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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Agenda for a meeting of the Health and Social Care Overview and Scrutiny Committee to be held on Thursday, 28 November 2019 at 4.30 pm in Committee Room 1 - City Hall, Bradford

Members of the Committee – Councillors

LABOUR	CONSERVATIVE	LIBERAL DEMOCRAT AND INDEPENDENT GROUP	BRADFORD INDEPENDENT GROUP
Greenwood Mir Godwin Kamran Hussain Lintern	Goodall Hargreaves	Jeanette Sunderland	Khadim Hussain

Alternates:

LABOUR	CONSERVATIVE	LIBERAL DEMOCRAT AND INDEPENDENT GROUP	BRADFORD INDEPENDENT GROUP
Akhtar Berry Iqbal Jenkins H Khan	Barker Riaz	Griffiths	Sajawal

NON VOTING CO-OPTED MEMBERS

G Sam Samociuk	Former Mental Health Nursing Lecturer
Susan Crowe	Bradford District Assembly Health and Wellbeing Forum
Trevor Ramsay	Healthwatch Bradford and District

Notes:

- This agenda can be made available in Braille, large print or tape format on request by contacting the Agenda contact shown below.
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- If any further information is required about any item on this agenda, please contact the officer named at the foot of that agenda item.

From:

Parveen Akhtar
City Solicitor
Agenda Contact: Jane Lythgow
Phone: 01274 432270
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To:

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. CLINICAL COMMISSIONING GROUPS' ANNUAL PERFORMANCE REPORT 1 - 22

The report of the Director of Quality and Nursing and the Chief Finance Officer, NHS Airedale, Wharfedale & Craven CCG, Bradford City CCG and Bradford Districts CCG, (**Document "P**") provides an update on the Clinical Commissioning Groups' performance.

Recommended –

That the report be noted.

(Michelle Turner and Robert Maden – 01274 237642)

6. HEALTH AND WELLBEING BOARD 23 - 34

The report of the Strategic Director, Health and Wellbeing, (**Document "Q"**), highlights the work undertaken for 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. In March 2018 the board took on the additional function of being the lead strategic partnership for the Bradford and Airedale district.

Recommended –

That the work undertaken by the Health and Wellbeing Board be noted.

(Sadia Hussain – 07929024881)

7. ADULT SOCIAL CARE ANNUAL PERFORMANCE REPORT 2018/19 35 - 52

The Strategic Director, Health and Wellbeing, will present a report (**Document "R"**) which provides a summary of performance within Adult Social Care and how performance reporting and business intelligence processes are being improved.

The views of Members are requested.

(Paul Swallow – 01274 435230)

8. WORK PROGRAMME 2019 - 2020

The Overview and Scrutiny Lead will provide a verbal update on the Committee's Work Programme 2019/2020.

(Caroline Coombes – 01274 432313)

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

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 28th November 2019

P

Subject: Clinical Commissioning Groups' Annual Performance Report

Summary statement: This report provides an update on the Clinical Commissioning Groups' performance

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Portfolio:

Health People and Places

Overview & Scrutiny Area

Health and Social Care

1. Summary

This report presents the latest performance against the NHS England Clinical Commissioning Group Improvement and Assessment Framework for Bradford City (BCCCG), Bradford Districts (BDCCG) and Airedale, Wharfedale and Craven (AWCCCG) Clinical Commissioning Groups. The report then provides an update on current performance against the key national NHS performance indicators and 'must dos' which reflect delivery of both the national Five Year Forward View (FYFV), the NHS Constitution standards and the NHS Mandate

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 2018/19 IAF Performance

The CCG IAF contains a range of indicators grouped within four domains: Better Health; Better Care; Sustainability; and Leadership, and an assessment against six national clinical priorities. NHS England use the IAF to provide oversight and holds quarterly and annual review meetings with the CCGs. The way the end of year ratings are calculated is across three areas: 25% for Financial Sustainability; 25% for Quality of Leadership; and 50% for the remaining indicators.

All three CCGs have demonstrated improvement across a number of areas during 2018/19, although AWCCCG moved from OUTSTANDING to GOOD this change was primarily as a consequence of the CCG agreeing a deficit financial plan for 2019/20. It is not seen as a reflection of any real deterioration in AWCCCG's performance. In total 102 (52.3%) of CCGs were rated as GOOD for 2018/19. Both CCCG and DCCG were rated OUTSTANDING. This result places both CCGs within the top 12% of CCGs in England. Overall results across England are shown figure 1 below.

For AWCCCG, the overall rating for Better Health and Quality of Leadership was GREEN. AWCCCG and BDCCG had a Better Care rating of AMBER. Both BCCCG and BDCCG had a Better Care rating of RED, indicating this as an area with the greatest need for improvement, but a Quality of Leadership rating of GREEN STAR. For BCCCG, Better Health was also rated RED. All 3 CCGs had a Sustainability rating of AMBER.

CCGs ACROSS ENGLAND (195)	2018/19	
	Number	%
OUTSTANDING	24	*12.3*
GOOD	102	*52.3*
REQUIRES IMPROVEMENT	58	*29.7*
INADEQUATE	11	*5.6*

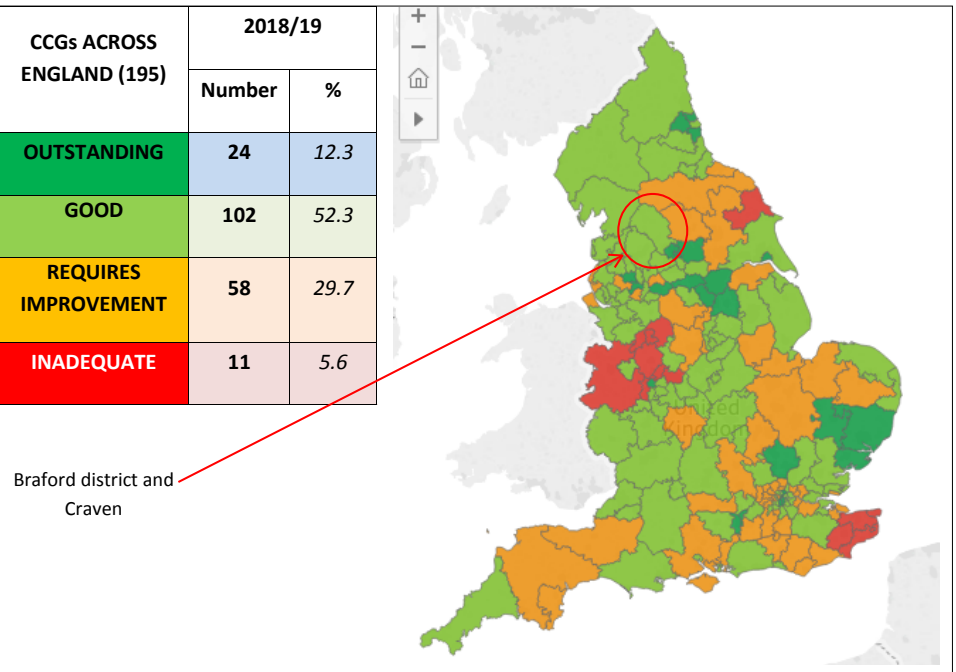

Figure 1: Overall results for 2018/19 across England

Previous ratings have also included an assessment against six clinical priority areas: cancer, mental health, maternity, learning disabilities, diabetes, and dementia. However, due to the move to the new NHS oversight framework from 2019/20, NHS England is no longer required to provide a separate assessment of CCG performance in these areas.

A combined Bradford district and Craven CCG Scorecard, containing the results for the end of year assessment, is attached as Appendix 1. Key points to note are:

- When benchmarking our results across our Integrated Care System (ICS) of West Yorkshire and Harrogate (WY&H), three CCGs were rated as OUTSTANDING, five CCGs were rated as GOOD, one was rated REQUIRES IMPROVEMENT and no CCGs were rated as INADEQUATE;
- As reflected across England, all three local CCGs were under pressure for key NHS constitutional standards throughout 2018/19 including cancer 62 day urgent GP referral, IAPT coverage and recovery, 18 week RTT, the Accident & Emergency (A&E) 4 hour waiting time standard and diagnostic 6 weeks waiting time. We are working with partners as part of the Bradford district & Craven Urgent Care and Planned Care programmes to manage demand and improve access to services and have seen recent improvements in performance. However, there is currently a national clinically led review of access standards that aims to check whether these standards remain relevant in today's NHS;
- The Five Year Forward View for Mental Health (MHFYFV) set out NHS England's approach to reducing the stark levels of premature mortality for people living with severe mental illness (SMI) who die 15-20 years earlier than the rest of the population, largely due to preventable or treatable physical health problems. A new indicator in the 2018/19 IAF measures the % of people on the General Practice (GP) SMI registers who have received a comprehensive physical health assessment in the 12 months. All 3 CCGs fell short of the 50 % target;

- All 3 CCGs had positive ratings for assessment of local relationships (effectiveness of working relationships in the local system) and patient and community engagement and patient safety (awareness of sepsis) was rated GREEN STAR for all 3 CCGs;
- Areas performing well across AWCCCG include childhood obesity, unplanned admissions following a fall, antibiotic prescribing, carers feeling supported, provider Care Quality Commission (CQC) ratings, cancer diagnosed at an early stage and 1 year survival from cancer, dementia diagnosis rate and post diagnostic support for dementia, mental health out of area placements (in patient care outside of the local health system), end of life care, extended access in primary care, sepsis awareness and uptake of the electronic GP referral service (eRS);
- Areas performing well in the BCCCG area include zero mental health out of area placements, a reduction in the use of inpatient beds for people with learning disabilities, an increase in the number of people with learning disabilities who have an annual physical health check, dementia diagnosis and a reduction in delayed discharges from hospital. Extended access in primary care (access to GP services outside of normal working hours) has reached 100% coverage and Continuing Health Care (CHC) assessments taking place in hospital, where eligibility for ongoing NHS funded care for people with long-term complex health needs is determined, were zero. Uptake of the eRS service has reached 99.9% and there were positive ratings for patient safety sepsis awareness and local relationships;
- BDCCG areas of good performance also include learning disabilities inpatient reduction, learning disabilities physical health checks, dementia diagnosis and support, delayed discharges, extended access in primary care, patient safety sepsis awareness, uptake of the e-referrals and local relationships;
- Across all 3 CCGs, there is still work to do to reduce urgent care admissions for conditions which could be managed out of a hospital setting. Managing demand on urgent care services continues to be challenging across the system as we continue to see higher than planned growth in A&E attendances and increased complexity in those needing urgent care. Our system wide Urgent Care Programme has been focussing on the following 4 areas of demand: frailty, mental health, respiratory and working age adults, to understand need and design interventions to manage the flow into urgent care services;
- All 3 CCGs also need to improve cancer patient experience. We are part of the West Yorkshire Cancer Alliance and actively involved in leading changes to cancer services provision. The overall objective of the alliance is for joined up working across West Yorkshire to implement the National Cancer Strategy and the Cancer Taskforce recommendations. We continue to work closely with Public Health and NHS England to support national educational and promotional campaigns including smoking cessation, as well as cancer screening services such as breast, bowel and cervical cancer. Through continuing to educate people and promote services, we will improve the uptake locally of these programmes and ultimately patient experience;
- Patient experience of GP services in the BCCCG area, as captured by the GP patient survey, is poor and we continue to try and improve this through providing improved access to services. Our GP extended access service is available to 100% of the Bradford population and operates from three hubs. Appointments are available 6.30-9.30pm Monday to Friday, and 10am-1pm Saturday and Sunday. This provides extended access to primary care services including GPs, physiotherapists, nurses, and specialists in children and young people's mental health;
- The Bradford CCGs performance needs improving in terms of, neonatal mortality and stillbirths and choice and experience in the maternity pathway. We have engaged with the West Yorkshire and Harrogate Local Maternity System programme to

implement Better Births and locally, we are learning from the Better Start Bradford research project and becoming an earlier adopter for perinatal mental health services; and

- AWCCCG's in-year financial performance for all quarters remained at AMBER and improvement is required in terms of diabetes treatment levels and structured education for newly diagnosed patients, and the % of patients with learning disabilities who receive an annual health check (although this has improved from 43.4% to 46%). Those diagnosed with type 2 diabetes are offered structured education. However, we recognise that not enough people attend and have created several new education options for patients and are now seeing a marked increase in numbers.

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 Airedale Hospital Foundation Trust (AHFT) performance has been above the national standard since October 2016, performance for August and September was below the 92% target, with pressures at specialty level in General Surgery, Orthopaedics, Ear Nose & Throat (ENT), Plastic Surgery, Gastroenterology, Cardiology, Respiratory Medicine and Neurology. There remain significant pressures in Neurology, and although the service has been unsuccessful in securing additional locum capacity to date, additional capacity has now been secured from a local GP with a special interest in Neurology (GPwSI).

A downward trend in planned care activity (a good proportion linked to the ongoing pension taxation matter affecting additional activity) is expected to result in continued deterioration of performance in October, and the total number of patients waiting has increased from 7,551 in March to 8,964 in September (899 above the trusts planned level). Of these, 12 are currently waiting over 40 weeks (a reduction of 25 on the previous month) and there were no people waiting more than 52 weeks.

Bradford Teaching Hospital Foundation Trust's (BTHFT) September performance improved slightly to 84.8%. However, although there was an increase in the total waiting list of 760, there were no patients waiting more than 52 weeks at the end of September and none are anticipated at the end of October. Outpatient activity in September significantly increased following a period of increased annual leave within the specialty teams in July and August. This resulted in a significant reduction in the number of patients waiting over 40 weeks from 94 at the end of August down to 74 at the end of September.

Weekly theatre activity targets have been set, including the minimum number of lists running per week and number of patients per list. These are being monitored at the Planned Care Access meeting. Recovery plans are in place for low performing specialties with a focus on demand and capacity analysis and prioritising productivity improvements.

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 has also been a challenge. AHFT performance improved in September, but continues to be affected mainly by Echocardiography, where there are currently some service pressures, and also Ultrasound. Further work is continuing to find a longer term, sustainable solution within Echocardiography but patients referred on an urgent basis continue to be prioritised and seen in a timely manner. The trust is working hard to sustain and improve this position and a revised recovery plan has now been agreed, which will see performance improve to 96% by the end of October, 97% in November and 98% in December.

BTHFT performance in September also improved, although it remains below target. Although the Endoscopy position is improving, cancer pressures continue which impact on the capacity to support recovery of the Trust's position. An additional Colorectal Consultant is in post from October and a Gastro Consultant post is out to advert with the interview planned for December. Additional Cystoscopy capacity has helped clear the waiting list for this test to only 6 people waiting over 6 weeks at the end of September. Performance above target is expected from October as a result

Cancer waits

Both Trusts have had challenges this year in delivering the 2 week wait (2WW) GP referral and 62 day standards. At AHFT there have been staffing pressures seen within the endoscopy department and the impact of capacity challenges linked to the national pension position. Work continues on the Trust's Cancer Recovery Plan including:

- Focussing on the redesign of pathways (how patients access and receive treatment);
- Improving outpatient and diagnostic capacity;
- Improving the recording of the stage of cancer as a key marker of a quality service;
- Progressing a strategic approach to prioritise early diagnosis and reduce urgent admissions via Emergency Departments (ED); and
- Reviewing the nationally published cancer patient experience survey responses and identifying areas for further improvement.

At BTHFT, the 2WW standard was reported below target in August at 92.15% but September is projected to achieve the standard as a result of significant improvements in the Lower Gastro Intestinal (GI) position. However, delivering the 62 Day standard remains a challenge with performance for September and October expected to remain below target as a result of high treatment numbers for patients waiting over 62 days.

Delays in the Urology pathway linked to capacity issues in Clinical Oncology and Robotic Surgery are the main concerns and additional surgical capacity is planned during November

During the past 12 months, the Trust has focussed on a number of areas to improve performance including:

- The Optimal Lung Pathway was introduced in September 2018 and has had a positive impact on the time to treatment but patient complexity remains a challenge. As a result, the service has implemented daily reviews to ensure that patients are diagnosed and referred to Leeds for treatment within 38 days;
- Improvement work in Urology has had a significant impact on 62 Day and 31 Day performance but Clinical Oncology capacity is creating pathway delays. Ongoing work with Leeds has secured some additional sessions to reduce this gap but a

significant backlog has been created which will need to be cleared before performance improves. Conversations to secure additional Clinical Oncology capacity are progressing with Leeds Teaching Hospitals;

- Improvements in Radiology reporting turnaround times and Endoscopy waits have impacted positively on the Lower GI position; and
- The diagnostic optimisation work-stream has supported a significant reduction in time to diagnosis across each tumour group.

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 continue to see increased attendances at our Emergency Departments (EDs) with increasing numbers of patients with complex needs resulting in high levels of bed occupancy. Pressures are continuing into October and the weekly winter system calls have now commenced earlier than the planned November date.

The A&E Delivery Board's four task and finish groups, (frailty, mental health, respiratory and working age adults), have now fed back recommendations to the Board and there are a number of proposals that will help improve A&E delivery:

- A&E Multiagency Teams within A&E at both hospitals: The plan is to build on multi agency working within BTHFT, which commenced last winter and was evaluated early this year as part of the Emergency Care Intensive Support Team (ECIST) support. Voluntary and Community Services (VCS) will provide workers to a Multi-Agency Team to provide specialist alcohol liaison, mental health peer support and community connectors to support people to of all ages in receiving advice, information and support in their communities;
- Care of the Elderly - in reach to surgical wards: This project proposes the development of an elderly medicine in-reach to frail elderly patients on surgical wards to avoid extended length of stay (LOS) and subsequent deterioration of mobility and independence;
- Care of the Elderly - rapid response team: A multidisciplinary rapid response team including a senior geriatrician, team of therapists, and social workers would provide comprehensive geriatric assessment and agree a personalised multi-disciplinary team (MDT) plan. Patients would be discharged home from ED with a wraparound plan of care which would be implemented through the virtual ward;
- Community Respiratory Service: This proposal to pilot a community respiratory service will build on existing digital health technology as a 24 hour access point to a community respiratory service. The service will have an assessment/advice function and work collaboratively with face to face providers (face to face delivery may be different across the Bradford and Airedale parts of the system) for the assessment and management of acute cases of Chronic Obstructive Pulmonary Disease (COPD) targeted in the community;
- Enhanced Care for Dementia: Valley View will be opening in September with capacity for 50 dementia friendly accommodation rooms. 30 of these beds will be a mixture of residential, nursing and rehabilitation to replace the capacity at Homewood. A further 20 beds will also be available as residential. The proposal is that the level of care for these 20 beds is enhanced during the winter months to allow a higher degree of care for dementia patients to avoid hospital admission or allow discharge form a hospital bed. This wrap around care would include a higher levels of nursing (enhanced supervision), telemedicine and technology support and input

from a geriatrician when required; and

- First Response Service (FRS)/Yorkshire Ambulance Service (YAS)/NHS 111 pathway & diversion: The project will see the utilisation of FRS capacity targeted at identified peak times across the system. Intelligence is suggesting this to be between the times of 11.30am -12am seven days a week. This increase will enable the service to respond to calls from YAS, offer rapid advice and respond to community face to face assessments within one to four hours to reduce the need for YAS to transport service users to ED for mental health assessments.

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 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 and access to IAPT services across the Bradford CCGs continues to improve as a result of the Reducing Inequalities in City (RICs) funded work. Recovery rates across AWCCCG and BDCCG remain above target and there has been significant improvement in the BCCCG area.

3.3. Quality of Care

Quality Improvement and Audit Feedback Project

Our research and development (R&D) team have run several successful audit and feedback quality improvement projects to reduce opioid and gabapentinoid prescribing. The projects have reduced the number of patients being prescribed these drugs inappropriately across our Integrated Care Partnership (ICS). This represents an improvement in the quality of care both received and delivered.

Antimicrobial Prescribing

The R&D team have also been working with Heads of Medicines Optimisation across the West Yorkshire and Harrogate Health and Care Partnership (our ICS) leading our next quality improvement audit and feedback project.

This time we are focusing on Lowering Anti-Microbial Prescribing (LAMP). LAMP will focus on prescribing associated with urinary tract infections (UTIs), 10 – 19 year olds prescribed Penicillin V, COPD, Cellulitis, Acne, dental abscess and upper respiratory tract infections (RTIs). This work directly contributes to the primary care strand of Tackling Antimicrobial Resistance 2019-2024, the UK's five year National action plan.

We have been held up as an exemplar of best practice - and our R&D team has recorded a podcast for Public Health England's website sharing our project as an example of best practice.

For the first time we are providing a digital tool kit for practices to use during the LAMP project. The tool kit was developed locally during the EU funded Learning Layers project which won the European Commission and the European Research Network on Vocational Education and Training (VET) 2018 award for excellence in research in VET. Practices will be able to access their LAMP reports, view all the references and download NICE and other guidance and further learning materials for use with their action plans for quality improvement.

Raising Awareness about Learning Disabilities (LD)

THiNK LD is a new initiative developed locally by the CCG's quality team for use across the health, social care and voluntary sector which prompts people to think about how the

services they provide impacts on the health of people with learning disabilities and what easy and simple steps they could take to improve people's experiences.

This is by prompting them with thinking about 'access, flexibly and equality' when engaging with persons with a LD. For instance, how can I help people with LD access services more easily; do I need to make any reasonable adjustments; how can the intervention be equivalent to patients who do not have specific needs?'

This is applicable across both health and social care and has been adopted by GP practices, Calderdale and Huddersfield NHS Foundation Trust, Bradford District Care Foundation Trust, Doncaster Hospitals Trust, Yorkshire Ambulance services and voluntary sector. The initiative has been recognised as excellent practice by NHS England, and is widely promoted and adopted nationally.

Health Care Acquired Infections

Health Care Acquired Infections (HCAIs) pose a serious risk to patient safety. 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. This is achieved through the use of Post Infection Review (PIR) panels to understand contributory factors and root cause of infections. It also provides opportunities for learning and improvement and enables implementation of agreed actions to reduce the likelihood of reoccurrence.

Cases of Methycillin-resistant Staphylococcus Aureus (MRSA) remain low, but against a challenging zero tolerance target; and clostridium difficile (Cdiff) infections continue to reduce in both an acute and community setting. Since 2018, we have also completed PIRs for Escherichia coli (E.coli) and Methycillin-susceptible Staphylococcus Aureus (MSSA) infections. There has been work across the system to reduce e coli through raising awareness and the implementation of a system wide hydration toolkit. Unfortunately this year the Trust had an outbreak of carbapenemase-producing enterobacteriaceae (CPE), and has been working with Public Health England to understand, learn and improve.

Mixed Sex Accommodation

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 of this standard remain rare across our two hospital sites, although there were 3 breaches of the mixed sex accommodation standard at AHFT in 2018/19. 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.

Improving care home quality

Bradford district and Craven CCGs and partner organisations locally have worked very closely with the sector to promote a "Better Together" ethos to support continuous improvement through a range of local initiatives and activities, such as

- Education and training programmes, including both clinical and leadership support e.g. falls awareness, root cause analysis, dysphagia, quality improvement, patient safety and human factors;
- Joint enhanced support visits to homes that are inadequate to support with improvement of operations through clinical audit, training, consultation and action planning;
- Joint Sector forums to look at best practice, themes and trends and issues facing the sector; and

- Establishment of a Joint care home service improvement board; and working closely with NHS partner organisations, Local Authorities and CQC to triangulate data and soft intelligence.

The programme of work with care home sector been commended by the CQC as being the 'most improved' in terms of care home quality locally. This can be demonstrated through a significant reduction in the number and percentage of homes rated inadequate by the CQC, from 36% in June 2015 to 5.8% in July 2017, and 1% in November 2019; and an increase in 'good' providers from 53% in July 2017 to 75% today with 4% of homes have an outstanding rating (comparable to national picture).

Implementation of the Red Bag Hospital Transfer Pathway

The Red Bag Hospital Transfer Pathway, to improve the care vulnerable people get in hospital, was launched by the CCG Quality Team and partner organisations across the Bradford district and Craven. To date over 120 care homes, 2 hospital Trusts and YAS have signed up to the Red Bag Pathway to ensure that when a person from a care home needs to go in to hospital personal information and possessions remain close to a person if they're admitted.

A red bag is used to transfer standardised paperwork, medication and personal belongings and stays with the resident throughout their hospital episode and is returned home with resident. The standardised paperwork will ensure that everyone involved in the care for the resident will have necessary information about the resident's general health, e.g. baseline information, current concern, social information and any medications, on discharge the care home will receive a discharge summary with the medications in the red bag.

As a result of the implementation care home staff thought the Red Bag Pathway had a positive impact on residents' experiences of going into hospital and had made things easier for care home staff.

CCG continue to influence continuous quality improvement across the sector through engagement, education and partnership working with BMDC and partner organisations.

3.4 Financial Performance and QIPP (Quality, Innovation, Productivity and Prevention)

As well as demonstrating that the CCGs achieve value for money in their use of public funds, the CCGs have a statutory duty to live within their resources, i.e. break-even, and to ensure that their running costs are within a target set by NHS England. The following table summarises the financial performance for each CCG in 2018/19 and shows that each CCG met its statutory financial targets.

For AWCCCG, BCCCG and BDCCG, the gap between our annual budgets and the increasing cost of providing healthcare to local people was £6.7m, £1.7m and £5.3m respectively during 2018/19. These gaps became our QIPP targets and performance

against these is also shown in the table below. The shortfall against the QIPP targets was met from other budget underspends.

2018/19 FINANCIAL PERFORMANCE	AWC CCG	CITY CCG	DISTRICTS CCG
In Year Resources	£238.4m	£170.6m	£500.9m
In Year Financial Performance	Break-Even		
Running Costs Within Target	Yes	Yes	Yes
Savings achieved (value and % of target)	£4.1m *(61.6%)*	£1.73m *(98.9%)*	£4.6m *(86.4%)*

Expenditure during the year reflected a number of service demand pressures and additional investment in national priorities with the main ones being:

- healthcare service demand pressures on acute hospital services;
- increased demand for continuing healthcare (nursing home placements and home care);
- additional investment in mental health services across including the expansion of the GP wellbeing service, funding to reduce waiting times for assessment and diagnosis of autism and ADHD and significant growth in other services for children and young people;
- primary medical care services and additional investment as part of the GP Five Year Forward View programme; and
- primary care prescribing costs where savings achieved through the implementation of the savings schemes were offset by higher than expected price concession cost pressures.

3.5 Financial Performance - Looking Ahead

CCG resource allocations that reflect the five year funding settlement for the NHS have now been issued. Whilst this does include additional growth funding, the cost of healthcare demand pressures, changes in national tariffs and the implementation of national policy requirements is expected to be greater than the total increase in CCG funding. Therefore, the financial outlook for our local health system remains challenging and will require further cost savings to be made over the medium term.

For 2019/20 only, BCCCG has received a resource uplift of 15.25%, which reflects the high level of deprivation and unmet health need in the local population. This is higher than the England average CCG resource uplift and means that we will be able to invest additional resources to help reduce health inequalities and improve mortality rates over time for the City population. Also, in line with national requirements we will be aiming to reduce our administration costs by 20% in real terms by 2020/21.

To ensure financial sustainability in the longer term, we have continued to work with local health organisations and the local authority in developing our health and care plan for the Bradford district and Craven. As part of this, our local health and social care system is implementing plans to deliver efficiencies through a combination of local and West

Yorkshire wide initiatives designed to improve the use of our resources and introduce new care models.

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.

The amount of QIPP that is needed to address the gap between anticipated incomes and planned spend for 2019/20, is shown below for all 3 CCGs:

- AWC CCG £5.0m
- Bradford City CCG £1.2m
- Bradford District CCG £7.1m

As part of the joint management structure the CCGs continue to work collaboratively with provider colleagues around QIPP to ensure that there is a joint approach to deliver these savings targets. The focus of our savings schemes continues to be about reducing inefficiency and waste and managing demand for hospital services. In particular:

Planned Care: Our Planned Care Programme is implementing a number of schemes to address unwarranted variation and inefficiencies across care pathways, whilst also improving waiting times for those patients who need hospital care.

Urgent Care: Schemes are being implemented that will help to reduce the number of inappropriate A&E attendances and to avoid non-elective admissions where that is appropriate. Schemes that look at people with frailty; respiratory conditions; and mental health conditions have been developed.

Prescribing: For all 3 CCGs, work continues on targeting inefficiency and on implementing NHS England guidance in relation to the prescribing of low value medicines and 'Over The Counter' medicines.

QIPP PLAN FOR 2019/20

£'000	AWC	CITY	DISTRICTS
Planned Care	**1,471**	**470**	**3,118**
Urgent Care	**383**	**45**	**75**
Prescribing	**1,007**	**543**	**1,179**
Personalised Commissioning	**223**	**70**	**200**
Community Services	**300**	**0**	**0**
Budget Review	**420**	**0**	**310**
Corporate	**249**	**80**	**325**
Other	**969**	**0**	**1,910**
Total	**5,022**	**1,208**	**7,117**

3.6 New ways of working (Integrated Care Systems)

All three CCGs continue to work towards the system wide vision and shared aim of 'Happy, Healthy at Home'. We are developing new ways of working to deliver care and support in a more integrated and coordinated manner which will reduce the complexities for patients; families and carers having to circumnavigate the complex health and social care system. To support this, we have agreed and signed a strategic partnering agreement to enable as a collective: decision making; empowerment and engagement of local communities; management of financial and system risk; and focus on population health.

All three CCGs in partnership with social care; the third sector; acute and community providers will continue their focus on the development of a community based offer, supporting 'Happy, Health, at Home' delivering an out of hospital programme of care. This joint partnership work will look at developing efficiencies within the system by doing things once and together, delivering support which is tailored to meet individual's needs and through this keep people at home reducing unnecessary admissions into the hospital.

This work includes a range of initiatives such as:

- Continuing to embed the community partnerships, which deliver a model of care based around integrated and aligned health and social care across populations of 30,000 to 60,000;
- Implementing the General Practice Forward View, the primary medical care elements of the NHS Long Term Plan, the new GP contract and the refreshed Primary Medical Care Commissioning Strategy. The aim is to ensure high quality, safe and sustainable primary medical care services are in place in Bradford and Craven which operate as part of wider system working;
- Developing a Community Assessment and Triage Unit (CAAT) to enable a comprehensive assessment of patients who may need enhanced health or social care input to prevent admission into hospital and avoiding them attending A&E;
- Continuing the focus on the development and delivery of a new model of care for diabetes including, where appropriate, clinical pathways across the Bradford district and Craven areas;
- Continuing the focus on Bradford Healthy Hearts and Bradford Breathing Better, to enable patients with cardiac or respiratory disease to better manage their conditions, to support earlier diagnosis and improved long term management of the conditions. We are also working at a West Yorkshire and Harrogate level footprint to ensure that we have consistent pathways reducing inequalities and inequities of care provision;
- Continuing the use of intermediate care as an alternative to hospital admission where appropriate;
- Focusing on Enhanced Health and Wellbeing at Home (EHWH), whether in a care home or a person's own home, to ensure residents receive the care they need at home and prevent unnecessary admissions into hospital;
- Prevention; self-care and self-management remain a priority theme along with asset based community development. Through these initiatives we aim to reduce demand on local services and activate citizens to take responsibility for their own health; engage with and build on local community assets, identifying and acting on further integration opportunities; and

- Expand the 'Health, Care and Housing network bringing a range of people and stakeholders together with a shared aim of addressing broader determinants of health, taking working together and integration to a new level

3.7 Look forward to 2019/20

New ways of working and integration remain a key priority for 2019/2020. All three CCGs, as parties to the Strategic Partnering Agreement have a shared responsibility for driving and enabling change. As a system, all partners are working towards the shared vision of people being happier and healthier with delivery of integrated care enabling them to stay independent and at home.

The programme of work to support this will continue across all three CCGs; tailored where necessary to local need. This includes work to deliver:

- System sustainability; new contracting and financial models;
- Population Health approach to using data and intelligence to predict and plan integrated care delivery tailored to need;
- Integrated working taking a whole person and whole system approach through Community Partnerships;
- Engagement with local elected members through community partnerships;
- Delivery of the requirements of the new GP contract; extended access and additional services supporting integration of primary medical care and delivery of the General Practice Forward View;
- New ways of working; build, develop and embed integration through Care Coordination;
- Approaches to address broader determinants of health;
- Engagement with citizens through more asset based community development workshops in local communities asking 'what's important to you' encouraging activation;
- Continued focus on Prevention and Early Help;
- Continuous improvement through reviewing the impact of work to date and continuous improvement through use of quality improvement techniques;
- Further development of integrated pathways of care; particularly to support consistent management of long term conditions (e.g. diabetes; respiratory; cardio vascular disease) and to reduce variation in planned care (with self-care information for patients embedded); and
- Community based approach to integrated care delivery.

3.8 NHS Oversight Framework for 2019/20

2019/20 will be a development year for a new framework with specific metrics identified in the NHS Long Term Plan implementation framework and will also incorporate the commitments in the People Plan to develop a leadership compact. This compact will be an important component of future oversight and will set out how the regional, national and local teams commit to behave towards one another.

As a transitional year, regional directors and their teams will lead on system oversight, taking a blended approach from the Single Oversight Framework for Providers and the Improvement and Assessment Framework (IAF) for CCGs. NHS England and NHS Improvement will retain use of existing tools and levers during this year including: licence

breach, powers of direction and special measures. Oversight will be characterised by five key principles:

- NHS England and NHS Improvement teams speaking with a **single voice**, setting consistent expectations of systems and their constituent organisations;
- A greater emphasis on **system performance**, alongside the contribution of individual healthcare providers and commissioners to system goals ;
- Working with and through **system leaders**, wherever possible, to tackle problems;
- Matching **accountability for results** with improvement support, as appropriate; and
- **Greater autonomy** for systems with evidenced capability for collective working and track record of successful delivery of NHS priorities

During 2018/19 there was an increased engagement of ICS' in the approach to CCG improvement and assessment, and this is set to continue in 2019/20. NHS England and NHS Improvement are developing a maturity matrix for systems that will determine the responsibilities and freedoms at each stage of maturity. CCGs and/or provider's support needs will be assessed and based on this assessment and regional teams will allocate organisations to a segment, as follows: maximum autonomy, targeted support, mandated support or special measures/legal directions. Oversight this year will incorporate quarterly system review meetings (or more frequently if there are material concerns) and these meetings will cover:

- Performance against a core set of national requirements;
- Emerging organisational health issues; and
- Progress with transformation objectives in the NHS Long Term Plan

Performance discussions will be enabled by national reporting and dashboards containing integrated performance data on activity and quality standards and will be available to organisations, systems, regional and national teams. The publication of these reports and dashboards aim to provide access to a single version of the truth for all.

The five themes of the Oversight Framework are illustrated in the table below:

CCGs	**Providers**
• New service models	• Strategic change
• Preventing ill health and reducing inequalities	
• Quality of care and outcomes	• Quality of Care • Operational performance
• Leadership and workforce	• Leadership and improvement capability (including effective boards and governance)
• Finance and use of resources	• Finance and use of resources

As in previous years, each of these themes contains a number of indicators which will be used to assess performance (a total of 65 oversight metrics).

Although individual organisations have a statutory responsibility for their own performance, to enable a more collaborative approach to managing issues across the Bradford & District system, we now have a system Finance & Performance Committee and Quality Committee in place. Along-side this, we are working more closely as system partners to ensure that provider and commissioner plans are aligned in terms of finance, activity, workforce and outcome metrics.

It is envisaged therefore that future performance reports to the HOSC will reflect this wider system working and will be presented as an integrated Bradford district and Craven report.

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

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

CCG Improvement & Assessment Framework - CCG Scorecard (2016/17 to 2019/20)
Bradford district & Craven - July 2019

	Metric and rationale	Latest period	National average	STP average	Airedale, Wharfedale & Craven CCG			Bradford City CCG			Bradford Districts CCG		
		Time	England	WY&H	First	Jul-19	Rank	First	Jul-19	Rank	First	Jul-19	Rank
A BETTER HEALTH	102a Child obesity: Percentage of children aged 10-11 classified as overweight or obese *(rationale: Overweight and obese children are more likely to become overweight or obese adults, with consequent health problems)*	2015/16 to 2017/18	33.5% to 34.2% ↑	33.4% to 35.2% ↑	31.7%	31.9% ↑	59	38.9%	41.7% ↑	187 *	34.8%	37.9% ↑	157
	103a. Diabetes patients that have achieved all the NICE recommended treatment targets: Three (HBA1c ; Cholesterol ; and Blood Pressure) for adults and one target for children HbA1c	2017-18	39.8% to 38.7% ↓	38.8% to 37.3% ↓	41.1%	32.4% ↓	188 *	35.2%	34.7% ↓	176	41.0%	39.1% ↓	104
	103b. Diabetes: People with diabetes diagnosed less than a year who attend a structured education course *(Rational: to incentivise CCGs to increase the number of diabetes patients attending structured interviews)*	2017/18 2016 cohort pts	5.7% to 8.54% ↑	7.31% to 6.81% ↓	2.3%	6.0% ↑	123	0.4%	1.25% ↑	183	2.6%	5.13% ↑	128
	104a. Falls: injuries from falls (age 65+ years) falls conversation *(rationale: Falls are the largest cause of emergency hospital admissions amongst older people and have a significant impact on their long term health)*	Q3 2018/19	1,925 to 2,051 ↑	1,972 to 2,125 ↑	1,773	1,620 ↓	36	1,687	1,932 ↑	82	1,922	2,729 ↑	181
	105b. Personalisation and choice: personal health budgets *(rationale: Provision of personal health budgets for certain patients is a key objective of the NHS)*	Q4 2018/19	11.3 to 75↑	10 to 38 ↑	12.0	27 ↑	105	20.3	19 ↓	139	10.6	23 ↑	116
	106a. Health inequalities: inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions *(rationale: Supporting patients with LTCs to manage their own condition better, thereby reducing demand on the NHS and enabling CCGs to meet legal duties to tackle health inequalities)*	Q2 2018/19	2,154 to 2,109 ↓	2,582 to 2,978 ↑	2,573	3,145 ↑	176	6,048	7,336 ↑	195*	2,789	4,148 ↑	192*
	107a. Anti-microbial resistance: Appropriate prescribing of antibiotics in Primary & Community Services *(rationale: Reducing inappropriate use of antibiotics will reduce anti-microbial resistance and support delivery of better health outcome)*	2019 02	1.066 to 0.962 ↓ Target ≤0.965	1.126 to 1.017 ↓	1.051	0.933 ↓	68	1.167	0.968 ↓	86	1.172	1.052 ↓	137
	107b. Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in Primary & Community Services *(rationale: Reducing inappropriate use of antibiotics will reduce anti-microbial resistance and support delivery of better health outcome)*	2019 02	9.7% to 8.71% ↓ Target=10%	6.5% tp 6.29% ↓	7.2%	7.0% ↓	36	6.2%	4.25% ↓	1	6.2%	5.38% ↓	7
	108a. Carers: The percentage of carers with a long term condition who feel supported to manage their condition CHANGE *(Rationale: this metric helps us understand the health status of carers)*	2018	0.59	0.6 Target = 1	0.67	0.65 ↓	17	0.61	0.51 ↓	186*	0.60	0.57 ↓	135
B BETTER CARE	121a. Care rating: Use of high quality providers - Hospitals *(rationale: Providing high quality care for all is a fundamental principle of health and care services)*	Q3 2018/19	no data	58 to 60 ↑	58	61 ↑	77	57	59 ↑	133	57	60 ↑	105
	121b. Care rating: Use of high quality providers - Primary Medical Services *(rationale: Providing high quality care for all is a fundamental principle of health and care services)*	Q3 2018/19	no data	67 ↔	69	68 ↓	30	68	65 ↓	142	68	66 ↓	99
	121c. Care rating: Use of high quality providers - Adult Social Care *(rationale: Providing high quality care for all is a fundamental principle of health and care services)*	Q3 2018/19	no data	57 to 60 ↑	57	63 ↑	63	52	60 ↑	161	55	59 ↑	177
	122a. Cancer: Cancers diagnosed at early stage *(rationale: Diagnosis at an early stage dramatically improves survival chances)*	2017	43.3% to 52.2% ↑ Traj=53.5%	37.4% to 51.5% ↑	35.9%	53.8% ↑	65	36.1%	47.1% ↑	181	38.3%	51.0% ↑	120
	122b. Cancer People with urgent GP referral having first definitive treatment Maximum 62 days of referral *(rationale: Shorter waiting times improve patient experience and can lead to better outcomes)*	Q4 2018/19	86.9% to 77.3% ↓ Std=85%	89.1% to 73.3% ↓	93.7%	83.4% ↓	47	82.6%	70.0% ↓	169	91.1%	70.9% ↓	166
	122c. Cancer One-year survival from all cancers *(rationale: Improving cancer survival is a key plank of improving cancer outcomes)*	2016	61.2% to 72.8% ↑ Ambition=75%	61.8% to 72.6%↑	65.0%	73.6% ↑	51	57.6%	71.4% ↑	140	61.8%	73.1% ↑	66
	122d. Cancer patient experience *(rationale: Key component of the strategy to achieve world-class cancer outcome)*	2017	no data	8.8	8.8	8.7 ↓	153	8.5	8.5 ↔	186*	8.7	8.6 ↓	178
	123a. Mental Health: Improving Access to Psychological Therapies (IAPT) - recovery rate *(rationale: Improving outcomes from psychological therapy is a key part of improving treatment of people with depression or anxiety)*	Q3 2018/19	50.6% to 51.8% ↑ Std= 50%	50.8% to 51.6% ↑	59.4%	55.1% ↓	43	44.8%	41.7% ↓	191*	53.8%	49.0% ↓	149
	123b. Mental Health: Improving Access to Psychological Therapies (IAPT) - access *(rationale: Improving outcomes from psychological therapy is a key part of improving treatment of people with depression or anxiety)*	Q3 2018/19	4.03% to 4.48% ↑ Traj=4.75%	3.3% to 3.87% ↑	4.56%	4.28% ↓	118	5.1%	3.48% ↓	176	4.0%	3.47% ↓	177
	123c. Mental Health: People with first episode of psychosis starting treatment with a NICE-recommended package of care within 2 weeks of referral *(rationale: Receiving the right treatment promptly results in improved outcomes)*	2019 03	71.3% to 75.9% ↑ Std=53%	72.9% to 68.2% ↓	68.8%	58.3% ↓	174	67.5%	59.3% ↓	170	73.5%	57.5% ↓	176
	123d. Mental Health: Children and Young People (CYP) receiving treatment from NHS funded community services as a proportion of the CYP population with a diagnosable mental health disorder	No data	no data	no data	-	No data available	-	-	No data available	-	-	No data available	-
	123f. Mental Health: Mental Health Out of area placements CHANGE	2019 02	126 to 124 ↓	113 to 90 bed days↓	0	0 ↔	1	0	0 ↔	1	2	24 ↑	78
	123e. Mental Health: crisis team provision	2017/18	no data	no data	-	50%	42	-	0%	114	-	25%	81
	123g. Mental Health: Proportion of people on GP severe mental illness regiser receiving physical health checks in primary care NEW	Q4 2018/9	30.3% Target >50%	no data	27.5%		102	44.7%		26	39.5%		43
	123h. Mental Health: Cardio-metabolic assessment in mental health environments - secondary care NEW	No data	no data	no data	-	No data available	-	-	No data available	-	-	No data available	-
	123i. Mental Health: Delivery of mental health investment standard NEW	Q4 2018/19	no data	no data	GREEN	GREEN ↔	N/A	GREEN	GREEN ↔	N/A	GREEN	GREEN ↔	N/A
	123j. Mental Health: Quality of mental health data submitted to NHS Digital (DQMI) NEW	2019 01	no data	0.83 to 0.82 ↓	0.77	0.75 ↓	183	0.77	0.75 ↓	182	0.77	0.75 ↓	184
	124a. Learning Disabilities: reliance on specialist inpatient care for people with learning disability and / or autism *(rationale: High numbers of people having inpatient care can indicate services being delivered poorly)*	Q4 2018/19	no data	no data	34	30 ↓	18	34	30 ↓	18	34	30 ↓	18
	124b. Learning Disabilities: Proportion of people with a learning disability on the GP register receiving an annual health check *(rationale: Annual health checks are an important tool to help improve health and reduce premature death in people with a learning disability)*	2017/18	37.1% to 51.4% ↑	38.1% to 50.5% ↑	39.5%	46.0% ↑	138	54.6%	67.5% ↑	11	51.1%	65.0% ↑	17
	124c. Completeness of the GP learning disability register	2017/18	0.47% to 0.49% ↑	0.56% to 0.56% ↔	0.55%		61	0.71%		11	0.63%		30
	125d. Smoking: Maternal smoking at delivery *(rationale: smoking during pregnancy can cause a range of serious health problems)*	Q3 2018/19	12.1% to 10.5% ↓ Target 6%	14.9% to 13.5% ↓	13.1%	11.2% ↓	97	10.6%	10.5% ↑	85	21.3%	17.1% ↓	172
	125a. Maternity: neonatal mortality and still births *(rationale: Improving safety in maternity services)*	2016	no data Amb=0.67	4.83 to 5.91 ↑	4.55	5.78 ↑	135	6.23	8.39 ↑	192*	7.37	6.47 ↓	177
	125b. Maternity women's experience of maternity services *(rationale: Improving the experience of mothers and families)*	2018	83.0 to 82.7 ↓	83.5 to 84.4 ↑	87.2	85.3 ↓	49	88.8	81.2 ↓	130	80.7	80.5 ↓	142
	125c. Maternity: Choices in maternity services *(rationale: Improving the experience of mothers and families)*	2018	60.8 to 60.4 ↓	60.2 to 62.3 ↑	61.4	63.7 ↑	44	69.7	57.1 ↓	156	58.6	63.4 ↑	49
	126a. Dementia estimated diagnosis rate for people with dementia *(rationale: Encouraging timely diagnosis leads to better-planned treatment)*	2019 03	67.9% to 68.7% ↑ Std=66.7%	73.4% to 73.3% ↓	78.7%	76.1% ↓	40	81.0%	83.2% ↑	11	81.6%	82.8% ↑	13
	126b. Dementia: Dementia care planning and post-diagnostic support *(rationale: Improving the quality of care and support for people with dementia)*	2017/18	77% to 77.5% ↑	78.8% to 78.9% ↑	77.8%	79.9% ↑	56	79.4%	76.4% ↑	141	81.0%	79.5% ↓	63
	127b. Urgent and Emergency Care: Emergency admissions for urgent care sensitive conditions *(rationale: Ensuring patients get the right care, in the right place, first time will increase efficiency of service delivery and improve quality of care)*	Q2 2018/19	2,395 to 2,409 ↑	2,768 to 2,756 ↓	2,485	2,556 ↑	123	4,429	4,972 ↑	195*	3,066	3,773 ↑	190*
	127c. Urgent and Emergency Care: Percentage of patients admitted, transferred or discharged from A&E within 4 hours *(rationale: Patients should be seen promptly, in accordance with the NHS Operational Standard)*	2019 03	90.5% to 86.6% ↓ Std=95%	84.5% to 87.5% ↑	93.4%	87.1% ↓	74	91.8%	71.3% ↓	187*	92.0%	74.9% ↓	183
	127e. Urgent and Emergency Care: delayed transfers of care (DTOC) attributable to the NHS per 100,000 population *(rationale: Minimising delayed transfers of care and enabling people to live independently are key outcomes of social care)*	2019 03	14.4 to 10.2 ↓ Amb=3½days	8.3 to 9.7 ↑	5.5	5.2 ↓	32	5.5	4.9 ↓	27	3.6	2.7 ↓	4
	127f. Urgent and Emergency Care: Population use of hospital beds following emergency admission *(rationale: May indicate poor operation of primary and community services)*	Q2 2018/19	499 to 499 ↔	503 to 532 ↑	422.40	461 ↑	62	471.9	496 ↑	105	417.2	502 ↑	110

CCG Improvement & Assessment Framework - CCG Scorecard (2016/17 to 2019/20)
Bradford district & Craven - July 2019

	Metric and rationale	Latest period	National average	STP average	Airedale, Wharfedale & Craven CCG				Bradford City CCG				Bradford Districts CCG			
		Time	England	WY&H	First	Jul-19		Rank	First	Jul-19		Rank	First	Jul-19		Rank
B BETTER CARE	105c. End of life care: Percentage of deaths with three or more emergency admissions in last three months of life	2017	6.89% to 7.4% ↑	7.05% to 7.52% ↑	4.8%	5.13%	↑	21	10.1%	10.5%	↓	187*	7.2%	9.30%	↓	165
	128b. Primary Medical Care: Patient experience of GP services *(rationale: Improving patient experience of Primary & Community Services)*	2018	86.7% to 83.8% ↓	86.5% to 84% ↓	88.8%	84.9%	↓	80	73.1%	72.4%	↓	195*	84.4%	81.2%	↓	144
	128c. Primary Medical Care: Primary & Community Services access - percentage of registered population offered full extended access	2019 03	46.6% to 99.8% ↑	27.9% to 100% ↑	0%	100%	↑	1	0%	100%	↑	1	0%	100%	↑	1
	128d. Primary Medical Care: Primary & Community Services workforce *(rationale: Improved access to timely, quality services)*	2018 09	1.05 to 1.05 ↔	1.03 to 1.09 ↓	1.03	1.14	↑	49	1.06	1.17	↑	41	1.06	1.18	↑	38
	128e. Primary Medical Care: count of the total investment in primary care transformation made by CCGs compared with the £3 head commitment made in GP forward view NEW	Q4 2018/19	no data	no data	GREEN	GREEN	↔	N/A	GREEN	GREEN	↔	N/A	GREEN	GREEN	↔	N/A
	129a. Elective Access:patients waiting 18 weeks or less from referral to hospital treatment *(rationale: Patients should be seen promptly, in accordance with the NHS Constitution standard)*	2019 03	90.3% to 86.7% ↓ Std=92%	89.7% to 89.6% ↓	92.2%	91.4%	↓	31	91.6%	87.0%	↓	110	92.8%	85.9%	↓	126
	130a. 7 day service: Achievement of clinical standards in the delivery of 7 day services *(rationale: Reducing risk to patients admitted at weekends)*	2017/18	no data	no data	3 out of 4	3 out of 4	↔	8	2 out of 4	2 out of 4	↔	56	2 out of 4	2 out of 4	↔	56
	131a. Continuing Health Care: Percentage of NHS Continuing Healthcare assessment taking place in an acute hospital setting *(rationale: To be assured of consistent application of the National Framework for NHS Continuing Healthcare)*	Q4 2018/19	26.5% to 6.91% ↓ Target=15%	14.6% to 6.88% ↓	23.1%	12.9%	↓	155	26.3%	0%	↓	1	16.7%	18.0%	↑	167
	132a. Patient Safety: Evidence that sepsis awareness raising amongst healthcare professionals has been prioritised by the CCG	2018	no data	no data	GREEN	GREEN STAR	↑	N/A	GREEN	GREEN STAR	↑	N/A	AMBER	GREEN STAR	↑	N/A
	133a. Diagnostics: Patients waiting six weeks or more for a diagnostic test NEW	2019 03	1.07% to 2.47% ↑ Target <1%	0.62% to 4.77% ↑	0.3%	3.24%	↑	152	0.34%	4.77%	↑	170	0.5%	4.03%	↑	163
C SUSTAINABILITY	141b. Financial sustainability: In-year financial plan CHANGE *(rationale: CCGs should reduce expenditure or improve outcomes where the opportunity to do so has been identified)*	Q4 2018/19	no data	no data	AMBER	AMBER	↔	N/A	GREEN	GREEN	↔	N/A	GREEN	GREEN	↔	N/A
	144a. Personalisation and choice: Utilisation of the NHS e-referral service to enable choice at first routine elective referral *(Rational: purpose is to measure the extent to which patients are being offered choice of provider at first referral)*	2019 03	53.1% to 99.8% ↑ Target=99.6%	63.7% to 99.9% ↑	48.0%	99.9%	↑	143	89.4%	99.9%	↑	103	79.4%	99.4%	↑	176
	145a, Demand Management: expenditure in areas with identified scope for improvement (NHS RightCare) NEW	Q3 2018/19	no data	no data	GREEN	RED	↓	N/A	RED	RED	↔	N/A	RED	RED	↔	N/A
D LEADERSHIP ACROSS THE ICS	162a. Probity and corporate governance: probity and corporate governance CHANGE *(rationale: CCGs need to manage such conflicts in an appropriate manner and demonstrate accountability to the public)*	Q4 2018/19	no data	no data	Partially compliant	Fully compliant	↔	N/A	Fully compliant	Fully compliant	↔	N/A	Fully compliant	Fully compliant	↓	N/A
	163a. Workforce engagement: staff engagement index *(rationale: Staff engagement and race equality are key to delivering high quality services)*	2018	3.8 to 3.82↑	no data	3.80	3.83	↑	35	3.77	3.83	↑	42	3.77	3.82	↑	44
	163b. Workforce engagement: Progress against workforce race equality standard: promotion and career progression *(rationale: CCGs have a legal duty to avoid harassment, discrimination and lack of equal opportunities)*	2018	1.12 to 0.14 ↓	no data	0.06	0.13	↑	96	0.11	0.18	↑	176	0.10	0.18	↑	165
	164a. CCGs' local relationships: effectiveness of working relationships in the local system *(rationale: CCGs need effective local relationships to be good local system leaders)*	2018/19	no data	no data	69.9	83.3	↑	8	77.5	78.7	↑	21	73.3	75.9	↑	43
	166a. Patient and Community Engagement: Assessing CCG compliance with statutory guidance standards of public and patient participation in commissioning health care	2017	no data	no data	AMBER	GREEN	↑	N/A	GREEN	GREEN	↔	N/A	GREEN	GREEN	↔	N/A
	165a. Quality of leadership: Quality of CCG leadership *(rationale: Effective CCGs need good leadership)*	Q3 2018/19	no data	no data	GREEN	GREEN	↔	N/A	GREEN STAR	GREEN STAR	↔	N/A	GREEN STAR	GREEN STAR	↔	N/A

Note: * indicates worst in the country

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 and 191 from April 19)

RTT			Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	<87%		88.7%	89.1%	90.0%	90.0%	90.1%	90.2%	91.0%	91.4%	91.5%	92.1%	91.6%	91.6%	90.0%
	>=92%	Rank	94	83	69	77	63	62	48	31	27	20	24	21	33
Number of patients waiting more that 52 weeks on incomplete pathways	>10		5	4	7	9	9	8	6	7	8	6	7	8	5
	0	Rank	91	81	115	145	148	138	127	163	166	160	160	163	152
Diagnostic			**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**
Percentage of patients waiting 6 weeks or more for a diagnostic test (15 key tests)	<6%		2.8%	0.8%	1.2%	1.4%	3.2%	3.0%	2.3%	3.2%	5.0%	5.1%	7.2%	2.5%	5.2%
	>=1%	Rank	151	59	112	117	156	132	146	152	154	144	170	107	142
Cancer Monthly			**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	<88%		72.2%	71.7%	64.7%	82.3%	94.1%	94.0%	95.2%	93.3%	91.9%	94.8%	86.0%	89.5%	81.9%
	>=93%	Rank	38	190	194	181	122	75	85	113	99	59	156	124	152
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially	<88%		98.1%	100.0%	97.8%	96.4%	87.3%	82.5%	95.6%	89.9%	80.5%	86.2%	92.6%	94.4%	90.0%
	>=93%	Rank	146	1	45	45	144	140	63	95	110	125	73	72	106
Maximum 31-day wait from diagnosis to first definitive treatment for all cancers	<91%		95.6%	100.0%	96.5%	97.6%	97.8%	93.9%	96.9%	97.8%	98.7%	98.7%	98.9%	98.9%	98.8%
	>=96%	Rank	1	1	122	78	85	144	101	69	27	30	31	36	30
Maximum 31-day wait for subsequent treatment where that treatment is surgery	<89%		100.0%	100.0%	100.0%	95.2%	88.9%	100.0%	89.5%	85.7%	92.9%	87.5%	88.2%	90.9%	100.0%
	>=94%	Rank	1	1	1	97	155	1	155	159	106	153	137	128	15
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%
	>=98%	Rank	1	1	1	1	2	1	1	1	30	33	27	30	25
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%	96.4%	100.0%	100.0%	93.3%
	>=94%	Rank	1	1	1	1	1	1	1	1	26	128	22	21	144
Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer	<80%		81.8%	82.2%	81.6%	86.0%	91.1%	76.3%	88.9%	86.8%	86.7%	93.2%	76.3%	84.7%	88.0%
	>=85%	Rank	87	74	76	40	17	104	21	27	33	4	108	44	28
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	<85%		100.0%	88.9%	92.9%	81.8%	75.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%
	>=90%	Rank	9	126	86	144	150	133	12	14	16	15	20	13	109
Maximum 62-day wait for first definitive treatment following a consultants decision to upgrade the priority of the patients (all cancers)	NA		87.5%	25.0%	100.0%	57.1%	100.0%	80.0%	100.0%	75.0%	85.7%	83.3%	25.0%	100.0%	100.0%
		Rank	103	193	7	186	12	127	7	150	103	100	178	7	9
Mixed Sex Accommodation			**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**
Breaches of Mixed-Sex Accommodation	>10		0	0	0	0	0	0	0	1	1	1	0	0	0
	0	Rank	1	1	1	1	0	0	1	73	76	65	15	15	12
Mental Health			**18-19 Q2**		**18-19 Q3**			**18-19 Q4**			**19-20 Q1**			**19-20 Q2**	
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%		96.6%		100.0%			100.0%			94.9%			100.0%	
	>=95%	Rank	99		1			1			122				
Dementia			**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**
Dementia diagnosis rate	<62%		76.0%	75.5%	75.8%	75.7%	76.0%	76.5%	76.1%	76.2%	75.9%	75.8%	76.9%	76.3%	76.6%
	>=67%	Rank			38		35	32	40		37	37	35	36	
IAPT Monthly			**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**
IAPT 6 Weeks First Treatment	<70%		90.9%	94.7%	100.0%	100.0%	100.0%	95.7%	100.0%	96.7%	91.3%	100.0%	97.1%	96.4%	100.0%
	>=75%	Rank		88	1	5	2	83	1	65	112	6		55	7
IAPT 18 Weeks First Treatment	<90%		100.0%	94.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	>=95%	Rank		189	1	5	2	1	1	1	27	23		29	27
IAPT (*Rolling 3 month*)			**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**
IAPT Access (rolling 3 months) *Q4 2018/19 4.75% (19% annually), Q4 2019/20 5.5% (22% annually)*	<4.75%		3.7%	3.4%	3.6%	4.1%	4.4%	4.3%	3.8%	3.9%	4.6%	4.7%	4.4%	4.1%	4.3%
	>=5.50%	Rank		166	158	117	116	117	163	153	120	96		149	139
IAPT Recovery rate (rolling 3 months)	<45%		48.3%	47.5%	49.1%	51.8%	55.6%	54.3%	58.9%	55.8%	59.2%	55.4%	56.3%	55.3%	56.4%
	>=50%	Rank		156	135	92	34	42	8	28	8	32		10	7
Early Intervention Psychosis - 2 Week Waits (*rolling quarter*)			**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**
Early intervention in psychosis - 2 week wait (Rolling quarter) *50% increasing to 60% by 2020/21 (2018/19 53%, 2019/20 56%)*	<53%		40.0%	42.9%	50.0%	58.3%	73.3%	81.3%	80.0%	63.2%	66.7%	72.7%	78.9%	83.3%	80.0%
	>=56%	Rank	184	187	179	163	114	73	90	145	138	115	98	76	
Safe Environment and Protecting from Avoidable Harm			**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**
Incidence of healthcare associated infection (HCAI) i) MRSA - Cases which have been assigned to the CCG following a Post Infection Review	>0		0	1	0	0	0	0	0	0	0	0	0	0	0
		Rank	1	141	1	1	1	1	1	1	1	1	1	1	27
Incidence of healthcare associated infection (HCAI) ii) C.difficile	>Ceiling		1	2	2	1	3	2	2	2	0	0	2	2	2
	<=Ceiling	Rank	4	25	20	15	72	29	45	32	1	1	20	16	26
	Ceiling		3	3	3	3	3	3	2	2					

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 and 191 from April 19)

RTT			Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	<87%		78.1%	78.7%	80.1%	0.0%	82.1%	83.7%	84.8%	85.9%	86.4%	87.1%	86.8%	86.1%	84.7%
	>=92%	Rank	191	187	186	182	173	148	39	126	116	109	93	97	101
Number of patients waiting more that 52 weeks on incomplete pathways	>10		31	15	14	15	15	15	13	15	16	14	10	13	14
	0	Rank	173	157	156	163	165	162	162	178	181	178	172	176	174
Diagnostic			**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**
Percentage of patients waiting 6 weeks or more for a diagnostic test (15 key tests)	<6%		1.1%	0.8%	9.1%	9.4%	6.8%	6.2%	4.9%	4.1%	3.6%	6.4%	6.6%	3.8%	3.9%
	>=1%	Rank	81	53	186	186	170	166	170	163	133	159	163	140	132
Cancer Monthly			**Mar-00**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	<88%		65.0%	67.3%	62.8%	80.2%	90.6%	90.3%	95.9%	95.1%	87.5%	90.9%	93.3%	93.9%	90.2%
	>=93%	Rank	195	194	195	184	169	145	69	64	143	130	81	65	111
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially	<88%		100.0%	100.0%	66.7%	85.7%	93.3%	92.9%	100.0%	93.3%	75.0%	73.3%	88.9%	80.0%	94.1%
	>=93%	Rank	1	1	182	146	96	79	2	63	121	146	101	136	84
Maximum 31-day wait from diagnosis to first definitive treatment for all cancers	<91%		94.2%	95.5%	92.1%	95.3%	90.5%	91.7%	92.8%	95.7%	100.0%	98.2%	97.5%	99.3%	98.3%
	>=96%	Rank	173	136	187	148	191	175	184	139	4	47	69	22	41
Maximum 31-day wait for subsequent treatment where that treatment is surgery	<89%		95.5%	97.0%	96.0%	96.4%	84.0%	86.8%	100.0%	96.6%	95.7%	96.9%	100.0%	97.1%	96.0%
	>=94%	Rank	94	79	75	86	181	146	1	88	84	78	17	73	80
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%
	>=98%	Rank	1	1	1	1	2	1	1	1	33	36	30	32	28
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	<89%		97.4%	100.0%	100.0%	100.0%	100.0%	97.8%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	97.1%
	>=94%	Rank	104	1	1	1	1	79	1	1	27	27	148	23	96
Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer	<80%		60.6%	67.5%	62.7%	61.8%	66.7%	77.7%	62.8%	71.6%	88.1%	87.1%	77.3%	86.9%	83.1%
	>=85%	Rank	194	181	189	190	187	94	186	167	18	14	89	21	66
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	<85%		100.0%	85.7%	81.8%	91.7%	100.0%	60.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%
	>=90%	Rank	9	140	143	92	13	174	12	14	19	16	22	15	115
Maximum 62-day wait for first definitive treatment following a consultants decision to upgrade the priority of the patients (all	NA		66.7%	50.0%	57.1%	25.0%	75.0%	63.6%	37.5%	100.0%	100.0%	75.0%	83.3%	66.7%	80.0%
		Rank	169	182	179	192	158	174	180	9	7	137	87	161	119
Mixed Sex Accommodation			**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**
Breaches of Mixed-Sex Accommodation	>10		0	0	0	1	0	1	1	0	0	0	0	1	0
	0	Rank	1	1	1	1	0	45	64	1	1	1	1	65	15
Mental Health			**18-19 Q2**		**18-19 Q3**			**18-19 Q4**			**19-20 Q1**			**19-20 Q2**	
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%		94.7%		98.2%			95.1%			96.2%			94.0%	
	>=95%	Rank	141		57			43			101				
Dementia			**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**
Dementia diagnosis rate	<62%		81.5%	80.9%	80.6%	80.6%	80.1%	79.2%	82.8%	79.0%	78.9%	79.0%	79.0%	79.0%	78.7%
	>=67%	Rank			18		19	22	13		25	26	28	28	
IAPT Monthly			**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Feb-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**
IAPT 6 Weeks First Treatment	<70%		97.9%	97.6%	98.0%	100.0%	100.0%	98.0%	96.6%	97.9%	97.8%	98.2%	98.4%	95.6%	98.5%
	>=75%	Rank		47	37	1	1	53	61	47	49	39		64	32
IAPT 18 Weeks First Treatment	<90%		97.9%	100.0%	98.0%	100.0%	100.0%	100.0%	98.3%	100.0%	97.8%	100.0%	100.0%	97.8%	100.0%
	>=95%	Rank		1	160	1	1	1	158	1	158	1		156	30
IAPT (Rolling 3 month)			**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Feb-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**
IAPT Access (rolling 3 months) Q4 2018/19 4.75% (19% annually), Q4 2019/20 5.5% (22% annually)	<4.75%		3.6%	3.2%	3.3%	3.3%	3.4%	3.5%	3.6%	3.9%	4.7%	5.1%	5.4%	5.2%	5.1%
	>=5.50%	Rank		175	171	173	185	176	168	149	112	52		47	68
IAPT Recovery rate (rolling 3 months)	<45%		49.6%	45.0%	44.0%	46.7%	48.7%	49.7%	51.0%	55.4%	55.2%	57.6%	55.3%	55.9%	53.4%
	>=50%	Rank		178	184	171	152	142	108	50	56	38		38	67
Early Intervention Psychosis - 2 Week Waits (rolling quarter)			**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**
Early intervention in psychosis - 2 week wait (Rolling quarter) 50% increasing to 60% by 2020/21 (2018/19 53%, 2019/20 56%)	<53%		29.8%	23.7%	39.4%	55.6%	77.4%	81.0%	84.1%	81.6%	82.2%	70.8%	67.2%	72.0%	81.1%
	>=56%	Rank	190	192	190	174	109	86	77	85	81	122	139	129	
Safe Environment and Protecting from Avoidable Harm			**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**
Incidence of healthcare associated infection (HCAI) i) MRSA - Cases which have been assigned to the CCG following a Post Infection Review	>0		0	1	0	1	0	2	0	0	1	1	0	1	0
		Rank	1	141	1	139	1	186	1	1	155	153	1	152	30
Incidence of healthcare associated infection (HCAI) ii) C.difficile	>Ceiling		4	6	8	5	6	5	2	7	4	0	10	8	5
	<=Ceiling	Rank	56	120	147	105	148	113	45	152	90	1	160	145	89
	Ceiling		10	10	9	10	9	9	9	11					

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 and 191 from April 19)

RTT			Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	<87%		76.5%	77.4%	79.8%	81.9%	82.8%	83.3%	84.0%	87.0%	87.5%	88.2%	88.0%	86.5%	85.3%
	>=92%	Rank	192	190	188	181	178	154	152	110	94	86	75	92	95
Number of patients waiting more that 52 weeks on incomplete pathways	>10		6	3	3	5	6	7	4	2	2	4	4	7	7
	0	Rank	102	68	79	115	125	132	109	111	108	140	138	160	161
Diagnostic			**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**
Percentage of patients waiting 6 weeks or more for a diagnostic test (15 key tests)	<6%		0.8%	1.0%	9.5%	9.4%	7.2%	6.9%	5.6%	4.8%	2.4%	4.5%	5.9%	3.0%	3.7%
	>=1%	Rank	44	83	188	185	171	169	177	170	88	136	155	124	128
Cancer Monthly			**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	<88%		69.9%	74.3%	72.0%	78.2%	90.3%	94.7%	93.6%	94.1%	88.4%	89.9%	90.6%	93.9%	95.0%
	>=93%	Rank	194	189	190	187	171	63	129	96	133	142	120	66	35
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially	<88%		50.0%	100.0%		50.0%	100.0%	100.0%		75.0%	100.0%		75.0%	80.0%	
	>=93%	Rank	188	1	1	187	1	1		141	1		148	1	
Maximum 31-day wait from diagnosis to first definitive treatment for all cancers	<91%		78.6%	81.3%	90.9%	100.0%	100.0%	85.7%	100.0%	89.5%	100.0%	96.6%	100.0%	96.0%	100.0%
	>=96%	Rank	195	195	191	1	1	194	1	189	5	99	6	135	6
Maximum 31-day wait for subsequent treatment where that treatment is surgery	<89%		0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%	75.0%
	>=94%	Rank	195	1	1	1	1	1	1	1	23	21	18	132	178
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%
	>=98%	Rank	1	1	1	1	2	1	1	1	35	38	32	34	30
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%
	>=94%	Rank	1	1	1	1	1	1	1	1	29	29	25	25	21
Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer	<80%		87.5%	72.7%	62.5%	60.0%	66.7%	57.1%	75.0%	72.7%	81.3%	61.1%	90.9%	69.2%	82.4%
	>=85%	Rank	29	154	190	193	187	194	114	158	79	185	9	163	76
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%	
	>=90%	Rank			1	1	1	1	12	14	20			16	
Maximum 62-day wait for first definitive treatment following a consultants decision to upgrade the priority of the patients (all cancers)	NA		50.0%	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%
		Rank	181	12	7	1	1	8	7	9	8	187	2	8	11
Mixed Sex Accommodation			**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**
Breaches of Mixed-Sex Accommodation	>10		0	0	0	0	0	0	0	0	0	0	0	0	0
	0	Rank	0	1	1	0	1	1	1	1	1	1	1	1	1
Mental Health			**18-19 Q2**			**18-19 Q3**			**18-19 Q4**			**19-20 Q1**			**19-20 Q2**
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%		94.4%			90.7%			100.0%			94.8%			94.1%
	>=95%	Rank	145			176			1			128			
Dementia			**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**
Dementia diagnosis rate	<62%		85.7%	85.6%	85.5%	84.2%	83.4%	82.7%	83.3%	83.3%	82.3%	83.7%	84.3%	84.6%	84.7%
	>=67%	Rank			8		9	10	11		14	11	11	9	
IAPT Monthly			**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**
IAPT 6 Weeks First Treatment	<70%		100.0%	100.0%	90.9%	100.0%	100.0%	100.0%	93.8%	100.0%	92.3%	91.7%	91.7%	100.0%	100.0%
	>=75%	Rank	4		119	1	1	1	99	1	106	108		8	9
IAPT 18 Weeks First Treatment	<90%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	>=95%	Rank	4		1	1	1	1	1	1	1	1		32	31
IAPT (Rolling 3 month)			**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**
IAPT Access (rolling 3 months) Q4 2018/19 4.75% (19% annually), Q4 2019/20 5.5% (22% annually)	<4.75%		4.1%	3.5%	3.5%	3.4%	3.4%	3.5%	3.6%	3.8%	4.4%	5.4%	6.0%	6.4%	6.4%
	>=5.50%	Rank		163	160	171	183	175	172	159	135	35		4	6
IAPT Recovery rate (rolling 3 months)	<45%		44.4%	44.7%	48.7%	43.2%	44.7%	41.7%	43.6%	45.7%	46.2%	42.9%	40.5%	48.6%	45.0%
	>=50%	Rank		180	138	187	185	189	182	181	177	185		156	180
Early Intervention Psychosis - 2 Week Waits (rolling quarter)			**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**
Early intervention in psychosis - 2 week wait (Rolling quarter) 50% increasing to 60% by 2020/21 (2018/19 53%, 2019/20 56%)	<53%		46.2%	50.0%	47.8%	53.8%	54.8%	68.0%	69.6%	80.0%	78.3%	87.5%	84.6%	90.0%	88.6%
	>=56%	Rank	179	180	185	178	169	142	138	90	105	53	69	54	
Safe Environment and Protecting from Avoidable Harm			**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**
Incidence of healthcare associated infection (HCAI) i) MRSA - Cases which have been assigned to the CCG following a Post Infection Review	>0		0	1	1	0	0	0	0	0	0	0	0	1	1
		Rank	1	141	140	1	1	1	1	1	1	1	1	153	148
Incidence of healthcare associated infection (HCAI) ii) C.difficile	>Ceiling		1	1	0	0	0	1	1	0	0	0	1	0	0
	<=Ceiling	Rank	4	7	1	1	1	9	13	1	1	1	7	1	1
	Ceiling		1	2	2	1	2	2	2	9					

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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Health and Wellbeing to the meeting of Health and Social Care Overview and Scrutiny Committee to be held on 28th November 2019

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Subject:
Health and Wellbeing Board

Summary statement:

This report highlights the work undertaken for 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. In March 2018, the board took on the additional function of being the lead strategic partnership for the Bradford and Airedale district.

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Strategic Director of Health and Wellbeing

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Portfolio:

Healthy People and Place

Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

This report highlights the work undertaken for 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. In March 2018, the board took on the additional function of being the lead strategic partnership for the Bradford and Airedale district. Members are asked to note the update of activity of the Health and Wellbeing from October 2018 to August 2019.

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 in October 2018. This report will look at:

The activity of the Board from October 2018 to August 2019

- 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 Senior Strategic Partnership role

In 2018, a decision was taken by the Bradford MDC Executive following recommendations from the Health and Wellbeing Board to transfer its responsibilities to the Health and Wellbeing Board. The Bradford and Airedale Health and Wellbeing Board took on the additional role of being *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.* (Terms of Reference, Bradford and Airedale Health and Wellbeing Board, April 2018). The Terms of Reference for the board were updated in April 2018 to reflect this new responsibility.

In additional to the statutory functions of the Health and Wellbeing Board, the board is required *To oversee the development and delivery of the outcomes within the Bradford District Plan 2016 – 2020, via the Districts strategic delivery partnerships (principal duties 3.8 Terms of Reference, Bradford and Airedale Health and Wellbeing Board, April 2018).* Currently, the chairs of the strategic partnership boards meet on a quarterly basis; the board also receives annual progress updates on the delivery of the Bradford District Plan. This plan runs until 2020. The strategic partnerships report to the Health and Wellbeing board on an annual basis and this includes an annual report from the Safeguarding Children and Adults Boards. The last report submitted to the Scrutiny committee detailed the changes and the implications for the Health and Wellbeing Board and the strategic partnerships that sit underneath it.

The Health and Wellbeing board has been operating as senior strategic partnership for approximately one year and therefore is currently undertaking an internal review its delivery of this function in order to ensure that its work remains effective and that it can afford due regard to both of its important functions. The outcome of the review is expected in November 2019 and will be discussed at a Health and Wellbeing board development session in December 2019. The Terms of Reference for the Board will be updated to reflect any changes once the recommendations of the review have been received and consulted upon with the Health and Wellbeing board.

3.2 Sub-Groups and projects

The Integration and Change Board (ICB) and Executive Commissioning Board (ECB) continue operate as sub-groups to the Health and Wellbeing Board and regular updates are provided to the board via the Chair's highlight reports.

In July 2019, a review of the ECB was undertaken; the review was in line with a commitment by the Chair and Vice-Chair of the ECB to undertake a review of the functioning of the board on an annual basis. The review recommended that ECB should exercise a temporary pause until such time that it has been able to re-evaluate its strategic fit within the revised health and care structures and governance mechanisms, which now include 2 health and care partnership boards and a number of function specific programme boards. In August 2019, a decision was taken to combine the functions of the ECB and ICB. This new model of delivery will allow wider system participation around joint commissioning decisions leading to better outcomes for service users. It is proposed that the new model will come into operation from March 2020.

In May 2019, an Early Help and Prevention project was commissioned by the Health and Wellbeing Board to develop and deliver an effective whole system approach to Prevention and Early Help that enables effective cross system working for the benefit of communities and individuals in need of support. The aim of this programme will be to deliver a whole-system, whole household/family approach to working with communities and individuals whilst promoting collaboration and partnership working. We envisage that this project will be completed by March 2020 with an Options paper being presented to the Health and Wellbeing Board in November 2019. This work will also consider the role of Community Partnerships and how these align to our system Early Help and Prevention vision.

3.3 Happy, Healthy at Home review

As with the review of its function of senior strategic partnership, the ICB commissioned a review of its Happy, Healthy at Home strategy to ensure that the programmes that run to support delivery of the strategy were effectively equipped to manage demand and need and delivering value for money. This review is expected to report back to the ICB by September 2019 and will include a refresh of the Happy, Healthy at Home strategy. The learning from the programme review is summarized in Appendix 2.

3.4 Areas of work covered by the Health and Wellbeing Board since October 2018

The Board received reports and considered a range of areas since the last meeting through both formal board meetings and development sessions. Since October 2019, these have included:

- The Joint Strategic Needs Assessment
- The Bradford District plan progress report
- A quarterly report on Logic Models and performance against indicators
- Air Quality in the Bradford and Airedale District
- Early Help and Prevention
- Knife Crime
- The Care Quality Commission local system review and subsequent action plan
- The Housing and Homelessness strategies
- The Five year strategy of the West Yorkshire and Harrogate Health and Care Partnership
- Alongside this, the board continues to receive progress and update reports from the strategic partnerships that report to it.

3.5 Logic Models.

The Joint Health and Wellbeing Strategy (***'Connecting People and Place': A Joint Health and Wellbeing Strategy for Bradford and Airedale*****)** was published in June 2018.

Logic model establishes a way of knowing whether or not what we have done has made a difference to the health and wellbeing of our population and the Health and Wellbeing Board receive quarterly updates on performance against the 41 outcome indicators monitored as part of the logic model, across the four outcome areas of the Joint Health and Wellbeing Strategy (Our Children have a great start to life, People in the Bradford district have good Health and Wellbeing, People in all parts of the district are living well and aging well and Bradford district is a healthy place to live, learn and work).

The Logic model approach provides a range of measures that are monitored on a quarterly basis to provide assurance to the HWBB that progress is being made against our strategies. The board has been receiving quarterly feedback on logic models at formal meetings. (Please see appendix one for the latest Logic Model Dashboard) A summary of information from Logic Models is below:

- Of the 41 outcome indicators, 9 are currently RAG (red, amber, green) rated as green, meaning that performance against these outcomes is improving, and we perform the same as or better than our statistical neighbours. Those areas where we are improving include: breastfeeding, smoking at time of delivery, suicide prevention, teenage pregnancy, mental wellbeing, physical activity in adults, successful treatment of non-opiate drug users, and people in employment.

- 11 outcome indicators are currently RAG rated as amber, meaning that our performance is neither getting better nor worse, but this is consistent with our statistical neighbours, or performance against these outcomes is improving but our performance is significantly worse than our statistical neighbours. Those outcomes that are currently rated as amber include: life expectancy, inequality in life expectancy, children achieving a good level of development, attainment 8 scores, dental decay in children, low birth weight babies, smoking in adults, sickness absence and killed or seriously injured on our roads.
- 21 outcome indicators are currently RAG rated as red, meaning that our performance against these outcomes is getting worse, or performance is unchanged and is worse than our statistical neighbours. Those outcomes that are currently rated as red include: healthy life expectancy, 16-17 year olds not in education, employment, or training, children in care whose SDQ scores are a cause for concern, infant mortality, improving access to psychological therapies recovery rate, early intervention for psychosis, premature mortality in people with a severe mental illness, adults meeting the 5 a day recommendation, completion of drug treatment for opiate users, childhood obesity, management of long term conditions, use of outdoor spaces, people qualified to NVQ level 3+, fuel poverty, employment rate for people with a mental illness, and air quality.

3.6 Joint Strategic Needs Assessment (JSNA)

The NHS and upper tier local authorities have had a statutory duty to produce a JSNA since 2007. The purpose of the JSNA is to inform the Joint Health and Wellbeing Strategy (JHWBS) which, in turn, aims to improve the health and wellbeing of the local population and to reduce inequalities. Both the JSNA and JHWBS are intended to be part of a continuous process of assessment and planning, supporting the identification of priorities and gaps for commissioning, based on both evidence and need.

JSNAs are assessments of the current and future health and social care needs of the local community. These are needs that could be considered to be best addressed by the local authority, CCGs, NHS England, or by working in partnership with others across the public, private and third sectors. JSNAs are produced by health and wellbeing boards, and are unique to each local area. The policy intention is for health and wellbeing boards to also consider wider factors that impact on their communities' health and wellbeing, and local assets that can help to improve outcomes and reduce inequalities. Local areas are free to undertake JSNAs in a way best suited to their local circumstances.

The recent approach to the JSNA is to take an asset based approach, this means looking at both the current needs and also the assets that enhance peoples health and wellbeing in the district i.e. examples of initiatives and projects that a making a positive impact on the health and wellbeing of the population.

The JSNA is a comprehensive document which looks at most aspects of the lives of those living in the Bradford district. Key messages from the JSNA were:

- People in Bradford District experience poorer health and wellbeing than people in many other parts of the country. We know this because life expectancy is lower, and a secondary measure, healthy life expectancy, tells us that people in Bradford District also spend more years of their life in poor health.
- There is an estimated 21 year difference in healthy life expectancy across the District.
- The main causes of early death in the District are the same as many other areas: cardiovascular disease, respiratory disease and cancer
- Long term conditions such as diabetes, asthma and COPD all influence levels of ill health and disability during a person's life.
- Evidence suggests that multi-morbidity is a driver that increases demand on health and care systems.
- Tackling these issues requires a whole system approach and must take into account the context in which people live their lives.

3.7 The Bradford system response to the needs identified in the JSNA.

3.8 Prevention.

The Health and Wellbeing strategy places a significant emphasis on prevention through a system approach. The Health and Wellbeing board have currently commissioned an early help and prevention project which is due to report back to the board in Nov 2019.

3.9 Wider Determents of health.

The causes of ill health are complicated and can depend on a range of factors therefore; the Bradford approach has been to focus on the causes of causes (also referred to as wider determents of health) as the partnership responsible for coordinating the work of the district plan and the health and wellbeing strategy, we continue to try to understand how factors such as housing, employment and education impact the health and wellbeing of communities. We receive quarterly updates on performance indicators and have directed action where performance has not improved.

3.10 Working as a system.

The Health & Care Strategic Partnering Agreement (SPA) is intended to promote integrated and partnership working within the local health and social care systems in order to progress the Happy, Health at Home vision. The SPA is designed to support greater partnership and collaboration between commissioners and providers and towards working as one system rather than separate individual organisations. It is intended to help us navigate the challenges that we collectively have in supporting the health and wellbeing of citizens in Bradford and was noted recently as an example of good practice in a recent Local Government Association report *What a difference a place makes: the growing impact of Health and Wellbeing boards'* Through joint consultation and discussions with partners around

commissioning decisions, it is envisaged that individual procurement decisions will lead to better outcomes for the citizens of Bradford and improved Health and Wellbeing outcomes. The principles of the Mental Health Concordat are reflected in the principles of the SPA.

A system Finance committee has now been established and meets regularly; this committee looks at the finances of both individual organisations and the finances of the Bradford system.

3.11 West Yorkshire and Harrogate Health Care Partnership (WYH HCP)

The West Yorkshire and Harrogate Health Care Partnership is made of 6 places including Bradford. Bradford, through its Health and Wellbeing Board and its sub-groups, has ensured that it continues to advocate in the best interests of the citizens of Bradford by influencing strategy and plans across the WYH partnership. The Health and Wellbeing board was recently consulted on and provided comments on the 5 year strategy of the WYH HCP and requested that greater emphasis be placed on *healthy* life expectancy rather then life expectancy itself as a measure of impact.

3.12 Areas of priority for the Health and Wellbeing Board

The Health and Wellbeing board have reviewed the forward plan to ensure that there is closer alignment to the Health and Social Care Overview and Scrutiny panel, the purpose of this exercise is to ensure that the work of the Health and Wellbeing board does not replicate/overlap with the work of the Health and Social Care Overview and Scrutiny panel but compliments it. All forward plans consider the work of the Overview and Scrutiny Panel.

The Joint Strategic Needs Assessment has recently been updated to become a “live” document that not only looks at the needs of our communities but also the assets within it. In July 2019, the Health and Wellbeing Board received an update on the JSNA. It was clear that poverty remains at the heart of many of the inequalities on our society (not just in the Bradford and Airedale district). The board requested, as a result of the discussion, that all of the Senior officers across the system including Trust Governors and Health and Social Care Finance and Performance committees receive and take into account the JSNA when making system decisions and that an accessible version of JSNA information was made available to the public to allow our communities to understand and act upon the content of the JSNA.

HealthWatch have been commissioned by the CCG to complete a piece of engagement work with the 14 Community Partnerships, this project will be completed in March 2019 and follows on from the successful “Big Conversation” work that was completed in 2017. The project aims to engage the communities being served by Community Partnerships to understand how best to utalise this support. The project will report to the Health and Wellbeing board in March 2020.

The Health and Wellbeing forward plan for the remainder of the 2019-20 financial year includes:

- The LGBT Charter
- The City of Culture Bid and inputs around Health and the Arts
- The Anti-Poverty Strategy
- The Community Safety Partnership annual report
- The Economic Partnership Annual report
- Safeguarding Children's and Adults Boards annual reports
- Mazars and LeDer: progress reporting.

The forward plan for 2020-21 is still in the process of being developed.

4. FINANCIAL & RESOURCE APPRAISAL

➢ If there are no financial issues arising this should be stated, but only on advice from the Assistant Director Finance and Procurement.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

A review of the function of the Health and Wellbeing board as Senior Strategic Partnership is currently being undertaken. Although there are currently no risk management or governance issues, the outcome of the review will consider if there are implications for risk management and governance in more detail.

6. LEGAL APPRAISAL

No issues.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

The work of the Health and Wellbeing board impacts the whole of the Bradford population, including those who work in it, as such, the Health and Wellbeing Board are continually mindful of the impact of decisions made by the board on the population of Bradford.

A priority for the Health and Wellbeing board is to tackle the health inequalities that exist in our communities and the wider determents that impact these such as Air Quality and poor housing. The Health and Wellbeing board plays a leading role in both tackling inequalities and promoting equalities.

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

The work of the Health and Wellbeing board affects all ward areas in the district.

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

7.9 IMPLICATIONS FOR CORPORATE PARENTING

None

7.10 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

None

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

N/A

10. RECOMMENDATIONS

That the Health and Social Care Overview and Scrutiny panel note the work undertaken by the Health and Wellbeing board.

11. APPENDICES

Appendix 1: Logic Model Dashboard-July 2019

12. BACKGROUND DOCUMENTS

- *What a difference a place makes: The growing impact of Health and Wellbeing Boards.* Local Government Association. June 2019.
- Logic Model update for Bradford and Airedale Health and Wellbeing board, July 2019.
- Joint Strategic Needs Assessment Update for Bradford and Airedale Health and Wellbeing Board, July 2019.

	Reporting period	Previous year value	Current value	5 year trend	Change from previous reporting period	How do we compare with our neighbours?	RAG rating	Comments
Overarching indciators								
Life expectancy at birth - males	2015-17	77.5	77.7	⟷	▲	Similar		
Life expectancy at birth - females	2015-17	81.5	81.6	⟷	▲	Similar		
Healthy life expectancy at birth - males	2015-17	61.8	60.4	▼	▼	Similar		
Healthy life expectancy at birth - females	2015-17	61.1	59.0	▼	▼	Worse		
Inequality in life expectancy at birth - males	2015-17	7.6	7.4	⟷	▼	Worse		
Inequality in life expectancy at birth - females	2015-17	6.3	6.8	⟷	▲	Similar		
Our children have a great start in life								
% of children achieving a good level of development at reception	2017/18	67.6	66.8	▲	▼	Worse		
Average attainment 8 score (UPDATED)	2017/18	42.4	43.5	⟷	▲	Similar		
% of 16-17 year olds NEET	2017	6.0	6.5	⟷	▲	Worse		
% of children aged 5-16 who have been in care for at least 12 months whose SDQ scores is cause for concern (UPDATED)	2017/18	29.4	36.7	▲	▲	Similar		
% of children breastfed at 6-8 weeks	2016/17	40.1	41.9	▲	▲	Better		
Smoking at time of delivery	2017/18	13.8	14.4	▼	▲	Similar		
% of 5 year olds who are free from dental decay	2016/17	62.5	60.2	▲	▼	Worse		
Infant mortality	2015-17	5.9	5.8	⟷	▼	Worse		
Low birth weight of term babies (UPDATED)	2017	3.6	4.0	⟷	▲	Similar		
Teenage pregnancy (UPDATED)	2017	20.0	19.1	▼	▼	Similar		
People in Bradford District have good mental wellbeing								
Mental wellbeing: high happiness score	2015/16	74.3	70.4	▲	▼	Similar		
Mental wellbeing: high satisfaction score	2015/16	78.9	77.8	▲	▼	Similar		
Suicide rate	2015-17	9.2	9.0	▼	▼	Better		
IAPT recovery rate: AWC CCG	Sep-18	47.0	47.0	▼	–	Worse		
IAPT recovery rate: Badford City CCG	Sep-18	45.0	44.0	⟷	▼	Worse		
IAPT recovery rate: Badford Districts CCG	Sep-18	45.0	49.0	▲	▲	Worse		
People experiencing a first episode of psychosis in receipt of a NICE approved care package within 2 weeks of referral: AWC CCG	2018/19	70.7	61.0	⟷	▼	Worse		
People experiencing a first episode of psychosis in receipt of a NICE approved care package within 2 weeks of referral: Bradford City CCG	2018/19	70.1	53.9	▼	▼	Worse		
People experiencing a first episode of psychosis in receipt of a NICE approved care package within 2 weeks of referral: Bradford Districts CCG	2018/19	68.9	57.5	▼	▼	Worse		
Excess under 75 mortality rate in persons with serious mental illness	2014/15	448.6	426.3	▲	▼	Worse		
People in all parts of the District are living well and ageing well								
% of physically active adults (UPDATED)	2017/18	63.7	61.9	▲	▼	Similar		
% of adults meeting the '5 a day' reccomendation (UPDATED)	2017/18	54.7	47.4	▼	▼	Similar		
Successful completion of drug treatment (opiate users)	2017	5.7	6.3	▼	▲	Similar		
Successful completion of drug treatment (non-opiate users)	2017	43.1	49.8	▲	▲	Better		
Child excess weight - Year 6	2017/18	37.9	38.6	▲	▲	Worse		
Smoking prevalence in adults	2017	22.2	18.9	▼	▼	Worse		
% of people with a LTC who feel supported to manage their conditon	2017/18	62.6	57.7	▼	▼	Similar		
Bradford District is a healthy place to live, learn and work								
% of people using outdoor spaces for exercise or health reasons	2015/16	8.4	12.4	⟷	▲	Worse		
% of people aged 16-64 in employment	2017/18	67.2	68.1	▲	▲	Similar		
% of working age population qualified to NVQ Level 3 or above (UPDATED)	2018	46.6	43.9	▼	▼	Worse		
% of working day week lost to sickness absence	2015-17	1.2	1.3	⟷	▲	Similar		
Fuel poverty	2016	15.0	14.3	⟷	▼	Worse		
The number of people reported killed or seriously injured on our roads	2015-17	35.9	34.9	▼	▼	Worse		
Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	2017/18	59.2	61.1	⟷	▲	Worse		
Concentration of NO2 (µg/m3) in AQMAs - Shipley Area Road (UPDATED)	2017	52.0	49.0	▼	▼	N/A		Note air quality has not been RAG rated using the criteria below. Rated as red due to the exceedance of the EU Directive
Concentration of NO2 in AQMAs - Mayo Avenue (UPDATED)	2017	56.0	49.0	▼	▼	N/A		
Concentration of NO2 in AQMAs - Thornton Road (UPDATED)	2017	45.6	30.0	▼	▼	N/A		
Concentration of NO2 in AQMAs - Manningham Lane (UPDATED)	2017	41.0	39.0	▼	▼	N/A		

Key

	Trend data is getting worse OR trend data is showing no change and we are worse than our statistical neighbours
	Trend data is not improving, but our outcomes are similar or better than our statistical neighbours OR trend data is getting better but outcomes are worse than our statistical neighbours
	Trend data is getting better and we are similar or better than our statistical neighbours

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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Strategic Director Health and Wellbeing to the meeting of Health and Social Care Overview and Scrutiny Committee to be held on 28th November 2019.

R

Subject: Adult Social Care Annual Performance Report 2018/19

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 2018/19, 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 key areas 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 where 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.

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 the financial year 2018/19. There were 29 measures calculated in 2018/19, of these performance has improved for 15 measures, worsened in 8 and stayed stable in 6.

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 statistical neighbour peer group as defined by The Chartered Institute of Public Finance & Accountancy (CIPFA).

3.3 There are 16 councils in our CIPFA peer group. Of the 29 ASCOF measures in 2018/19, Bradford performs strongly and is in the top quartile for 14 measures, and needing to improve from a position of being in the bottom quartile on 4 measures.

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

Ref	Indicator Name
1A	Social care-related quality of life score
1B	The proportion of people who use services who have control over their daily life
1C1B	The proportion of carers who receive self-directed support
1C2B	The proportion of carers who receive direct payments
1D	Carers Quality of Life
1H	The proportion of adults in contact with secondary mental health services living independently, with or without support
1I1	The proportion of people who use services who reported that they had as much social contact as they would like
1I2	The proportion of carers who use services who reported that they had as much social contact as they would like
2A1	Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population
2C (1)	Delayed transfer of care per 100,000 population (All delays)
2C (2)	Delayed transfer of care per 100,000 population (attributable to Social Care)
2C (3)	Delayed transfer of care per 100,000 population (attributable to both NHS and Social Care)
3A	Overall satisfaction of people who use services with their care and support
4A	The proportion of people who use services who feel safe

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

Ref	Indicator Name
1C1A	The proportion of people who use services who receive self-directed support
1C2A	The proportion of people who use services who receive direct payments
2B2	The proportion of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital

3.4 The proportion of people who received self-directed support has increased from 82% to 88%. Whilst performance is in the bottom quartile a further increase will be seen in 2019/20 through reviewing and assessment activity. We are seeing growth in the proportion of people accessing a service via a direct payment continuing into 2019/20, though we are currently in the bottom quartile. Work is taking place to ensure that the BEST service is able to fully utilise staffing resources on providing reablement services rather than long term support. This work will make us more able to offer reablement to those people who would benefit from the service, improving performance on measure 2B2 and ensuring performance on Delayed Transfers of Care remains high.

Summary of Bradford Metropolitan District Councils 2018/19 ASCOF Performance

- Position improved 15
- Position Stable 6
- Position Worsened 8

	Comparator Group		
	England	Region	CIPFA
Councils in Group	152	15	16
BMDC Top Quartile Measures	12	9	14
BMDC Bottom Quartile Measures	2	4	3

						2018/19 rankings		
ASCOF Measure	Good is;	Bradford Trend	16/17	17/18	18/19	England	Region	CIPFA
1A - Social care-related quality of life score	High		19.4	19.2	19.6	16	3	1
1B - The proportion of people who use services who have control over their daily life	High		75.1	79	82	16	3	1
1C1A - The proportion of people who use services who receive self-directed support	High		82	82	88	103	11	14
1C1B - The proportion of carers who receive self-directed support	High		100	100	100	1	1	1
1C2A - The proportion of people who use services who receive direct payments	High		16.7	21.1	23	105	9	14
1C2B - The proportion of carers who receive direct payments	High		82.6	95	100	1	1	1
1D - Carers Quality of Life	High		8.2		7.9	17	5	2
1E - The proportion of adults with a learning disability in paid employment	High		3.2	3.6	2.1	130	14	12
1F - The proportion of adults in contact with secondary mental health services in paid employment	High		7	7	8	70	8	5
1G - The proportion of adults with a learning disability who live in their own home or with their family	High		88.8	88.1	86.3	35	5	10
1H - The proportion of adults in contact with secondary mental health services living independently, with or without support	High		70	72	72	39	6	3
1I1 - The proportion of people who use services who reported that they had as much social contact as they would like	High		50.3	47	48.6	41	7	3
1I2 - The proportion of carers who use services who reported that they had as much social contact as they would like	High		41.6		40.5	15	2	2
1J - Adjusted Social care-related quality of life – impact of Adult Social Care services	High			0.43	0.395	105	12	10
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		17.1	14.6	7.9	30	2	3
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		571.3	492.9	548.7	63	4	5
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		87.8	87.9	82.9	88	10	6
2B2 - The proportion of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital	High		2.6	1.1	1.7	128	11	16
2C (1) - Delayed transfer of care per 100,000 population (All delays)	Low		3.2	3.5	2.6	4	2	1
2C (2) - Delayed transfer of care per 100,000 population (attributable to Social Care)	Low		0.9	0.9	0.2	7	1	1
2C (3) - Delayed transfer of care per 100,000 population (attributable to both NHS and Social Care)	Low			0.1	0	1	1	1
2D - The outcome of short-term services: sequel to service	High		63	61.2	69.7	110	11	12
3A - Overall satisfaction of people who use services with their care and	High		64.5	65	66	53	7	3
3B - Overall Satisfaction of carers with social services	High		37.4		34.9	104	14	11
3C - The proportion of carers who report that they have been included or consulted in discussions about the person they care for	High		74.9		67.9	90	12	10
3D1 - The proportion of people who use services who find it easy to find information about support	High		69.9	72	70.1	79	9	5
3D2 - The proportion of carers who use services who find it easy to find information about support	High		72.4		61.3	87	10	8
4A - The proportion of people who use services who feel safe	High		73.1	69	74	23	4	2
4B - The proportion of people who use services who say that those services have made them feel safe and secure	High		86	84	85.4	93	10	7

4 Performance and Business Intelligence framework update

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

4.2 The Health and Wellbeing Directorate Management Team meet each week and have been having a monthly meeting dedicated to Finance and Performance since December 2019. The meetings are designed to provide updates on Finance and Performance and to agree any corrective actions as well as celebrating successes. To aid the meeting a report has developed to which tracks performance against agreed targets and sets out issues and mitigations. The focus of the report and agreed targets allow us to track progress against the objective of delivering quality services whilst maximising independence.

4.3 To ensure that performance and finances are discussed across the department and to build understanding and accountability, Senior Adult Social Care Management Teams meet the week before the Finance and Performance Directorate Management Teams meetings to discuss the information that will be presented and provide narrative to the report.

4.4 Increased levels of understating and accountability for performance is now being seen. Work has recently started with Team Managers to support them in building up their knowledge and skills around the performance framework and the intelligence they have available to understand how they can apply the intelligence we hold alongside the performance reporting framework to understand and improve their teams performance. Workshops and dedicated sessions with small groups of managers are taking place.

4.5 To enable the performance framework to function effectively we have developed the Adult Social Care Development Intelligence Hub, a webpage hosted on Bradnet the council intranet site. The hub is home to a series of Power Bi reports. The reports have been co-produced with team managers and are built to enable users to access high level data and then drill into the data and gain insights via the engaging and interactive reports. The reports extract data from the care management system, SystemOne and the finance system, ContrOCC. Data extraction is automated and the reports are refreshed on a daily basis. The reports increase the transparency of the data and allow us to target areas where data quality needs to be improved.

4.6 We are playing an increasingly active role within the Association of Directors of Adult Social Services (ADASS) regional Performance and Standards network as part of sector led improvement. As part of this group we have showcased how we are delivering information reporting in Bradford to regional peers and hosted an Adult Social Care intelligence event in Bradford. This helps us support the network but also provides us with assurance that the approach we are taking around information reporting and performance improvement is fit for purpose. Reporting is now in line with established best practice and is robust and sustainable. Adult Social Care are now attending and contributing to the Bradford District Council Digital Programme Board.

4.7 The new Performance and Business Intelligence frameworks build around and complement our transformation programme is allowing us to embed evidence and intelligence into daily and strategic decision making more effective and efficient uses of council resources and allowing outcomes to be met more effectively. We are monitoring and reporting on the impacts of the Home First strategy, tracking the reduction in demand, and understanding how to best target resources to manage demand and improve outcomes.

4.8 In addition we are building our Information Governance knowledge and capability within Adult Social care to ensure that we are able to effectively meet our legislative requirements. We are delivering Information Governance Awareness sessions to 300 staff from September to November.

5 Impact and Transformation

5.1 The improved Performance and Business Intelligence frameworks have seen increased rigour. The department has greater ability to make evidenced based decisions, complementing the transformation activity taking place across the department; this is all contributing to the underspend of £1.6m in the Department of Wellbeing reported as part of September's revenue monitoring process. Our transformation priorities are:

- Prevention and Early Help
- Maximising Independence
- Commissioning
- Performance and Workforce Development

5.2 These transformation priorities are positively impacting upon performance across our service arears. In the last 12 months as a result of our transformation programme we have seen improved processes and/or outcomes across all service arears. A flavour of the impacts being seen across the main service areas within Adult Social Care are set out in paragraphs 5.3-5.11. In addition, please see appendices A to G which give greater detail on a number of the transformational projects currently taking place. These projects were showcased as part of the staff engagement roadshows which took place in October and November 2019, these were events were attended by over 300 staff from across the department.

5.3 **Older People and Physical Disabilities.** There has been a reduction of 49 people in residential/nursing placements since March 2019. At the end of September there were 1,034 people in placements versus a target of 1,059. This reduction continues the long term trend of reducing numbers of people in placement's. This reduction has resulted in the top quartile performance for the ASCOF measure on new care home placements for people aged 65+.

5.4 Whilst we are seeing reductions in the number of people in care homes we have seen an increase in the number of purchased Home Care hours. In September there were 102,000 hours purchased versus a target of 91,000. Following a period of stability in 2018 we have seen a return to the upward trend. As part of the

performance framework the Directorate Management Team are now sighted on monitoring and managing this trajectory.

5.5 **Mental Health.** There has been a reduction of 11 people in residential/nursing placements since March 2019. At the end of September there were 157 people in a placement versus a target of 174. We have seen a downward trend since June 2018.

The number of Home Care hours purchased in Mental Health also continues to fall. There were 3,050 fewer hours purchased in September 2019 than in March 2019. In September we purchased 10,039 hours versus a target of 14,300.

5.6 **Learning Disabilities** There has been a reduction of 31 people in residential/nursing placements since March 2019. At the end of September there were 178 people in a placement versus a target of 193.

5.7 **Commissioning and Quality.** Back in July 2017 just 57% of the Adult Social Care service providers in Bradford were rated either good or Outstanding by the Care Quality Commission. At the time the average across England was 80%. At September 2019 the proportion of good or outstanding providers in Bradford has risen to 81%. The England average was 84%. The council and CCG have invested in this area with the contracts and commissioning team developing and facilitating service improvement boards working across the sector and with in-house providers. The gap has been closed significantly and the target is to close the gap between Bradford and the England average completely, we expect this to happen in 2020. At this point we will review our position and explore setting a revised target that would see care quality provision in Bradford to be at a high standard when compared to our statistical neighbours.

5.8 **Safeguarding and Depravation of Liberty Safeguards (DoLS)** In 2018/19 we received 1,538 DoLS applications, an increase of 3% on the previous financial year. The number of applications completed rose significantly from 929 in 2017/18 to 2,353 in 2018/19 reducing backlogs.

5.9 This increase in completed applications reduced the number of applications that had not been completed, dropping from 1,122 at 31st March 2018 to 406 at 31st March 2019.

5.10 In 2018/19 Adult Social Care received 4,510 safeguarding concerns, a reduction of 6% since the 4,815 concerns received in 2017/18. New data recording systems were implemented in 2018 alongside the implementation of new safeguarding procedures. These two issues combined led to a reduction in the proportion of concerns that were recorded as Section 42 enquiries. In the first 6 months of 2019/20, 56% of concerns have been recorded as Section 42 enquiries.

5.11 The work taking place in the **Independence Advice Hub**, formally Access, to embed strengths based practice within all their conversations and advice. This practice alongside the improved business intelligence framework has seen an increase in the number of contacts that are signposted rise from 59% in the 1st half of 2018/19 to 90% in 2018/19.

5.12 The transformation work has taken place and led to evidenced impact and improved outcomes. The work which has taken place in 2019/20 is part of a three-year transformational programme. It is recognised that whilst progress is being seen, significant challenges remain in years 2 and 3 of the programme to ensure that targets around demand management and outcomes are met. Appendix H shows an overview of the transformation workstreams and the work ahead.

6 FINANCIAL & RESOURCE APPRAISAL

6.1 There are no direct financial implications arising from the detail of the report.

7. RISK MANAGEMENT AND GOVERNANCE ISSUES

8. LEGAL APPRAISAL

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

9. OTHER IMPLICATIONS

10. NOT FOR PUBLICATION DOCUMENTS

11. OPTIONS

12. RECOMMENDATIONS

Members are invited to comment on the report

13. APPENDICES

A – Community Led Support
B – Integrated Working, Mental Health teams
C – Valley View and Fletcher Court
D – Liberty Protection Safeguards
E - Preparation for Adulthood
F – Learning Disabilities
G – Time Out
H – Priority transformation workstreams

14. BACKGROUND DOCUMENTS

Appendix A – Community Led Support

What Issues Does This Address?

A key objective of this, is to identify local resources and build a resource map to share with other professionals in the area – as well as highlight any gaps that the council and partnership may need to address through their commissioning strategy.

Working at a local level to connect people to each other and community support is designed to better identify and support people's needs earlier to reduce the number of people requiring more formal short or long term care

What work has been done?

Strengths based practice is a key element where the conversation you have with care professionals will look at your strengths, ie. what you do well or wish to do well again, and utilise their skills and expertise to help you build upon these aspects to maintain and strengthen your independence and quality of life.

linking people to relevant and appropriate community resources such as meeting groups for individuals with similar issues or interests. Examples can include:

- volunteering which can boost socialisation and combat loneliness;
- linking to the Walk from home service via Age UK for those who have lost confidence due to a fall allowing people to regain their confidence and independence;
- access to Silverline, a 24h confidential information, friendship and advice service.

Professionals are active and linked into the local community and so are constantly aware and up to date of the scope and variety of resources available.

By understanding the community resources professionals will build and maintain a valuable intelligence and insight resource. This is also beneficial for commissioners who will utilise this information to place shape accordingly.

In addition, through Community Led Support there is a commitment to be accessible in a number of ways and includes so called "community hubs" as appropriate to each locality. For example, in Keighley a hub has been established in the local market where people can just pop in for a chat, widening participation. The concept of hubs means that by their very nature they are not actively targeted rather they are a conveniently placed catch all for people.

What impact has been made?

Transformation Board approved the request to trial the initial conversation paperwork and a Support Budge Guide (SBG), a revised indicative budget guide to replace the current Resource Allocation System (RAS) assessment. Inherent within the trial was some key performance indicators to assess its impact.

The trial took place over May & June 2019. The results were:

Overall
21 people submitted 79 cases, out of which 78 Let's Connect completed

Minimise bureaucracy
On average Let's Connect took just over an hour to complete
SBG guide - 53 completed
Average time to complete 1h 30m vs 3h for a RAS = 50% time saving

RAS comparison
22 cases compared. Cost comparison:
Overall SBG was 12% lower budget
12 SBG cases were cheaper and 4 cases were within 10% variance

Staff feedback
60 completed – 91% led to the same or better outcomes
46% led to better outcomes

User Feedback
40 completed – 82% found useful; others satisfactory - none unsatisfactory

These results gave confidence to implementing fully into Keighley over summer 2019

Appendix B - Integrated Working, Mental Health teams

What Issues Does This Address?

- Parity of esteem between health and social care.
- Recovery focussed support planning using strengths based conversations.
- Promoting individuals independence and wellbeing.
- Looking at alternatives to traditional care and support packages.
- Promoting social care at the forefront of peoples recovery.

What work has been done?

- The Community Mental Health Team (CMHT) have developed multi-disciplinary daily huddles which promote integrated biopsychosocial model to mental health care.
- Mental health presence at the Community Partnerships promoting Happy, Healthy and at Home.
- Collaborative work with the Voluntary and Community Sector (VCS)
- Duty social worker supports VCS services and attend daily
- Promoting Community Led Support (CLS) and building positive links with the local community.
- Improved links with peers in the Local Authority, including adult and children services.
- Upholding peoples legal and human rights within a medical model.
- Increase in peer support

What impact has been made?

- Improved moral within the teams
- Biopsychosocial approach to person centred care which ensures people get the right support right care at the right time.
- Promoting human rights based practice and ensuring the rights of individuals are upheld.
- Achieve savings at time of austerity.
- Strong social work leadership within mental health.
- Improved relationships with police, hospitals, housing, ambulance, GP's and the CCG

Lessons Learnt

- Social care within integrated mental health teams became diluted over the years. In the last 18 months there has been a strong promotion on social care achieving parity with health.
- Looking at outcomes when designing support plans and the panel process being more robust to be accountable for recovery focussed work.

Appendix C – Valley View and Fletcher Court

What Issues Does This Address?

- This scheme supports the implementation of the integrated system strategy Happy, Healthy at Home, in relation to accommodation and support services for older people, as well as enhancing partnerships and integrated service provision to support older people (including people living with dementia) to remain independent for as long as possible and have choice and control about how they live their lives
- Looking at alternatives to traditional care and support packages.
- Lack of extra care provision

What work has been done?

- The extra care scheme Fletcher Court has 69 extra care apartments (32 two-bedded and 33 one-bedded)
- The 50 bedded residential unit called Valley View will accommodate dementia specialist services currently based at HolmeWood, Keighley. The remaining beds will be used for short-term care for both assessment and intermediate care in partnership with health services.
- The scheme has been designed to the HAPPI (Housing our Ageing Population: Panel for Innovation) principles which will ensure high standards and that the scheme remains fit for purpose in to the future.
- The scheme had adopted high energy & ecological standards in particular in relation to high thermal efficiency.
- Facilities such as hairdressing/barber and nail bar, along with the Garner Restaurant will be just some of the services available which will also be open to the community to access.

What impact has been made?

- People have control over their own care needs.
- People feel more independent.
- The short term beds will enable a timely discharge from hospital allowing the individual to regain their confidence and facilitate a period of comprehensive multi-agency assessment and support back in to the community.
- Established and enhanced relationships with the community who are keen to be involved ie healthy living champions, autism hub.
- Received a gold award by design from the police for safety and security.
- The scheme was shortlisted for a Public-Private Partnership of the Year (for the Extra Care + Residential Care development) + Residential Development of the Year (for the Housing development) at the Insider Yorkshire Property Industry Awards.

Lessons Learnt

- To hold a vision & values sessions at the beginning to set ground rules at the outset and principles of key outcomes.
- Contract in future have a design and build which reviews the requirements and specification as various steps along the way.
- Robust change control in place with one document repository.

Appendix D – Liberty Protection Safeguards

What Issues Does This Address?

- Following royal assent being granted to the Mental Capacity Amendment Act (2017) the Liberty Protection Safeguards go live in October 2020.
- Preparation is underway to implement the new LPS arrangements which will replace the Deprivation of Liberty Safeguards.

What work has been done?

- A partnership steering group has been established with representation from the 3 NHS Trusts, the CCG and the Council to manage the implementation.
- Briefings have been held with Bradford Care Association.
- Work has begun to scope out transition from the DoLS to the LPS.
- The Teaching Partnership have committed to make LPS a core strand of their offer to support the Department.

What impact has been made?

- The LPS will impact on all social workers
- Some BIAs may convert to AMCAP roles
- Anyone 100% CHC funded who is subject to DoLS will transfer to the CCG as the Responsible Body from 1st October 2020
- Some care home registered managers may taken on the role of Responsible Body from 1st October 2020, this is to be determined

Lessons Learnt

- There will need to be a large programme of briefings and CPD to support social workers with this work and providers

Appendix E – Preparation for Adulthood

What Issues Does This Address?

- Repositioning the transitions from children to adult services for disabled young people as Preparation for Adulthood

What work has been done?

- Support from the National Development Team for Inclusion (NDTi) Preparation for Adulthood Team funded by the Department of Education to run 2 coproduction events with disabled young people and their families spring 2019
- The establishment of our new disabled young people's reference group to reshape the service autumn 2019
- 4 Personal Assistants networking events being held in autumn 2019
- Gig buddies and School of Rock and Music offering reshaped support model
- Implementing the Preparation for Adulthood outcomes from Year 9 Early Help offer

What impact has been made?

- All 62 young people transferred with an agreed plan from education and children's services to adult services this summer
- No new placements have been made in residential care in 2019

Lessons Learnt

- Coproduction approaches ensure that young people and their families own the plan
- Early help and prevention ensures that pathways to maximise independence avoid restrictive residential homes

Appendix F – Learning Disabilities

What Issues Does This Address?

- Transformation of the learning disabilities offer supported by the Big Conversation to ensure that people's voices are central to all decisions and that their rights are upheld

What work has been done?

- Big Conversation 2 taken place spring/summer 2019 building on Big Conversation 1 outcomes
- Community Learning Disabilities Front Door fully live with new short term support offer in place
- Training rolled out across all 4 CTLD Locality Teams on Mind Space supported by Impower
- Impower Reviews processes implemented

What impact has been made?

- 589 learning disabled and autistic adults have attended 12 workshops (6 autumn 2018/winter 2019 and 6 spring/summer 2019)

Lessons Learnt

- People want 4 key outcomes from us: a place to live which is in my community near my family; meaningful paid employment; someone to love and if I become a parent help to be a good mum or dad; hope – believe in my dreams and work with them

Appendix G – Time Out

What Issues Does This Address?

- Lack of awareness of the service by the public and colleagues within the authority/Adult services.

What work has been done?

Promotion of the service through team meetings, video publicity and of open days. The promotion is highlighting what the service can offer;

- carers relief, one to one support,
- support with indoor and outdoor activities.
- short term support.
- waking nights
- Help prevent carers breakdown and prevent hospital admission and respite for the cared for

What impact has been made?

New Carer/client matches have been made, inclusive of people who have differing faiths . We are embracing and supporting the faiths of Bradford and coming together from different communities.

Lessons Learnt

- Engagement with service users at an early stage to understand need and to co produce support solution.
- Robust induction plan for new starters to ensure they are equipped with the appropriate skills and tools to undertake their role

Appendix H – Priority transformation workstreams

Health and Wellbeing Priority Transformation Workstreams

Our high level three year plan focuses on 4 key transformation work streams. Each of the work streams are assigned to a member of the Directorate Management Team (DMT) as a Senior Responsible Officer. These workstreams are reviewed on a monthly basis by the Health & Wellbeing Transformation and Change Board to ensure that targets and milestones are being met. These workstreams are also reviewed as part of the annual planning process to ensure that resources are focused on identified priorities.

The following does not take into account everything a service area is focusing on.

Maximising independence SRO: Rob Mitchell	Early help & prevention SRO: Sarah Muckle	 SRO: Lyn Sowray	Commissioning SRO: Jane Wood	Performance framework SRO: Bev Maybury
1.Embed 3 tier approach and CLS – LD reviews / Transitions, home support, Access 2.Update policies and procedures and embedding into practice 3.Implement quality assurance process including supervision, audit, etc.	1.Implement and embed whole system framework for early help and prevention 2.Implement and embed health living: 3.Implementation of Bradford district clean air action plan	1. Embed strategic packages for early intervention approaches including: • Embedding assistive technology • Carers • VCS • ADL 2. Review of Health & care interface	1.Implementation of Commissioning framework 2.New Supported Living Units 3.Home support locality contract implementation 4.Reimagining days: HfT day care strategy and contract	1.Enhance and embed the use of performance data and intelligence within strategic and operational teams. 2.Work with district to develop a shared approach to business intelligence. 3.Continue to strengthen and enhance workforce skillsets to support service improvement. 4. Enhance and strengthen Information platforms to support service users and staff.