EPR system had some impact on effectively recording assessments, BTHFT has revised its approach to VTE, driven by a lead Consultant. A VTE assurance group has been re-established, reporting directly to the Patient Safety Committee and VTE incidents which have occurred have been reported and investigated via existing quality monitoring processes. As a result, the risk assessment position of the trust for VTE has improved in 2018/19. As part of an ongoing VTE action plan, further work is required to revise the VTE policy and Root Cause Analysis (RCA) tool, to reflect national guidance and support learning and governance associated with the outcome of the root cause analysis investigations

Health Care Acquired Infections (HCAIs) pose a serious risk to patients, staff and visitors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention and control is a key priority and the CCGs continue to work with all providers across the system to minimise the number of HCAIs, through the use of Post Infection Review (PIR) panels to understand the root cause of infection, prevention and control actions and share learning. Cases of MRSA remain low, but against a challenging zero tolerance target, and CDiff infections continue to reduce in both an acute and community setting. In 2017/18 we also started to complete PIRs for E.Coli and MSSA infections. Going forward, through joint working between primary and secondary care, we hope to facilitate further reductions in the HCAIs.

The NHS Operating Framework for 2012-2013 confirmed that all providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient. Breaches remain rare across our two hospital sites, although there were 2 breaches of the mixed sex accommodation standard at AHFT in 2017/18. Any breaches are reported within one working day to the CCGs, with an overview report of the circumstances. Following this a full investigation is undertaken by the provider and evaluated by the CCGs' Quality team.

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

Nationally, the NHS is going through one of the most challenging periods in its history. As well as achieving the best possible patient outcomes through high quality, clinically effective services, we must also ensure that the NHS lives within its financial means. Our QIPP programme is all about making sure that each pound spent brings maximum benefit and quality of care to the public. Our approach to QIPP delivery is that the majority of schemes are delivered through our system change programmes.

For AWCCCG, BCCCG and BDCCG, the gap between our annual budgets and the increasing cost of providing healthcare to local people was £6m, £3.5m and £13.3m respectively during 2017/18. These gaps became our QIPP targets.

During the year there was an increased focus on delivery against the QIPP agenda, with a clear joined up approach to deliver our targets. Delivery for the year realised an over achievement of £0.3m for AWCCCG and a slight under performance of £0.1m for BCCCG. The challenge for Districts was much greater due to the high target, with a final achievement reported of £7.7m.

3.4 Looking Forward: QIPP 2018/19

The amount of QIPP that is needed to deliver the gap between anticipated incomes and planned spend for 2018/19, is shown below for all 3 CCGs:

- AWC CCG £6.67m
- Bradford City CCG £1.7m
- Bradford District CCG £5.3m

As part of the joint management structure the CCGs are working collaboratively with provider colleagues around QIPP to ensure that there is a joint approach to deliver these savings targets. There is now an alignment of programmes and schemes, where work is done once across the system that benefits our whole population. The table below outlines the QIPP plan for 18/19 for all 3 CCGs.

QIPP Plan Financial Year 2018/19

CCG	Airedale Wharfedale and Craven	Bradford City	Bradford Districts
Programme Areas	'£000		
Planned Care	1,864	463	1,904
Urgent Care	65	364	567
Primary and Community Development	328	32	95
Mental Health and LD	-	-	
Personalised Commissioning	100	100	315
Prescribing	1,565	561	1,877
Transactional	712	120	349
Unidentified	2,045	105	195
Total	6,679	1,745	5,302

Planned Care: The current growth in planned care activity is financially unsustainable. Our Planned Care Programme work has identified a number of opportunities where addressing patient flow will help to create a more sustainable health economy by addressing unwarranted variation and inefficiencies across care pathways, whilst also

improving waiting times for those patients who need hospital care.

Urgent Care: Work continues in the system Urgent Care Programme to develop schemes that assist in managing demand on A&E. Areas being reviewed include further development of GP streaming services within A&E to reduce inappropriate attendances, reviewing pathways of emergency care including developing services around ambulatory care and reviewing children and young people who visit A&E more frequently than average.

Prescribing: For all 3 CCGs, work continues on targeting inefficiency and waste within the area of medicine management spend. It is also an area that is leading in developing schemes that include working directly with external colleagues, and sharing benefits, be it resources or financial gains. Areas where the CCGs are focusing in 2018/19 are:

- Developing a new type of gain share model with our primary care colleagues to switch patients to more appropriate and cost effective medicines;
- Developing a risk share arrangement with our colleagues at BDCFT around wound care products, to develop a more financially sustainable service across our system;
- Continued work around oral nutritional supplements, vitamins and baby milk with our colleagues at BTHFT, where we have supported a continuation of a role that works across both organisations; and
- Working to support the national directive around cost effective medicine use.

New ways of working (Integrated Care Systems): All CCGs have a vision to develop new types of services that will deliver care in a more integrated manner and that will reduce the complexities for patients having to circumnavigate the complex health and social care system. To support this, work has commenced with our local partners to develop new contracting models that will support this direction of travel and enable management of financial and system risk as a collective.

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

- The transformation of community services to form a new model of care based around integrated and aligned health and social care 'Primary Care Home (PCH) communities which will understand and meet the needs of populations of 30,000 to 60,000.
- In-depth work on the role of community beds is being undertaken, in order to create an integrated, needs-led community bed resource for adults with complex health, care and support requirements.
- Development of a Community Access Network (CAN) to act as a front door to all community services in Bradford; and
- The implementation of the General Practice Forward View and the Bradford CCGs Primary Medical Care Commissioning Strategy is being overseen by the Enhanced Primary Care Implementation Group. The aim is to ensure high quality, safe and sustainable primary medical care services are in place in Bradford.

The AWC New Models of Care will ensure people in AWC receive individual and seamless care to reduce their need for unplanned and urgent care by pro-actively

managing their physical, psychological and social care needs. Specific work includes:

- The introduction of GP practice ‘at scale models’ which comprise of one super partnership and one large alliance. This approach will support delivery of improved population health within a sustainable CCG patch whilst retaining individual organisational statutory accountabilities;
- Looking at alternatives to hospital admission by streamlining pathways and reducing unnecessary/emergency hospital admissions;
- Primary and community led models of care are being developed and tested with self-care and prevention embedded and mental and physical health having equal importance; and
- Use of intermediate care as an alternative to hospital admission where appropriate continues to mature.

4. Options

Not Applicable

5. Contribution to corporate priorities

A number of metrics relate to joint working across the Bradford District and contribute to corporate priorities.

6. Recommendations

6.1 That the Health and Social Care Overview & Scrutiny Committee note the content of the report

7. Background documents

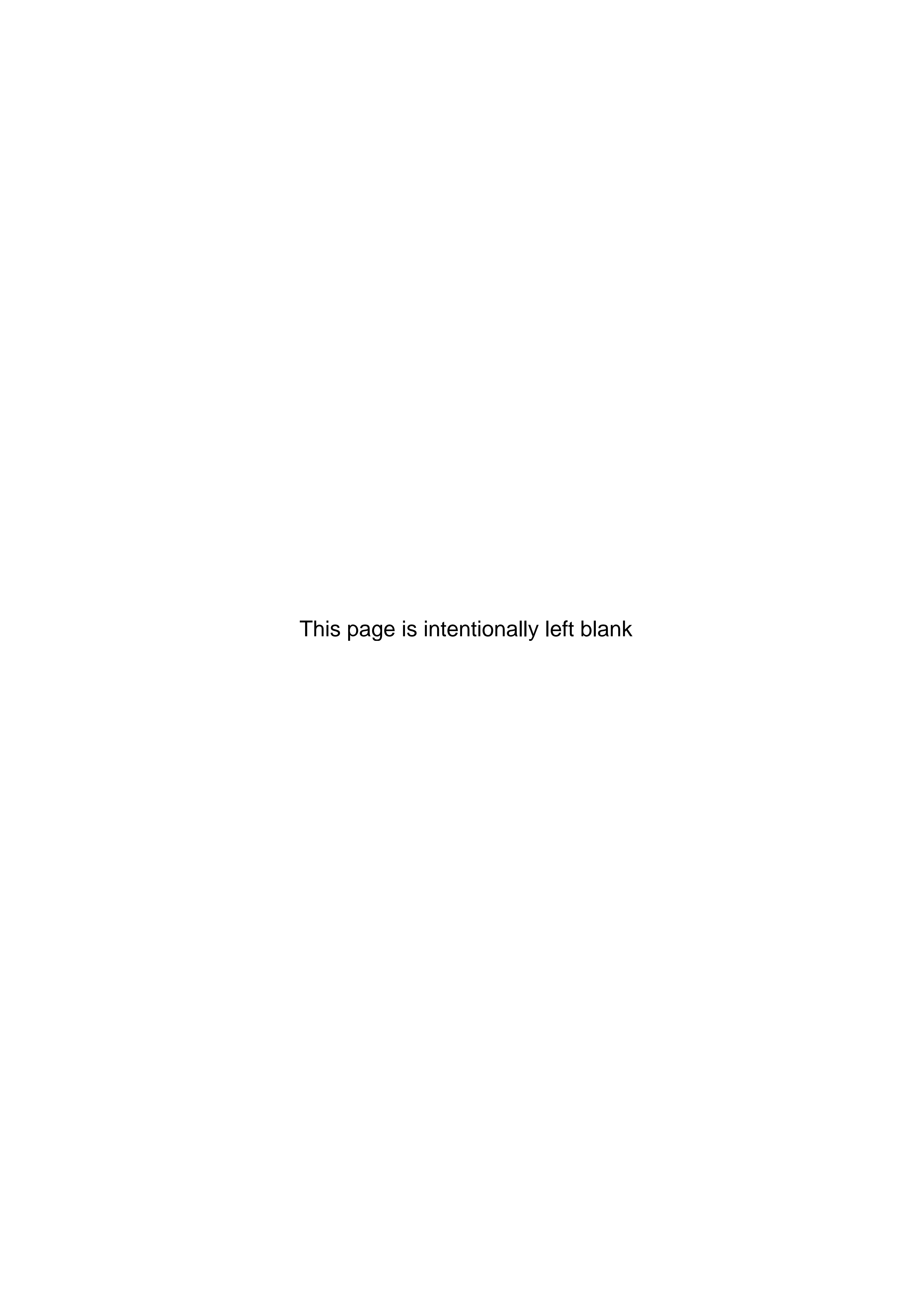
None

8. Not for publication documents

None

9. Appendices

1. CCG Improvement and Assessment Framework
2. CCG Scorecards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CCG IMPROVEMENT & ASSESSMENT FRAMEWORK

Annual Rating - OUTSTANDING | Year 2 – Qtr4 | 2017/18

Status across domain areas

NHS Airedale, Wharfedale & Craven CCG

We spend approximately **£1,564** for every person registered with a GP in Airedale, Wharfedale & Craven and this money gives both local doctors and local people more say in how our healthcare is organised. We buy services on behalf of people living in our area which include an increasingly older population with a fifth over 65 years of age and we want to care for our elderly in particular those who are becoming frail

Better Health – Health inequalities, Obesity

Better care – CQC ratings & NHS Constitution

Sustainability – In-year finance, QIPP, E-referrals

Leadership – Quality of Leadership relationships

*** Better *** Similar *** Worse compared to England

Self-care

Better self-care: training

***

10.3% of staff across health and social care have attended training to support people with better self-care

Community Services

Carers with a Long-Term-Condition

***

0.67 score for carers reporting they feel supported to manage their LTC(s) ranked well amongst England's CCGs

Urgent & Emergency Care

Urgent Care Sensitive conditions

***

We have a high rate of emergency admissions for urgent care sensitive conditions 2,475 per 100,000 population

Collaborating Hospitals

Gastroenterology

Gastroenterology specialty considering a 24/7 acute model across 2 sites at Airedale Hospital and Bradford Royal Infirmary

Better Health

Childhood obesity

***

3 out of 10 children aged ten or eleven years of age are overweight or obese, this result is better than the average across England

Health Inequalities

***

The frequency of people being admitted to hospital for long term conditions, from our poorest communities is higher than other areas in England

Better Care

Care quality ratings

***

Ratings for primary care are the best. However, ratings for hospitals & community services and for care homes and residential homes are in need of improvement

THE NHS CONSTITUTION the NHS belongs to us all

NHS Constitution Standards

***

Waiting times for cancer treatment were met. However, were not met for hospital outpatient appointments or Accident and Emergency, although results were similar to across England

Sustainability

Financial performance – Green

We want to make every pound go further and have developed plans to improve quality whilst saving money.

Uptake of new e-referrals system

***

Currently 3 out of 5 referrals are made electronically via the e-referrals services. This needs to be the way all patients are referred from the 1st of October 2018

Leadership

Quality of Leadership – Green Star

In 2017/18 the quality of our leadership was assessed as amongst the best in England, an improvement on last years Green rating

Effectiveness of relationships

Working relationships as assessed by our annual 360 degree stakeholder survey were the highest across England, ranked 8 out of 207

CCG IMPROVEMENT & ASSESSMENT FRAMEWORK

Annual Rating - OUTSTANDING | Year 2 – Qtr4 | 2017/18

Status across domain areas

NHS Bradford City CCG

We spend approximately **£1,331** for every person registered with a GP in the city and this money gives both local doctors and local people more say in how our healthcare is organised. We are recognised as being the most deprived CCG in England as we have some of the poorest communities living in our city and we want to tackle inequalities that contribute to ill health

Better Health – Health inequalities, Obesity

Better care – CQC ratings & NHS Constitution

Sustainability – In-year finance, QIPP, E-referrals

Leadership – Quality of Leadership and relationships

★★★ Better ★★★ Similar ★★★ Worse compared to England

Self-care

Better self-care: training

★★★

10.3% of staff across health and social care have attended training to support people with better self-care

Out of Hospitals

Carers with a Long-Term-Condition

★★★

0.61 score for carers reporting they feel supported to manage their LTC(s) ranks low amongst England's CCGs and we need to improve

Urgent & Emergency Care

Urgent Care Sensitive conditions

★★★

We have the highest rate of emergency admissions for urgent care sensitive conditions in England with 4,374 per 100,000 population

Planned Care

Gastroenterology

★★★

Gastroenterology specialty considering a 24/7 acute model across 2 sites at Airedale Hospital and Bradford Royal Infirmary

Better Health

Childhood obesity

★★★

2 out of 5 children aged ten or eleven year olds are overweight or obese, this result is higher than the England which is 3 out of 10

Health inequalities

★★★

The frequency of people being admitted to hospital for long term conditions, from our poorest communities is 3 ½ times higher than the England average.

Better Care

Care quality ratings

★★★

Ratings for primary care is similar to England, however for hospitals and community services and for care homes and residential homes ratings show there is a need for improvement in our area

NHS Constitution Standards

★★★

Waiting times for cancer treatment, for hospital out patient appointments and in Accident and Emergency are not meeting the recommended standard

Sustainability

Financial performance – Green

We want to make every pound go further and have developed plans to improve quality whilst saving money.

Uptake of new e-referrals system

★★★

Currently under ½ of referrals are made electronically via the e-referrals services. This needs to be the way all patients are referred by the 1st of October 2018

Leadership

Quality of Leadership – Green Star

In 2017/18 the quality of our leadership was again assessed as amongst the top CCGs in England

Effectiveness of relationships

★★★

Working relationships as assessed by our annual 360 degree stakeholder survey were the highest across England, ranked 15 out of 207

CCG IMPROVEMENT & ASSESSMENT FRAMEWORK

Status across domain areas

Annual Rating - GOOD | Year 2 – Qtr4 | 2017/18

NHS Bradford Districts CCG

We spend approximately **£1,486** for every person registered with a GP across Bradford (not including the city). This money gives both local doctors and local people more say in how our health care is organised. We buy services for our communities including some of the poorest communities in England and we want to tackle inequalities that contribute to ill health

Better Health
Health inequalities
Obesity

Better care
CQC ratings & NHS Constitution

Sustainability
In-year finance
QIPP
E-referrals

Leadership
Quality of Leadership & relationships

*** Better *** Similar *** Worse compared to England

Self-care

Better self-care: training
***

10.3% of staff across health and social care have attended training to support people with better self-care

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Out of Hospitals

Carers with a Long-Term-Condition
***

0.60 score for carers reporting they feel supported to manage their LTC(s) ranks low amongst England's CCGs and we need to improve

Urgent & Emergency Care

Urgent Care Sensitive conditions
***

We have the high rate of emergency admissions for urgent care sensitive conditions in England with 3,178 per 100,000 population

Planned Care

Gastroenterology
***

Gastroenterology specialty considering a 24/7 acute model across 2 sites at Airedale Hospital and Bradford Royal Infirmary

Better Health

Childhood obesity
***

Almost 2 out of 5 children aged ten or eleven year olds are overweight or obese, this result is the same as the England rate

Health inequalities
***

The frequency of people being admitted to hospital for long term conditions, from our poorest communities is much higher than other areas in England

Better Care

Care quality ratings
***

Ratings for primary care is similar to England, however for hospitals and community services and for care homes and residential homes ratings show there is a need for improvement in our area

NHS Constitution Standards
***

Waiting times for cancer treatment, for hospital out patient appointments and in Accident and Emergency are not meeting the recommended standard

Sustainability

Financial performance — Amber

We want to make every pound go further and have developed plans to improve quality whilst saving money. At this time we are not fully delivering planned savings.

Uptake of new e-referrals system
***

Currently under ½ of referrals are made electronically via the e-referrals services. This needs to be the way all patients are referred by the 1st of October 2018

Leadership

Quality of Leadership — Green Star

In 2017/18 the quality of our leadership was again assessed as amongst the top CCGs in England

Effectiveness of relationships
***

Working relationships as assessed by our annual 360 degree stakeholder survey were the highest across England, ranked 44 out of 207

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CCG SCORECARD

NHS Airedale, Wharfedale And Craven CCG

Commissioner data with CCG plans in grey. CCGs are ranked out of 23 Yorkshire & Humber CCGs until Jun 17, out of 207 CCGs nationally until May 18 (reduced to 195 from June 18)

RTT			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	<87%		92.3%	92.0%	91.4%	92.1%	93.0%	92.9%	92.6%	89.6%	89.2%	88.2%	88.3%	88.5%	88.6%
	87% to 92%		#N/A												
	>=92%	Rank	7/23			61/207		44/207	35/207	104/207	103/207	114/207	105/207	111/207	105/195
Number of patients waiting more that 52 weeks on incomplete pathways	>10		1	1	1	1	1	0	1	1	2	3	2	2	4
	1 to 10														
	0	Rank	15/23					20/207	53/207	50/207	74/207	93/207	70/207	71/207	68/195

Diagnostic			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Percentage of patients waiting 6 weeks or more for a diagnostic test (15 key tests)	<6%		3.9%	4.4%	1.4%	0.7%	0.9%	1.0%	4.8%	3.9%	2.3%	3.5%	5.8%	8.8%	5.0%
	1% to 6%		#N/A												
	>=1%	Rank	19/23			59/207		113/207	193/207	186/207	176/207	182/207	178/207	184/207	170/195

Cancer Monthly			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	<88%		95.0%	92.3%	89.2%	96.4%	95.6%	79.1%	75.0%	76.2%	81.1%	75.9%	76.3%	75.8%	75.4%
	88% to 93%		#N/A												
	>=93%	Rank	9/23			54/207		203/207	207/207	205/207	204/207	204/207	187/207	192/207	170/195
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	<88%		100.0%	97.9%	93.3%	100.0%	96.3%	95.2%	96.4%	98.3%	96.2%	93.1%	86.6%	93.6%	95.8%
	88% to 93%		#N/A												
	>=93%	Rank	1/23			5/207		134/207	96/207	41/207	98/207	114/207	129/207	78/207	38/195
Maximum 31-day wait from diagnosis to first definitive treatment for all cancers	<91%		98.8%	100.0%	100.0%	98.5%	100.0%	96.8%	96.9%	100.0%	98.4%	98.8%	100.0%	98.8%	99.0%
	91% to 96%		#N/A												
	>=96%	Rank	9/23			74/207		148/207	156/207	3/207	76/207	54/207	6/207	57/207	33/195
Maximum 31-day wait for subsequent treatment where that treatment is surgery	<89%		93.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.6%	100.0%	95.7%	95.8%	93.8%	100.0%
	89% to 94%		#N/A												
	>=94%	Rank	18/23			18/207		23/207	26/207	135/207	20/207	124/207	106/207	122/207	1/195
Maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen	<93%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	93% to 98%		#N/A												
	>=98%	Rank	1/23			29/207		32/207	34/207	30/207	34/207	35/207	34/207	33/207	1/195
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	<89%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%
	89% to 94%		#N/A												
	>=94%	Rank	1/23			22/207		28/207	31/207	22/207	23/207	186/207	29/207	28/207	1/195
Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer	<80%		88.5%	77.8%	94.1%	85.7%	86.7%	83.0%	75.6%	83.1%	88.1%	87.5%	81.3%	76.3%	78.9%
	80% to 85%		#N/A												
	>=85%	Rank	3/23			63/207		99/207	185/207	84/207	45/207	78/207	121/207	148/207	114/195
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	<85%		100.0%	100.0%	88.9%	75.0%	100.0%	100.0%	100.0%	87.5%	80.0%	66.7%	50.0%		100.0%
	85% to 90%		#N/A												
	>=90%	Rank	1/23			165/207		17/207	20/207	116/207	144/207	180/207	172/207		12/195
Maximum 62-day wait for first definitive treatment following a consultants decision to upgrade the priority of the patients (all cancers)	NA		66.7%	100.0%	80.0%	100.0%	100.0%	80.0%	66.7%	100.0%	80.0%	100.0%	80.0%	80.0%	50.0%
			#N/A												
		Rank	#N/A			10/207		146/207	176/207	14/207	136/207	10/207	127/207	133/207	181/195

Mixed Sex Accommodation			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Breaches of Mixed-Sex Accommodation	>10		0	0	0	0	0	0	1	2	0	0	2	0	0
	1 to 10														
	0	Rank	1/23				14/207		83/207	108/207	16/207	13/207	128/207	24/207	1/195

Mental Health			14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4	16-17 Q1	16-17 Q2	16-17 Q3	16-17 Q4	17-18 Q1	17-18 Q2	17-18 Q3	18-19 Q1
Care Programme Approach (CPA): Percentage of people under adult mental illness specialities on CPA who were followed up within 7 days of discharge from psychiatric inpatient care during the period	<90%		96.8%	96.4%	98.0%	98.1%	100.0%	97.9%	100.0%	100.0%	100.0%	100.0%	97.6%	100.0%	100.0%
	90% to 95%														
	>=95%	Rank	19/23	12/23	7/23	8/23	1/23	10/23	1/23	1/23	1/23	6/207	81/207	12/207	1/195

Dementia			Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Dementia diagnosis rate	<62%		78.2%	78.0%	78.4%	77.5%	78.6%	78.2%	77.5%	77.3%	76.9%	75.7%	75.4%	76.0%	77.5%
	62% to 67%														
	>=67%	Rank	-	-	-	30/207		28/207			28/207		32/207	29/195	

IAPT Monthly			Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
IAPT 6 Weeks First Treatment	<70%		95.5%	100.0%	100.0%	96.6%	91.7%	100.0%	96.6%	95.3%	100.0%	100.0%	95.8%	96.4%	100.0%
	70% to 75%														
	>=75%	Rank	8/23												
IAPT 18 Weeks First Treatment	<90%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.7%	100.0%	96.4%	100.0%	100.0%	100.0%
	90% to 95%														
	>=95%	Rank	1/23												

IAPT (*Rolling 3 month*)			Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
IAPT Access (rolling 3 months)	<4.20%		4.0%	4.6%	4.6%	4.6%	4.1%	3.8%	3.8%	4.7%	4.6%	4.7%	3.5%	3.6%	3.3%
			4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%
	>=4.75%	Rank													
IAPT Recovery rate (rolling 3 months)	<45%		60.0%	58.7%	59.4%	59.7%	59.7%	54.4%	50.0%	49.0%	50.0%	52.3%	52.2%	54.1%	54.4%
	45% to 50%														
	>=50%	Rank	2/23												

Early Intervention Psychosis - 2 Week Waits (*rolling quarter*)			Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Early intervention in psychosis - 2 week wait (Rolling quarter)	<45%		66.7%	63.6%	65.0%	55.6%	66.7%	70.6%	69.2%	80.0%	75.0%	77.8%	57.1%	53.3%	41.7%
	45% to 50%														
	>=50%	Rank					144/207	133/207			124/207		161/207	175/195	

Safe Environment and Protecting from Avoidable Harm			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Incidence of healthcare associated infection (HCAI) i) MRSA - Cases which have been assigned to the CCG following a Post Infection Review	>0		0	0	0	0	0	0	0	0	1	0	0	0	1
		Rank	1/23			19/207		34/207	30/207	28/207		32/207	34/207	26/207	151/195
Incidence of healthcare associated infection (HCAI) ii) C.difficile	>Ceiling		1	2	0	2	2	0	3	1	0	3	1	4	2
	<=Ceiling	Rank	1/23			22/207		202/207	122/207	186/207		127/207	29/207	93/207	28/195
	Ceiling	35	3	3	3	3	3	3	3	3	3	3	3	3	3

CCG SCORECARD

NHS Bradford Districts CCG

Commissioner data with CCG plans in grey. CCGs are ranked out of 23 Yorkshire & Humber CCGs until Jun 17, out of 207 CCGs nationally until May 18 (reduced to 195 from June 18)

RTT			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	<87%		89.7%	89.5%	87.3%	92.8%	93.0%	93.2%	92.8%	81.7%	80.2%	77.1%	77.3%	78.4%	77.9%
	87% to 92%		#N/A												
	>=92%	Rank	15/23			38/207		38/207	28/207	195/207	197/207	198/207	187/207	189/207	190/195
Number of patients waiting more that 52 weeks on incomplete pathways	>10		0	0	0	0	0	0	0	0	1	4	7	13	11
	1 to 10														
	0	Rank	1/23	1/23				23/207	24/207	23/207	49/207	104/207	139/207	169/207	129/195

Diagnostic			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Percentage of patients waiting 6 weeks or more for a diagnostic test (15 key tests)	<6%		3.5%	3.3%	4.0%	1.3%	1.1%	1.3%	2.3%	1.8%	0.3%	0.6%	0.7%	0.8%	0.9%
	1% to 6%		#N/A												
	>=1%	Rank	17/23			121/207		131/207	163/207	137/207	19/207	49/207	42/207	69/207	74/195

Cancer Monthly			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	<88%		94.2%	94.2%	91.8%	98.5%	97.3%	71.6%	76.0%	72.8%	76.4%	72.8%	65.1%	66.3%	69.6%
	88% to 93%		#N/A												
	>=93%	Rank	14/23			8/207		206/207	206/207	206/207	206/207	207/207	194/207	194/207	193/195
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	<88%		100.0%	100.0%	100.0%	100.0%	91.7%	92.3%	91.7%	100.0%	86.7%	94.1%	93.8%	84.2%	94.1%
	88% to 93%		#N/A												
	>=93%	Rank	1/23			7/207		177/207	170/207	7/207	189/207	93/207	58/207	147/207	64/195
Maximum 31-day wait from diagnosis to first definitive treatment for all cancers	<91%		99.2%	97.0%	100.0%	98.1%	90.3%	97.6%	100.0%	95.2%	99.2%	98.0%	98.1%	96.6	96.9%
	91% to 96%		#N/A												
	>=96%	Rank	3/23			93/207		107/207	10/207	153/207	51/207	99/207	75/207	152/207	130/195
Maximum 31-day wait for subsequent treatment where that treatment is surgery	<89%		100.0%	100.0%	100.0%	100.0%	100.0%	92.9%	91.3%	100.0%	93.3%	100.0%	93.1%	100.0%	100.0%
	89% to 94%		#N/A												
	>=94%	Rank	1/23			21/207		159/207	162/207	16/207	151/207	25/207	134/207	25/207	1/195
Maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen	<93%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	93% to 98%		#N/A												
	>=98%	Rank	1/23			32/207		35/207	37/207	33/207	37/207	38/207	37/207	30/207	1/195
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	<89%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.1%	100.0%	100.0%	100.0%
	89% to 94%		#N/A												
	>=94%	Rank	1/23			24/207		31/207	33/207	23/207	25/207	113/207	31/207	29/207	1/195
Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer	<80%		77.8%	79.1%	83.3%	84.4%	41.7%	72.4%	81.3%	73.2%	69.6%	79.3%	77.8%	69.2%	58.4%
	80% to 85%		#N/A												
	>=85%	Rank	19/23			85/207		191/207	142/207	173/207	187/207	166/207	154/207	182/207	194/195
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	<85%		100.0%	100.0%	100.0%	100.0%		81.0%	100.0%	88.9%	100.0%	100.0%	85.7%	85.7%	85.7%
	85% to 90%		#N/A												
	>=90%	Rank	1/23			29/207		164/207	22/207	111/207	23/207	25/207	123/207	129/207	137/195
Maximum 62-day wait for first definitive treatment following a consultants decision to upgrade the priority of the patients (all cancers)	NA		100.0%	100.0%	100.0%	100.0%	0.0%	75.0%	100.0%	100.0%	100.0%	100.0%	75.0%	66.7%	66.7%
			#N/A												
		Rank	#N/A			183/207		162/207	12/207	191/207	11/207	11/207	138/207	164/207	172/195

Mixed Sex Accommodation			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Breaches of Mixed-Sex Accommodation	>10		2	0	0	0	0	0	0	0	0	0	0	0	0
	1 to 10														
	0	Rank					17/207		17/207	17/207	19/207	16/207	19/207	27/207	1/195

Mental Health			14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4	16-17 Q1	16-17 Q2	16-17 Q3	16-17 Q4	17-18 Q1	17-18 Q2	17-18 Q3	18-19 Q1
Care Programme Approach (CPA): Percentage of people under adult mental illness specialities on CPA who were followed up within 7 days of discharge from psychiatric inpatient care during the period	<90%		98.0%	99.1%	98.9%	93.7%	96.0%	98.3%	97.0%	98.8%	100.0%	97.1%	98.0%	95.5%	94.2%
	90% to 95%														
	>=95%	Rank	14/23	4/23	6/23	21/23	20/23	8/23	14/23	10/23	1/23	105/207	96/207	143/207	

Dementia			Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Dementia diagnosis rate	<62%		82.0%	82.1%	82.4%	83.0%	83.5%	82.9%	82.3%	81.3%	81.3%	81.6%	81.6%	81.6%	80.9%
	62% to 67%														
	>=67%	Rank				13/207		14/207			16/207		15/207		

IAPT Monthly			Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
IAPT 6 Weeks First Treatment	<70%		95.3%	95.9%	97.8%	95.8%	94.3%	93.9%	94.6%	96.9%	95.3%	98.4%	95.7%	92.5%	97.7%
	70% to 75%														
	>=75%	Rank	9/23												
IAPT 18 Weeks First Treatment	<90%		100.0%	100.0%	100.0%	97.9%	98.1%	98.0%	98.2%	98.4%	100.0%	100.0%	97.9%	98.1%	100.0%
	90% to 95%														
	>=95%	Rank													

IAPT (Rolling 3 month)			Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
IAPT Access (rolling 3 months)	<4.20%		3.8%	4.1%	4.0%	3.9%	3.6%	3.5%	4.0%	4.1%	3.9%	3.6%	3.5%	3.5%	3.5%
			4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%
	>=4.75%	Rank	14/23												
IAPT Recovery rate (rolling 3 months)	<45%		52.1%	56.0%	54.2%	51.1%	46.8%	46.2%	47.7%	48.4%	49.4%	49.4%	50.7%	51.0%	48.5%
	45% to 50%														
	>=50%	Rank	11/23	11/23											

Early Intervention Psychosis - 2 Week Waits (rolling quarter)			Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Early intervention in psychosis - 2 week wait (Rolling quarter)	<45%		80.4%	71.7%	68.8%	68.5%	70.0%	74.1%	61.4%	62.2%	51.3%	59.4%	61.3%	66.7%	64.7%
	45% to 50%														
	>=50%	Rank					138/207	121/207			173/207				

Safe Environment and Protecting from Avoidable Harm			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Incidence of healthcare associated infection (HCAI) i) MRSA - Cases which have been assigned to the CCG following a Post Infection Review	>0		0	0	1	0	0	0	0	0	0	0	1	1	0
		Rank	19/23			199/207			33/207	31/207		35/207	40/207	151/207	1/195

Incidence of healthcare associated infection (HCAI) ii) C.difficile			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
	>Ceiling		8	7	1	3	4	5	4	4	2	7	3	2	3
	<=Ceiling	Rank	19/23			105/207			91/207	104/207		49/207	69/207	43/207	53/195
	Ceiling	115	8	10	14	9	8	8	9	9	9	11	10	9	10

CCG SCORECARD

NHS Bradford City CCG

Commissioner data with CCG plans in grey. CCGs are ranked out of 23 Yorkshire & Humber CCGs until Jun 17, out of 207 CCGs nationally until May 18 (reduced to 195 from June 18)

RTT			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	<87%		88.7%	87.7%	88.8%	90.5%	92.0%	91.8%	91.9%	81.6%	81.0%	76.7%	75.8%	75.9%	74.9%
	87% to 92%		#N/A												
	>=92%	Rank	17/23			113/207		84/207	51/207	196/207	195/207	199/207	193/207	194/207	194/195
Number of patients waiting more that 52 weeks on incomplete pathways	>10		0	0	0	0	0	0	0	1	2	2	2	2	5
	1 to 10														
	0	Rank	1/23					26/207	26/207	52/207	75/207	68/207	71/207	72/207	85/195

Diagnostic			Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Jan-00	May-18	Jun-18
Percentage of patients waiting 6 weeks or more for a diagnostic test (15 key tests)	<6%		4.1%	4.2%	3.6%	1.6%	1.2%	1.1%	2.1%	1.8%	0.2%	0.0%	0.3%	0.1%	0.4%
	1% to 6%		#N/A												
	>=1%	Rank	21/23			137/207		120/207	152/207	138/207	6/207	1/207	6/207	1/207	17/195

Cancer Monthly			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	<88%		94.7%	96.6%	93.9%	90.5%	100.0%	68.3%	80.7%	71.5%	77.5%	75.0%	70.4%	66.4%	76.4%
	88% to 93%		#N/A	#N/A											
	>=93%	Rank	15/23	5/23			1/207	207/207	204/207	207/207	205/207	205/207	193/207	193/207	188/195
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	<88%			100.0%		100.0%	100.0%	100.0%		100.0%				100.0%	50.0%
	88% to 93%		#N/A	#N/A											
	>=93%	Rank		1/23			8/207	6/207	-	8/207				1/207	182/195
Maximum 31-day wait from diagnosis to first definitive treatment for all cancers	<91%		100.0%	100.0%	100.0%	96.8%	100.0%	88.2%	86.7%	100.0%	88.9%	100.0%	94.1%	93.3%	76.5%
	91% to 96%		#N/A	#N/A											
	>=96%	Rank	1/23	1/23			6/207	206/207	207/207	4/207	1	6/207	185/207	191/207	195/195
Maximum 31-day wait for subsequent treatment where that treatment is surgery	<89%		100.0%	100.0%	100.0%	96.3%		100.0%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	83.3%
	89% to 94%		#N/A	#N/A											
	>=94%	Rank	1/23	1/23			-	26/207	29/207	19/207	25/207	192/207	19/207	27/207	183/195
Maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen	<93%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	93% to 98%		#N/A	#N/A											
	>=98%	Rank	1/23	1/23			35/207	38/207	40/207	36/207	40/207	41/207	39/207	38/207	1/195
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	<89%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	89% to 94%		#N/A	#N/A											
	>=94%	Rank	1/23	1/23			27/207	34/207	36/207	26/207	28/207	30/207	33/207	31/207	1/195
Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer	<80%		68.8%	90.0%	72.7%	85.9%	100.0%	80.0%	71.4%	100.0%	40.0%	33.3%	57.1%	80.0%	66.7%
	80% to 85%		#N/A	#N/A											
	>=85%	Rank	23/23	1/23			2/207	136/207	197/207	1/207	207/207	207/207	194/207	112/207	181/195
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	<85%		100.0%	100.0%	66.7%	100.0%		100.0%	0.0%			50.0%			
	85% to 90%		#N/A	#N/A											
	>=90%	Rank	1/23	1/23			-	20/207	194/207	-		188/207			
Maximum 62-day wait for first definitive treatment following a consultants decision to upgrade the priority of the patients (all cancers)					100.0%	100.0%		100.0%					100.0%		
			#N/A	#N/A											
		Rank					-	12/207	-	-			0		

Mixed Sex Accommodation			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Breaches of Mixed-Sex Accommodation	>10		0	1	0	0	0	0	0	0	0	0	0	0	1/195
	1 to 10														
	0	Rank	NA				20/207		20/207	19/207	22/207	19/207	22/207	30/207	

Mental Health			14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4	16-17 Q1	16-17 Q2	16-17 Q3	16-17 Q4	17-18 Q1	17-18 Q2	17-18 Q3	18-19 Q1
Care Programme Approach (CPA): Percentage of people under adult mental illness specialities on CPA who were followed up within 7 days of discharge from psychiatric inpatient care during the period	<90%		95.2%	89.7%	94.6%	97.5%	92.7%	100.0%	100.0%	96.5%	100.0%	100.0%	89.6%	96.0%	96.0%
	90% to 95%														
	>=95%	Rank	17/23	23/23	19/23	12/23	21/23	1/23	1/23	#N/A	1/23	7/207	196/207	135/207	

Dementia			Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Dementia diagnosis rate	<62%		81.8%	82.3%	81.1%	80.9%	83.0%	82.1%	81.8%	86.4%	83.7%	82.8%	82.6%	83.3%	83.1%
	62% to 67%														
	>=67%	Rank				20/207		16/207	16/207		9/207		12/207		

IAPT Monthly			Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
IAPT 6 Weeks First Treatment	<70%		100.0%	90.9%	85.7%	92.9%	92.9%	92.9%	93.3%	90.9%	91.7%	92.9%	100.0%	81.8%	92.9%
	70% to 75%														
	>=75%	Rank													
IAPT 18 Weeks First Treatment	<90%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.9%	100.0%	90.9%	100.0%
	90% to 95%														
	>=95%	Rank													

IAPT (Rolling 3 month)			Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
IAPT Access (rolling 3 months)	<4.20%		5.0%	5.4%	5.1%	4.7%	4.3%	4.2%	4.3%	4.4%	4.1%	3.8%	3.4%	3.3%	3.0%
			4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%
	>=4.75%	Rank													
IAPT Recovery rate (rolling 3 months)	<45%		45.5%	44.1%	48.3%	50.0%	48.6%	45.2%	41.9%	42.5%	36.8%	40.5%	36.1%	42.9%	42.9%
	45% to 50%														
	>=50%	Rank													

Early Intervention Psychosis - 2 Week Waits (rolling quarter)			Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Early intervention in psychosis - 2 week wait (Rolling quarter)	<45%		75.0%	69.2%	57.1%	62.5%	67.7%	77.8%	63.0%	62.2%	66.7%	76.2%	71.0%	61.3%	47.4%
	45% to 50%														
	>=50%	Rank					143/207	103/207			142/207				

Safe Environment and Protecting from Avoidable Harm			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Incidence of healthcare associated infection (HCAI) i) MRSA - Cases which have been assigned to the CCG following a Post Infection Review	>0		0	0	1	0	0	0	0	0	0	0	0	0	0
		Rank	1/23			132/207		40/207	36/207	33/207	38/207	38/207	43/207	30/207	1/195
Incidence of healthcare associated infection (HCAI) ii) C.difficile	>Ceiling		1	2	0	0	1	1	1	2	2	0	1	1	2
	<=Ceiling	Rank	1/23					185/207	181/207	157/207		202/207	30/207	29/207	28/195
	Ceiling	22	0	0	1	2	2	1	2	2	2	9	2	2	2

Report of the Strategic Director of Health and Wellbeing to the meeting of the Health and Social Care Overview and Scrutiny Committee to be held on 4 October 2018

N

Subject: Adult Social Care Annual Performance Report 2017/18

Summary statement:

The following report sets out a summary of performance within Adult Social Care and how performance reporting and business intelligence processes are being improved.

Bev Maybury
Strategic Director Health and Wellbeing

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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 Department of Health and Wellbeing's performance across the Adult Social Care Outcomes Framework (ASCOF) in 2017/18, as well as an updated position on the NHS-Social Care Interface Dashboard.

1.2 The report also provides an up to date position of the work taking place across 6 key areas including 4 transformation programmes within Adult Social Care.

1.3 There is also an update on the implementation of revised performance improvement and business intelligence frameworks within Adults Social Care.

2. BACKGROUND

2.1 ASCOF is used both locally and nationally to set priorities for care and support, measure progress and strengthen transparency and accountability.

The key roles of the ASCOF are:

- It provides councils with robust information that enables us to monitor the success of local interventions in improving outcomes, and to identify our priorities for making improvements.

- Regionally, the data supports sector led improvement; bringing councils together to understand and benchmark their performance. This, in turn, stimulates discussions between councils on priorities for improvement, and promotes the sharing of learning and best practice. In Bradford we are fully engaged in the Y&H Sector Led Improvement Programme and the ASCOF measures are monitored on a quarterly basis together with Risk Awareness via the Regional Performance and Standards Network.

- At the national level, the ASCOF demonstrates the performance of the adult social care system as a whole, and its success in delivering high-quality, personalised care and support.

2.2 The NHS-Social Care Interface dashboard brings together a range of metrics which show how health and social care partners in every Local Authority area in England are performing where health and social care work most closely together. It presents data for six (plus two for context) key metrics from across the sector and assesses local areas against their statistical nearest neighbours (CIPFA) and nationally. The metrics are: emergency admissions (65+) per 100,000 65+ population; 90th percentile of length of stay for emergency admissions (65+); total delayed days per day per 100,000 18+ population; NHS delayed days per day per 100,000 18+ population; proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services; proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services; proportion of discharges (following emergency admissions) which occur at the weekend.

3. REPORT ISSUES

ASCOF

3.1 The table overleaf summarises the latest ASCOF outcomes measures, compared to previous year's performance and showing direction of travel and an overall rating based on latest comparator data available. The latest comparator data is for 2016/17, the data form 2017/18 will be released by the Department Of health in late 2018.

3.2 ASCOF outturns are ranked against 3 comparator peer groups, All councils in England, all councils in the Yorkshire and Humber region and all councils in Bradford's nearest neighbour peer group as defined by The Chartered Institute of Public Finance & Accountancy (CIPFA). Of the 20 ASCOF measures in 207/18, Bradford performs strongly and is forecast to be in the top quartile for 7 measures, and needing to improve from a position of being in the bottom quartile on 3 measures.

Bradford's areas of strength in comparison to our CIPFA group are;

-The proportion of carers who receive self-directed support

- Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population

- Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

- The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

- Delayed transfer of care per 100,000 population (All delays)

- Delayed transfer of care per 100,000 population (attributable to Social Care)

- Overall satisfaction of people who use services with their care and support

Bradford's areas for improvement in comparison to our CIPFA group are;

- The proportion of people who use services who receive self-directed support

- The proportion of people who use services who receive direct payments

- The outcome of short-term services: sequel to service

Bradford Metropolitan District Council - ASCOF Analysis

2017/18 Analysis. All 17/18 data is provisional, with the exception of the DToC measures. Rankings have been calculated by comparing Bradford's provisional 17/18 data with confirmed 2016/17 data. DTOC rankings have been calculated by analysing published data.

	Comparator Group		
	England	Region	CIPFA
Councils in Group	152	15	16
BMDC Top Quartile Measures	5	6	7
BMDC Bottom Quartile Measures	3	3	3

ASCOF Measure	Good is;	12/13	13/14	14/15	15/16	16/17	17/18 Provisional	Bradford Trend	2017/18 Provisional rankings		
									England	Region	CIPFA
1A - Social care-related quality of life score	High	19.1	19.1	19.4	19.5	19.4	19.2		62	9	6
1B - The proportion of people who use services who have control over their daily life	High	76.7	78.1	77.8	79.2	75.1	79		62	6	6
1C1A - The proportion of people who use services who receive self-directed support	High			79.4	86.8	82	82		124	11	14
1C1B - The proportion of carers who receive self-directed support	High			81.9	82.5	100	100		1	1	1
1C2A - The proportion of people who use services who receive direct payments	High			14.8	17.5	16.7	21.1		115	9	15
1C2B - The proportion of carers who receive direct payments	High			81.9	81.9	82.6	95		71	4	10
1E - The proportion of adults with a learning disability in paid employment	High				5.5	3.2	3.6		107	13	10
1G - The proportion of adults with a learning disability who live in their own home or with their family	High	83.1	83	84.4	86.3	88.8	88.1		19	3	6
1I1 - The proportion of people who use services who reported that they had as much social contact as they would like	High	46.4	49	52.2	51.3	50.3	47		57	7	6
2A1 - Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population	Low			14	14	17.1	14.6		98	8	8
2A2 - Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Low			561.6	506	571.3	492.9		42	3	2
2B1 - The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	High	92	93.2	88.8	88.2	87.8	87.9		43	6	4
2C (1) - Delayed transfer of care per 100,000 population (All delays)	Low	3.1	3.7	3.7	3.2	3.2	3.5		6	2	1
2C (2) - Delayed transfer of care per 100,000 population (attributable to Social Care)	Low	1	1.2	0.6	0.1	0.9	0.9		23	3	3
2C (3) - Delayed transfer of care per 100,000 population (attributable to both NHS and Social Care)	Low	New Measure					0.1		15	2	1
2D - The outcome of short-term services: sequel to service	High			68.4	64.8	63	61.2		128	12	14
3A - Overall satisfaction of people who use services with their care and support	High	60.6	61.9	62.5	63.1	64.5	65		73	8	4
3D1 - The proportion of people who use services who find it easy to find information about support	High	72.5	71.6	73.3	70.8	69.9	72		102	10	8
4A - The proportion of people who use services who feel safe	High	67.1	71.5	70.7	73.2	73.1	69		93	9	9
4B - The proportion of people who use services who say that those services have made them feel safe and secure	High	70.5	73.3	82.3	84.7	86	84		99	13	8

3.4 NHS & Social Care Interface Dashboard

NHS England have updated the NHS-Social Care Interface Dashboard. This dashboard was originally published in July 2017 and provides a set of measures indicating how health and social care partners in every local authority area in England are performing at the interface between health and social care. The dashboard has been developed by the Department of Health and Social Care and the Ministry of Housing, Communities and Local Government working with stakeholders.

3.5 There are 6 measures which are then weighted and combined to give an overall national ranking. **Bradford's overall rank is 5 (ie 5th best out of 152)**. Bradford were ranked 4 in 2017. A breakdown of the overall ranking and at indicator level can be found below.

Measure	Rank	National Quartile
Overall Rank	5	1

Measure	Period	Data Source	Result	Rank	National Quartile
Emergency Admissions (65+) per 100,000 65+ population	Apr 2017 - Mar 2018	Hospital Episode Statistics (HES) - NHS Digital	30,502	116	4
90th percentile of length of stay for emergency admissions (65+)	Apr 2017 - Mar 2018	Hospital Episode Statistics (HES) - NHS Digital	16	5	1
TOTAL Delayed Days per day per 100,000 18+ population	Apr 2017 - Mar 2018	Delayed Transfers of Care - NHS England	3.5	6	1
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	2016/17	ASC Outcomes Framework - NHS Digital	87.8	43	2
Proportion of older people (65 and over) who are discharged from hospital who recieve reablement/rehabilitation services	2016/17	ASC Outcomes Framework - NHS Digital	2.6	85	3
Proportion of discharges (following emergency admissions) which occur at the weekend	Apr 2016 - Mar 2017	NHS Digital - 7 day service statistics	21.6	4	1

3.6 Of the 6 individual measures Bradford are ranked in the top quartile on 3, DTOC, Length Of Stay in Hospital and % of admissions at the weekend. We are in the bottom quartile on 1 measure, the number of emergency admissions for people aged 65. People are moved out of hospital quickly with little delay, but too many people are being admitted into hospital.

3.7 Performance and Business Intelligence framework update

A revised Performance and Business Intelligence framework is being implemented in Adult Social Care.

3.8 Performance Clinics have been launched, which focus around 6 key areas, 4 of which are current transformation programmes. The first of these clinics took place on 10th September. The clinics will increase accountability and provide a platform

for the leadership group to act as a critical friend to the lead officers providing both challenge and support. At each clinic a performance paper will be written for key areas to be discussed, focusing on performance information from ASCOF and local management information, what work is currently happening to drive improvement and what else needs to happen in the future as well as identify issues with finance and any data development needs. Key performance indicators linked to each of these key areas will be agreed and tracked and discussed on an exceptions basis. Narrative from the performance papers can be found in appendices A-F. The 6 key areas are;

3.9 **Delayed Transfers Of Care**, see appendix A – The report highlights Bradford's good performance in this area, both in relation to our peers but also against NHS England's expectation levels. Whilst focus needs to remain to ensure that the level of performance is maintained we also need to ensure that positive longer term outcomes are being seen and that the number of avoidable hospital admissions is reduced

3.10 **Safeguarding and Deprivation of Liberty Safeguards (DOLS),** See appendix B – Significant work is taking place around process improvement, data recording and information reporting in both the Safeguarding and DOLS teams. Whilst work is taking place to more effectively keep people safe much of this is dependent on securing additional full time resource for the teams, work to secure this resource is on-going.

3.11 **Front Door**, See appendix C – There is evidence of improved outcomes being achieved at first contact with Adult Social Care, with an increased number of contacts being dealt with without the need for a formal care act assessment. Recent observations of call handing in Access have shown the team to be effectively having strengths based conversation and reducing/delaying/preventing people needing on-going long term support. Contacts via the hospital need to be monitored to ensure that good outcomes are achieved.

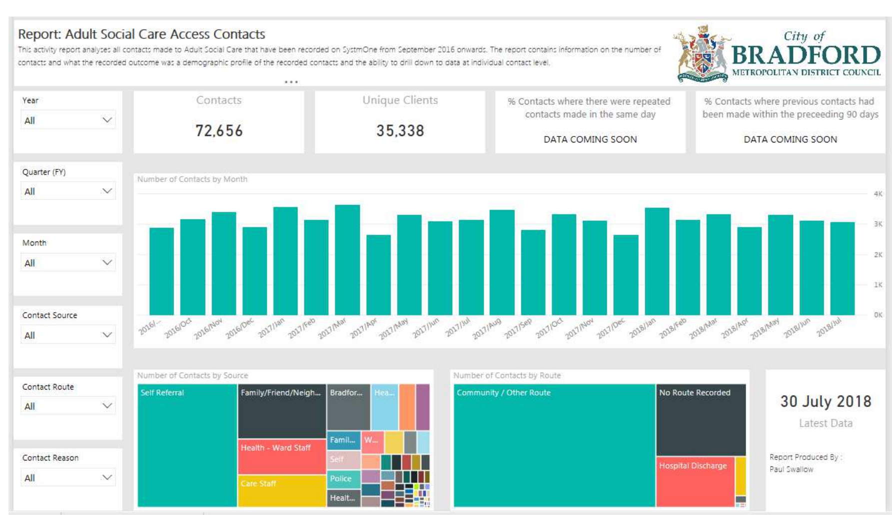
3.12 **Effective Community Support**, See appendix D – A lot of work is taking place within Bradford to identify best practice around providing appropriate short term response to social care needs to allow people to regain their independence and access the right community support quickly, reducing the demand for long term support. This work will impact upon the number of people accessing reablement. Reablement outcomes are an area for improvement, reducing the number of people in reablement would allow workers to spend more time with people in the service to work with them and reduce the reliance on long term care to meet their needs.

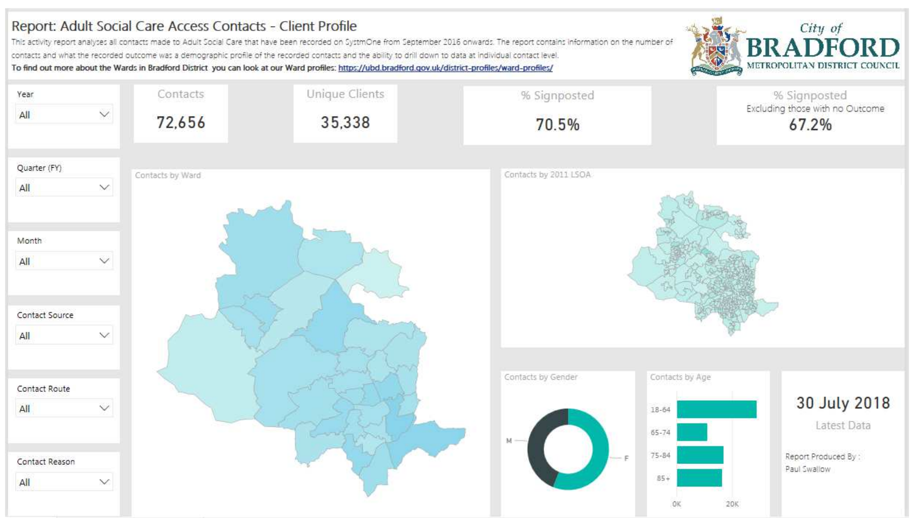
3.13 **Long Term Support**, See appendix E – There are currently 5,711 people in Bradford in receipt of long term Adult Social Care services, the gross cost of these services is over £2m/week. Work taking place at the front door and improved community support options will impact by reducing the number of people in long term support and also the average weekly cost of this support. There has been a significant shift in how needs are met with a much lower proportion of people now living in a care home than there were 2 years ago. It is important that the demand management ethos is also embedded through the reviewing process when people have been identified as having care and support needs. Reviews need to be more robust and consistent.

3.14 **Learning disabilities**, See appendix F – This is an area where there is potential for significant improvement. Outcomes around employment and independent living can be achieved as well as needing to reduce the number of younger adults living in a care home. More flexible and outcome focussed support needs to put in place to allow young adults with a learning disability to live more independent and enriching lives.

3.15 Alongside the performance clinic work is taking place implement a fit for purpose, robust and resilient business intelligence platform. The department is working with colleagues within the corporate Business Intelligence team and IT to develop reporting using Microsoft Power BI. Power BI allows users to interactive dashboards and reports to be developed which allow end users to interrogate their data and gain deeper insight. Data will be extracted from Adults Social Care management system, SystmOne, as well as other key systems, business intelligence reports will be updated on a daily basis.

3.16 Work started in August, to date a report on contacts made to Adult Social Care has been development and put live, and report on case management activity will be live in early October, followed by a report on all commissioned service activity in late October. Two screenshots from the contacts report can be seen below.





3.17 When a development has been put live we are working with users to ensure they can confidently and quickly use the reports to make the best use of the data within them. We will be working with the service managers to understand how they can use the reports to monitor and improvement performance around key performance indicators.

3.18 The new Performance and Business Intelligence framework will allow us to embed evidence and intelligence into daily and strategic decision making more effective and efficient uses of council resources and allow people outcomes to be met more effectively. We will be able to monitor and report on the impacts of the Home First strategy, tracking the reduction in demand, already being seen in residential and nursing care services, for long term support and understanding how to best target resources to manage demand and improve outcomes.

4. FINANCIAL & RESOURCE APPRAISAL

4.1 There are no direct financial implications arising from the detail of the report. As a result of implementing actions in the report we will see increased quality data and as a result will be in a position to better model costs and forecast spend. This is a very positive step going forward.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

NA

6. LEGAL APPRAISAL

There are no recommendations or actions of the Council on this report being sought, for legal to comment on at this time

7. OTHER IMPLICATIONS

NA

8. NOT FOR PUBLICATION DOCUMENTS

NA

9. OPTIONS

NA

10. RECOMMENDATIONS

Members are invited to comment on the report

11. APPENDICES

A - Delayed Transfers Of care
B - Safeguarding and Deprivation of Liberty Safeguards (DOLS)
C - Front Door
D- Effective Community Support
E - Long Term Support
F - Learning disabilities

12. BACKGROUND DOCUMENTS

None

Appendix A

Key Area – Delayed Transfers of Care

What is the data telling us?

During the whole of June 2018 there was a total of 283 delayed days, of which 222 were in acute care. This equates to an average 9.4 patients delayed each day, of which 7.4 were acute patients. 79.5% of all delayed days were attributable to the NHS, 20.5% were attributable to Social Care. Bradford's June position ranks us as a good performer against our peers, compared to all single tier and county councils in England, Bradford is ranked 4 on the overall rate of delayed days per 100,000 population aged 18+, with a rank of 151 given to the area with the highest rate. It is ranked 11 on the rate of delayed days attributable to the NHS, and 24 on the rate of delayed days attributable to social care. The days delayed in June 2018 showed a slight rise from May though there has been a trend of improvement in DTOC performance since September 2017

What are we doing to improve and is there evidence of impact?

NHS performance expectations were implemented in 2017. Bradford's target is 3.8 delayed days on average per 100k population. Bradford has consistently achieved this target.

There continues to be tight controls around DTOC, continued good relationships have been developed between stakeholders. There has been significant improvement in performance and NHS expectation levels are consistently met. Focus will be on maintaining this high level of performance.

What else needs to happen?

- Work with ADASS and further develop communication flow across the regional. In each of the previous 3 months there have been health providers outside of Bradford who have attributed delayed transfer of care days to us. On each occasion we were not communicated with by the relevant hospital provider, and did not pick this up until data was published by the department of health.

- Process needs to be developed and embedded within the Multi agency discharge team operating model which ensures that staff, hospital patients and their families and carers understand that they will be discharged from hospital and assessed at home, rather than assessed in hospital. This leads to more timely hospital discharges and assessments taking when people are at home rather than in an unfamiliar hospital setting, leading to improved outcomes.

- Work with Airedale hospital to implement a new ambulatory care unit. And work with the Bradford hospitals on embedding a multi agency assessment unit based within Accident and Emergency departments. This work will be focused on reducing the number of avoidable hospital admissions which will impact positively on DTOC performance.

Appendix B

Key Area -Safeguarding and Deprivation of Liberty Safeguards (DOLS)

What is the data telling us?

In early 2018 the number of DOLS applications awaiting screening, prior to being allocated stood at over 1,000, significant work has taken place to reduce this number. On a day to day basis this number is now fewer than 100. Currently there are 638 applications that have been screened and are waiting to be allocated; There are 504 applications that are being dealt with. Whilst significant work has taken place to reduce the number of cases waiting screening without adequate resource this number could rise again.

There were 4,815, Safeguarding concerns raised in 2017/18 and 1,425 received in Q1 of 2018/19. The 1,425 concerns received in 2017/18 Q1 equate to 362 per 100k of adult population, this is slightly above the average across the region of 313. 30% of the concerns raised in Q1 progressed to a section 42 enquiry, the average across the region is 46%,this conversion rate ranges from 11% to 99%. Work is taking place within the regional performance and Quality group to understand the range of conversion rates across the region.

Both the DOLS and Safeguarding statutory returns have been submitted, there are no ASCOF measures attached to these returns, though the Department of Health will publish comparator data later in the year.

What are we doing to improve and is there evidence of impact?

New safeguarding procedures are being implemented which will see screening of safeguarding concerns take place in both Access and MASH to ensure that they are dealt with appropriately and in a timely manner. A smaller proportion of concerns will be dealt with by the Care Management and Safeguarding team as a result but these will be the more complex concerns and section 42 enquires.

Alongside the implementation of the new procedures a business case has been written to provide additional permanent staffing resource for both the Safeguarding and DOLS teams. There is significant reliance on agency staff to meet the demands of the workload. The business case will be considered by the councils executive group in December 2018. If approved this will allow both teams to be more resilient to the demands and provide a higher quality response.

SystemOne is being developed and a new workspace for Safeguarding and amendments to the DOLS workspace are expected to go live in early 2019. Alongside this, Power BI reporting functionality will be developed to allow improved performance management of the services.

What else needs to happen?

The Deprivation of Liberty Safeguards are in the process of being reformed by the government. They will be replaced by the ‘Liberty Protection Safeguards’. The reforms seek to introduce a simpler process that involves families more and gives swifter access to

assessments and allow the NHS, rather than local authorities, to make decisions about their patients, allowing a more efficient and clearly accountable process

There will be a significant impact upon the council, Health and care providers. Work is already taking place to understand the impacts upon the council and how we will need to work with partners to ensure that they are prepared. Timescales on when the Liberty Protection Safeguards will be passed in to law are currently unclear.

Appendix C

Key Area – Front Door

What is the data telling us?

There have been 22,408 contacts recorded on SystmOne in 2018 up to 31st July. Of these 69 % where a decision has been recorded have been signposted, with 31% 'Progressing to Assessment'. In 2017 67% of contacts did not Progress to Assessment.
When looking at the contacts that have been dealt with in Access, there have been 9,698 contacts recorded on system one in 2018 up to 31st July. Of these 57 % of cases where a decision has been recorded have been signposted, with 43% 'Progressing to Assessment'. In 2017 56% of contacts did not Progress to Assessment.

The 9,698 contacts dealt with in Access related to 7,208 unique clients , 43% of these contacts were either a self-referral or a contact made by friends or family. The majority of the remaining contacts were made either by Social care staff, health partners or other partners.

What are we doing to improve and is there evidence of impact?

A Power BI report has been developed and put live analysing the contacts made. Access have been involved in the development of this report. This development work has highlighted improvements that need to be made to more accurately report the level of signposting and low level work that is taking place to meet outcomes. The contact outcome of 'Progress to Assessment' is used to record many things including a referral to Best and also passing a case through to care management to complete a care act assessment.

The recording is having a significant impact on the reported levels of performance. Whilst a slight increase in the level of signposting has been evidenced a change in how activity is reported needs to be made. Work is taking place to review both the options available to record in system 1 and how people should use them.

Since July 2018 Impower have been working with Adult Social Care to review the transformation and change plans, as part of this they have been observing call handling within Access and have reported positively of their findings and that there is a good level of screening taking place to prevent / reduce/ delay people being brought into long term services.

What else needs to happen?

- There needs to be an evaluation of Access following on from Impowers observations so that successes and impacts to demand for services resulting from Access can be evidenced. It is envisaged that we would see a reducing in the number of people being signposted to BEST and BUSH as a result of the screening taking place in Access as people with lower level needs have their outcomes met without the need to refer to these services.

- To build upon the evaluation of Access call handling by Impower we will train peer

reviewers to evaluate the quality of the call handling on an ongoing basis, this data will be built into a key performance indicator set around monitoring the impact of the Front Door.

- Care coordination in place by winter and closer relations with Safe and Sound and district nursing need to be developed to ensure that people can access appropriate Telecare equipment and community nursing when required.

- The majority of contacts reported on SystemOne are not made via Access, therefore we need to scale up working practice in Access roll out more widely across the wider health and social care sector, this should result in a reduced number of contacts being made as the sector as a whole focuses more closely on demand management.

Appendix D

Key Area – Effective Community Support

What is the data telling us?
Adult Social Care Outcome Framework (ASCOF data) shows that reablement outcomes in Bradford to be poorer than that of comparator councils. ASCOF 2D, shows that 61% of people are discharged from reablement without long term care and support needs, this places Bradford in the bottom quartile against regional, CIPFA and All England peers. Bradford perform better on ASCOF 2B1 which measures the proportion of people who access reablement who are still living at home 91 days after discharge from hospital, Bradford are an average performer against the region and all England, and in the top quartile against the CIPFA peer group with 88% of people still at home after 91 days.

The 2017/18 data shows that 54% of all new social care contacts went on to receive on going low level support, such as Telecare. This is higher than what was reported in 2016/17 by the majority of councils in our comparator group. Month by month comparison of performance from June 2017 and June 2018 shows a positive change in the proportion of people whose query is resolved by Access from 60% in June 2017 to 65% in June 2018.

What are we doing to improve and is there evidence of impact?
The Early Help And Prevention (EHAP) pilot began in Access in May with occupational therapists integrated within the team. The aim is to respond quickly to contacts to prevent issues escalating and reducing the need for reablement and potentially long term support. So far of 71 cases only 7 have been passed through to reablement. Previously all 71 cases would have progressed through to BEST for support. People are visited the same day or the next day at the latest, Providing small pieces of equipment or advising where these can be purchased and advising on voluntary sector organisations that can support. All 77 of the cases seen to date could have potentially been passed to reablement if they had not been seen by the EHAP service.

Supported by the National Development Team for Inclusion (NDTI)Community Led Social Work programme, we are developing Let's Connect hubs across the district so that people can have a face to face chat with a social care worker. Co-production brings people and organisations together around a shared vision. There is a focus on communities and each will be different. Let's Connect Keighley has hubs in Keighley Healthy Living Centre on Tuesday and will soon be opening in the Market on a Thursday. Let's Connect Bradford has a hub in the Bedale Centre on Buttershaw estate. This approach focusses on community and working in a person centred way with a focus on seeking alternatives to paid support and if support is needed not going straight to 'traditional options'.
Roll out of Let's Connect has begun with the Community Learning Disabilities Team who have seen 36 'less complex ' cases to date of which 33 have been signposted to universal community based services.

What else needs to happen?

- NDTI Community led Support programme to be fully implemented across Learning Disabilities and Transitions Services.

- Impower evaluation of the effectiveness of the adult social care front door to be reported on during September 2018 and associated recommendations.

- As part of the renewal of the Better Care Fund Plan following publication of the Social Care Green Paper this autumn, a full return on investment to be undertaken aligned to the home care recommissioning process led by the incoming Assistant Director Of Integration and Commissioning of reablement outcomes commissioned through the Better Care Programme.

- Outcomes from the OT led review of effectiveness of early help and prevention to be escalated to DMT with proposals for implementation.

Appendix E

Key Area – Long Term Support

What is the data telling us?

There are 5,711 people in receipt of long term adult social care support in Bradford. 42% are aged 18-64 and 58% aged 65+. The total gross weekly cost to the council is £2.1m, with an average package cost of £19.5k.

The data is showing a significant change in how people are accessing services with a shift away from Residential and Nursing services, to community based services. In April 2017, 37% of all people accessing long term services were in either a residential or Nursing setting, this has now fallen to 31%. Reflecting this the ASCOF measures linked to new care home placements show improved performance. Provisional ASCOF data shows 493 new placements /100k population for people aged 65+, this puts Bradford as a good performer. In the 18-64 age band there were 14.6 new placements per 100k population in 2017-18 which puts Bradford in a similar position to its peer groups. This shift should improve long term outcomes and reduce costs.

Performance needs to improve on the % of people receiving self direct support (82% per 2017/18 ASCOF) and % of people accessing Direct Payments (21% per 2017/18 ASCOF), Bradford are a bottom quartile performer on both of these measures. Based on 2016/17 finance data, Bradford spends more on Long term adult social care per 100k population than 14 of the other 15 councils in its CIPFA peer group.

What are we doing to improve and is there evidence of impact?

Change in practice is being evidence by the shift toward more community based services. Work within the department to improve outcomes from initial contacts and from reablement will have an impact upon the numbers of people accessing long term care. We expect the overall number to begin to fall as demand for services continues to be managed more effectively.

Budgets and support plan costs need to be monitored and managed more effectively. We are developing care management power BI report, to track outcomes of assessment and level of indicative budgets, following this data on commissioned services will be passed into Power BI so numbers and costs of services can be tracked on a daily basis.

What else needs to happen?

- Ensure people are pro actively reviewed to ensure package sizes are managed and that crisis is avoided. There should be a review within 3 months of a person coming into long term services and then on-going annual reviews. This more timely review will allow us to identify if people needs are increasing and that the CHC funding threshold is met sooner. This is not currently happening consistently and the resources needed to ensure it does need to be identified.
- The culture of embedding independence that we are seeing within Access, Community Led Support and our short term services needs to embedded within long term support.

- Explore imbedding the Personal Outcomes Evaluation Tool (POET) survey as part of review and assessment, this will allow us to more closely monitor outcomes on and on-going basis both for the service as a whole and also to track individuals outcomes.
- Ensure that all clients in receipt of long term support have had a RAS assessment and have an indicative budget
- Further promote the use more flexible types of community service delivery such as Direct Payments and Individual Service Fund's.

Appendix F

Key area – Learning disabilities

What is the data telling us?

Currently 3,500 people with a LD on GP register. 85% of the population are over 18. 2,300 are known to Adult Social Care . 1,476 people were in receipt of long term support funded by Bradford council at 1st July 2018. 60% of people are attending traditional day care services. Weekly packages sizes range from £12 to £4,463. The wide variance in the package sizes, and the high numbers of people receiving day services indicates inconsistencies of practice. An element of expenditure is against block contracts which do not pull through into SystmOne resulting in inaccuracies in financial forecasting. Impower benchmarking against CIPFA family group neighbours indicates that we have an unusually low number of learning disabled people who live at home with family and an unusually high number of people who live in commissioner funded supported living settings. 3.3% of learning disabled people are in employment, this is half the national average which is extremely low and reflects endemic low aspiration and ambition for outcomes for people with a learning disability.

What are we doing to improve and is there evidence of impact?

A dedicated transformation programme has been set up and the management capacity is being significantly enhanced to strengthen core decision making. All agency workers are due to be replaced by contracted staff recruitment taking place during August 2018. A review has taken place of all contacts through Community Learning Disabilities Team (CTLD) over the last 24 months to identify trends and themes emerging from referrals to the team.

A review is taking place with the team of the criteria for acceptance into Transitions and CLTD. At the end of August changes were made to the panel quality and assurance processes. The Panel process is being strengthened to ensure visible management footprints across all cases. The Resource Allocation System was switched on from 1st July 2018 and is being calibrated through till end September to provide for a transparent decision making process for setting Personal Budgets and agreeing Support Plan Values.

Targeted reviews are taking place, reviewing people Out of Area and with larger packages sizes (>£50k). We are already seeing success with this, eight cases resolved during August 2018 resulted in reductions/reclaiming of responsible commissioner funds/ordinary residence to the value of £1M.

What else needs to happen?

- Roll out of the NDTI supported community led social work ethos to underpin the Let's Connect approach towards completing strengths based conversational assessment.

- Review of Team structure to reflect enhanced management capacity and supervisory oversight to ensure visible management footprints across decision making.

- Bradford Talking Media, supported by the Public Health England Learning Disabilities Observatory co-hosted by NDTI and Lancaster University as the research and evaluation partner, to lead a self-advocate led Big Learning Disabilities Conversation defining what a better life looks like and what makes you happy. Work to be underpinned by the Big Lottery Hear Our Voice project (due to be announced Sept 2018 by Big Lottery).

- Personal Outcomes Evaluation Tool (POET) to be implemented to track people's outcomes.

Agenda Item 9/

Report of the City Solicitor to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 4 October 2018

O

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

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

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Portfolio:
Healthy People and Places

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

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) 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) Bradford District and Craven Integrated Workforce Programme's workforce strategy	Update	Michelle Turner	Resolution of 7 December 2017
3) Report on the findings of the consultation on carers services in the District	The Council and local NHS have listened to carers across Bradford District & Craven about their lives and the support that would help them. This consultation ran from 1st June, 2018 to 23rd July, 2018.	Victoria Simmons (on behalf of local NHS and Council)	
4) £2m contract report: services for carers	Report presented in accordance with the Council's Contract Standing Orders	Kerry James	
5) Council consultation with vulnerable groups	Following Judicial Review, what is being done to improve the Council's consultation processes	Darryl Smith	resolution of 8 September 2016

Health and Social Care O&S Committee

Scrutiny Lead: Caroline Coombes tel - 43 2313

Work Programme

Agenda	Description	Report	Comments
Thursday, 22nd November 2018 at City Hall, Bradford			
Chair's briefing 07/11/2018. Report deadline 09/11/2018			
1) Respiratory health / smoking cessation	Item to include the involvement of the Clinical Lead and service users delayed due to legal advice regarding the pre-election period	Toni Williams	Resolutions of 6 April 2017. Report
2) Care Quality Commission (CQC)	Annual update on social care inspection activity in the District	Sarah Drew (CQC)	
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 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
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) Department of Health and 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 (Victoria Wallace)	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	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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