Public Document Pack

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Agenda for a meeting of the Health and Social Care Overview and Scrutiny Committee to be held remotely on Tuesday, 16 February 2021 at 4.30 pm

Members of the Committee – Councillors

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

Alternates:

LABOUR	CONSERVATIVE	LIBERAL DEMOCRAT AND INDEPENDENT GROUP	BRADFORD INDEPENDENT GROUP
Akhtar Berry Iqbal Jenkins H Khan	Sullivan Barker	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:

- Please note that, under the current circumstances, we are only able to produce limited paper copies. A webcast of the meeting will be available to view live on the Council's website at https://bradford.public-i.tv/core/portal/home and later as a recording
- Any non member Councillors or members of the public who wish to make a contribution at the meeting are asked to email jane.lythgow@bradford.gov.uk by **10.30am on Friday 12 February 2021** and request to do so. In advance of the meeting those requesting to participate will be advised if their proposed contribution can be facilitated and, if so, they will be provided with details of how to electronically access the meeting. Councillors and members of the public with queries regarding making representations to the meeting please email Jane Lythgow.
- Approximately 15 minutes before the start time of the meeting the Governance Officer will set up the electronic conference arrangements initially in private and bring into the conference facility the Chair and Members so that any issues can be raised before the start of the meeting. The officers presenting the reports at the meeting will have been advised by the Governance Officer of their participation and will be brought into the electronic meeting at the appropriate time.

From: **To:**

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

A. PROCEDURAL ITEMS

1. ALTERNATE MEMBERS (Standing Order 34)

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

2. DISCLOSURES OF INTEREST

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

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

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

Notes:

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

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

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

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

3. INSPECTION OF REPORTS AND BACKGROUND PAPERS

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

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

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

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

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

(Jane Lythgow - 01274 432270)

4. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

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

B. OVERVIEW AND SCRUTINY ACTIVITIES

5. END OF LIFE CARE IN BRADFORD DISTRICT 1 - 12

Document "U" provides a summary and overview of End of Life Care (EOLC) across Bradford District. The report includes what is good EOLC, resuscitation, advance care planning and reports how people are supported in their last days of life.

Recommended –

That the report be noted.

(Beverley Gallagher – 07832475700)

6. PUBLIC HEALTH OUTCOMES FRAMEWORK (PHOF) PERFORMANCE REPORT 13 - 48

The report of the Director of Public Health, **Document "V"** provides an overview of the health and wellbeing of the population of the Bradford District based on the indicator and sub indicators within the Public Health Outcomes Framework (PHOF).

The report summarises how indicators and sub indicators compare against the England average and provides a summary of some of the key areas of Public Health relevant to the District.

Recommended –

That the report be noted and the Director of Public Health be requested to provide a further report on Public Health Outcomes Framework indicators in 2021.

(Jonathan Stansbie – 01274 436031)

7. HEALTH AND WELLBEING COMMISSIONING STRATEGY AND INTENTIONS - ADULT SOCIAL CARE 2021 UPDATE 49 - 60

The report of the Strategic Director, Health and Wellbeing (**Document "W")** provides an update, and advises Members, on the progress of the 2019-2021 Adult Social Care Commissioning Strategy and intentions of the Council's Department of Health and Wellbeing.

Recommended –

That the report be noted.

Jane Wood / Holly Watson - 07812 490 705

8. HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME 2020/21

A work planning discussion will take place on the Committee's work programme for the remainder of the 2020/21 municipal year.

The views of Members are requested.

(Caroline Coombes - 01274 432313)

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of End of Life Care in Bradford District to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 16th February 2021

U

Subject: End of Life Care in Bradford District

Summary statement:

This report provides a summary and overview of End of Life Care (EOLC) across Bradford District. This includes what is good EOLC, resuscitation, advance care planning and how we support people in their last days of life.

Dr Clare Rayment, Consultant, Palliative Medicine, Bradford Teaching Hospitals Foundation Trust Chair of BAWC Palliative Care Managed Clinical Network
Liz Price, Lead Nurse for Palliative Care, Bradford Teaching Hospitals Foundation Trust
Dr Sara Humphrey, Associate Clinical Director Frailty/Dementia and LD
Karen Dawber, Chief Nurse, Bradford Teaching Hospitals Foundation Trust

Report Contact: Beverly Gallagher
Phone: 07832475700
E-mail: bev.gallagher@bradford.nhs.uk

Portfolio:

Healthy People and Places

1. Summary

This report provides a summary and overview of End of Life Care (EOLC) in Bradford District. This includes what is good EOLC, resuscitation, advance care planning and how we support people in their last days of life.

2. Background

The Health and Scrutiny Committee requested clarity on End of Life practices and what systems and process are in place across Bradford and Craven to support people who are approaching the end of life so that they can have a dignified, peaceful and supported death. In addition, to understand the rationale for DNACPR, what this means and what are the impact and implications of this.

This presentation gives an overview of:

- End of Life Care
- What is good EOLC
- Advance Care Planning
- What is CPR and DNACPR
- What does the data tell us
- What changed during COVID

3. Report content

Introduction

Dying is a process that affects us all, at all ages; the living, the dying and the bereaved. Not only do we face our own mortality, but the majority of us will also be involved in supporting at least one friend, family member or service user at the end of their own life, and experience bereavement after their death.

More than half a million people die each year, and many live with a life expectancy of less than a year at any one time. This is set to increase with an ageing population, so more people are expected to die at an older age. We will all therefore experience EOLC in some form and appreciate the lasting impact that good (or poor) care can have (NHSEI, 2017).

It is therefore vital that the highest quality end of life care services are available to all who need it, irrespective of diagnosis, age, gender, ethnicity, religious belief, disability, sexual orientation, and social economic status. Effective and compassionate care and support needs to be in place for people who are approaching the end of life so that they can have a dignified, peaceful and supported death.

Defining End of Life

EOLC is a term that is used to describe the care and support given to people who have an illness that is not possible to cure and may get worse over time. The aims of palliative care are to help with pain or other symptoms and to look at ways of helping and supporting patients and their families/friends. EOLC may be delivered by disease-specific specialists and their associated teams; by generalists such as primary care teams or hospital-based generalists (for example, elderly care); or by palliative care specialists in hospices, hospitals and community settings (NICE, 2019).

The Leadership Alliance for the Care of Dying People provides a useful definition of end of life and palliative care in the *'One Chance to get it Right'* report (2014) that states:

Patients are 'approaching the end of life' when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions
- general frailty and co-existing conditions that mean they are expected to die within 12 months
- existing conditions if they are at risk of dying from a sudden acute crisis in their condition
-

Similarly The World Health Organisation (WHO) in 2013 defines palliative care as:

"An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care provides relief from pain and other distressing symptoms".

What is Good EOLC?

Good EOLC is set out in Ambitions for Palliative and EOLC: a national framework for local action 2015 – 2020, which notes six key requisites to ensure a high quality, person centred approach to EOLC provision:

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is coordinated
- All staff are prepared to care
- Each community is prepared to help

Over the many years, partners across Bradford and Craven have been working collaboratively and engaging with stakeholders to realise these ambitions and understand what matters to people and have developed a range of support to people, carers and staff which includes:

- Supporting staff across health and social care with training and education
- Managed Clinical Network making connections and improvement in palliative care across health and social care
- Resources: website which provides links and multiple documents to support clinicians which includes advance care planning and guidance on cardio pulmonary resuscitation and DNACPR. More information is available at: http://www.palliativecare.bradford.nhs.uk/Pages/Home.aspx
- Adoption of the Gold Standards Framework (GSF). The GSF is a framework used by many GP practices, care homes and hospitals to enable earlier recognition of patients with life-limiting conditions, helping them to plan ahead to live as well as

possible right to the end.
- End of life facilitator provides bespoke EOL training for care homes and other social care organisations (based on GSF)
- Goldline – a 24/7 single point of access telephone contact for patients in their last year of life and their carers which is answered by a trained nurse with access to the health records
- Practical care: rapid access to practical support for those in the last year of life – (fastrack team, palliative care support teams)
- Supporting people to plan ahead through advance care planning and roll out of ReSPECT across Bradford

My Future Wishes (Advance care planning and ReSPECT)

An important element of EOLC is supporting people to plan ahead for the end of life. This is sometimes called advance care planning which offers people the opportunity to confirm their future wishes while they have the capacity to do so. Often people are not given the opportunity to consider and express their future wishes in a timely way and this can lead to regret on behalf of both families and professionals. Starting these discussions early gives the opportunity for conversations to evolve over a period of time without any pressure on the individual or family to make rapid decisions.

An advance care plan may include a person's:

- Concerns e.g. for things that they don't want to happen in future or who will care for loved ones or pets
- Important values or personal goals for care
- Future wishes
- Understanding of illness and prognosis
- Preferences for types of care or treatment that may be helpful in future and an understanding of the availability of these
- Wishes for someone to make decisions for you using a lasting power of attorney
- Carer emergency care plans and refusing specific treatment, if they wish to.

Planning ahead like this means peoples wishes are more likely to happen as well supporting family members to know what their loved ones would wish for in specific circumstances.

What is ReSPECT?

ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. It is a very specific type of advance care planning that summarises the emergency care part of a wider advance or anticipatory care plan

The ReSPECT process creates a summary of peronalised recommendations for a person's clinical care in a future emergency in which they may not have capacity to make or express their wishes or choices at that time. Such emergencies may include death or cardiac arrest, but are not limited to those events. The process is intended to respect both patient preferences and clinical judgement. The agreed realistic clinical recommendations that are recorded include a recommendation on whether or not CPR should be attempted if the person's heart and breathing stop.

https://www.resus.org.uk/respect/respect-healthcare-professionals

What is Cardio Pulmonary Resuscitation (CPR)?

CPR was introduced in the 1960s as a medical treatment to try to re-start the heart when people suffer a sudden cardiac arrest from a heart attack from which they would otherwise make a good recovery. Since then, attempts at CPR have become more widespread in other clinical situations.
CPR involves chest compressions, delivery of high-voltage electric shocks across the chest, attempts to ventilate the lungs and injection of drugs. The likelihood of recovery varies greatly according to individual circumstances; the average proportion of people who survive following CPR is relatively low.

- Out of hospital arrests < 1 in 10 survive
- In hospital arrests success 1 in 5 survive to discharge
- Features associated with almost no chance of success are advanced cancer, gross frailty, multiple co-morbidities, multi-organ failure

Therefore CPR is started if there is a realistic expectation of it being successful and if there is no valid Do Not attempt Cardio Pulmonary Resuscitation

There is multiple guidance supporting decision making from the General Medical Council, British Medical Association, Royal College of Nursing and Resus Council, please see references for further information.

What is Do Not Attempt Cardio Pulmonary Resuscitation?

When cardiac arrest occurs and we do not attempt to restart the heart but allow a natural death. It should be noted that DNACPR does not mean that other appropriate and sometimes invasive treatments are not given e.g. painkillers, antibiotics, drugs for symptom control, feeding or hydration (by any route), investigations and treatment of a reversible condition

A DNACPR can be put in place where:

- A patient with capacity declines CPR
- A clinician considers that attempting resuscitation is likely to be futile (i.e. it will not work); and/or
- It is not in the patient's best interests (for example because they are unlikely to have a good quality of life even if resuscitation is successful).
- The decision as to whether CPR should be attempted is a medical decision and can only be made by a clinician. It cannot be overridden by a patient or a family member, even someone with legal power of attorney for health and welfare.

What is physician-assisted dying?

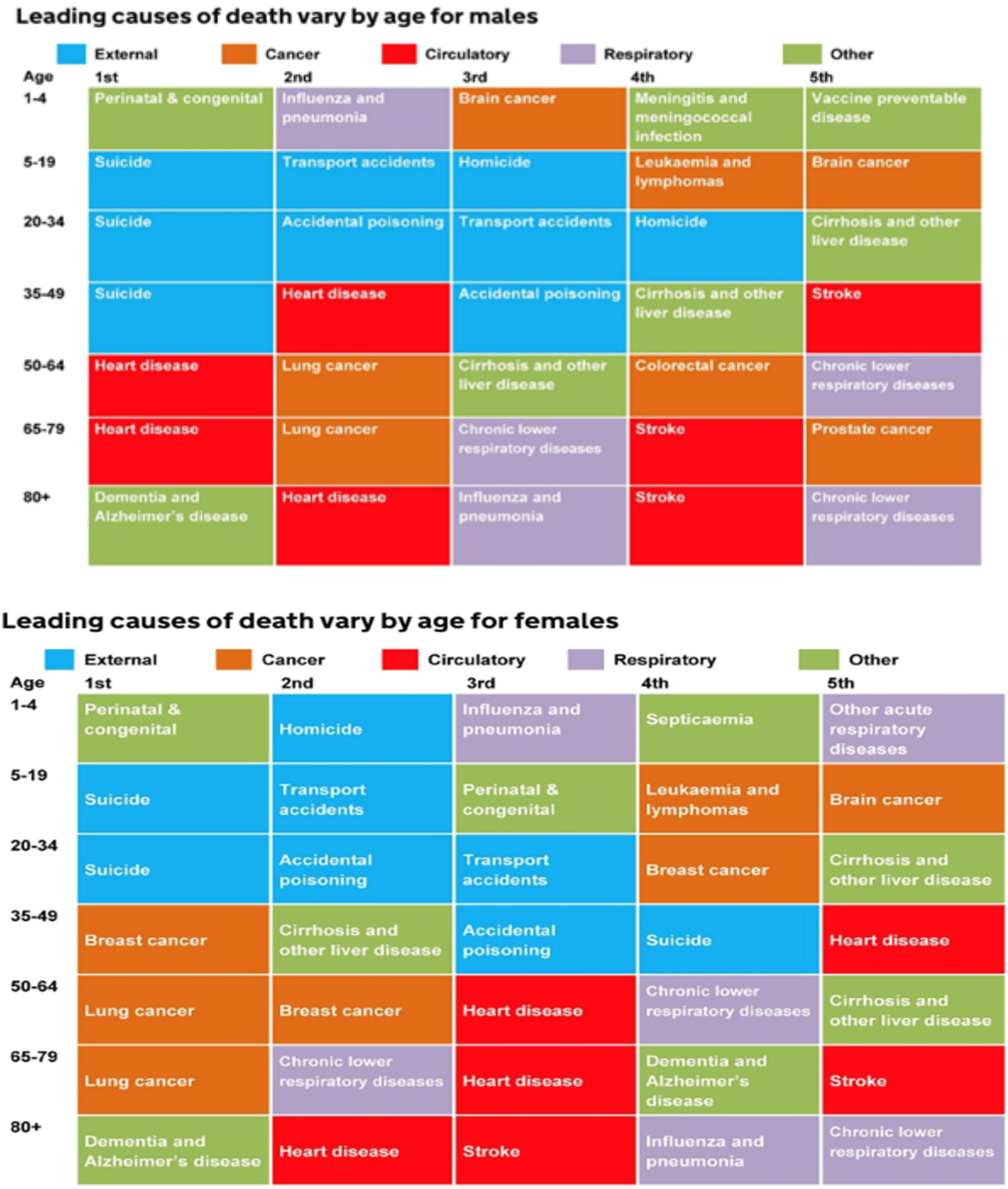
Physician-assisted dying refers to doctors' involvement in measures intentionally designed to end a patient's life. It covers situations where doctors would prescribe lethal drugs at the voluntary request of an adult patient with capacity, who meets defined eligibility criteria, to enable that patient to self-administer the drugs to end their own life. It is illegal to support assisted dying in the UK. Somebody being not for resuscitation is NOT a form of physician assisted dying.

https://www.bma.org.uk/media/2353/bma-physician-assisted-dying-info-pack-april-2020.pdf

What does the data tell us?

According to the Office for National Statistics (2019) each year around 500,000 people die. The causes of death vary across age and gender groups (See figure 3 and 4). An average GP will see about 20 deaths a year. 5 from cancer, 6 from organ failures, 7 from frailty, dementia or multiple illness and 2 sudden deaths

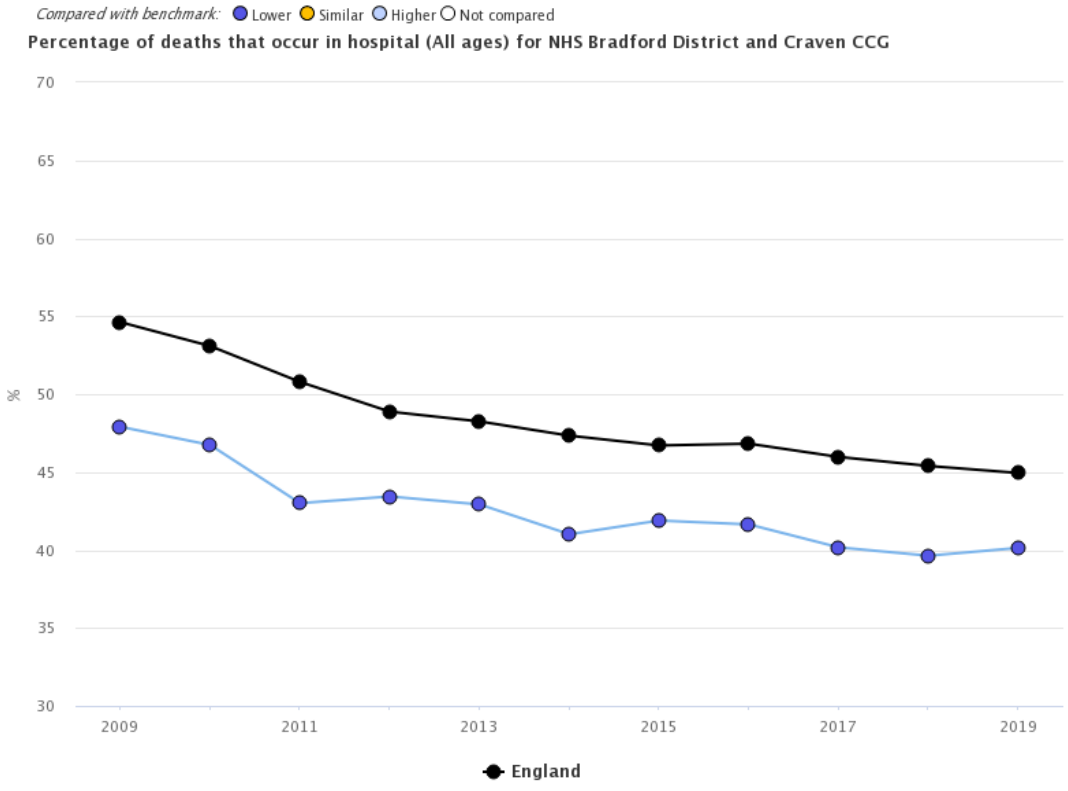
Figure 3 and 4: Leading causes of death by age and gender (2015)

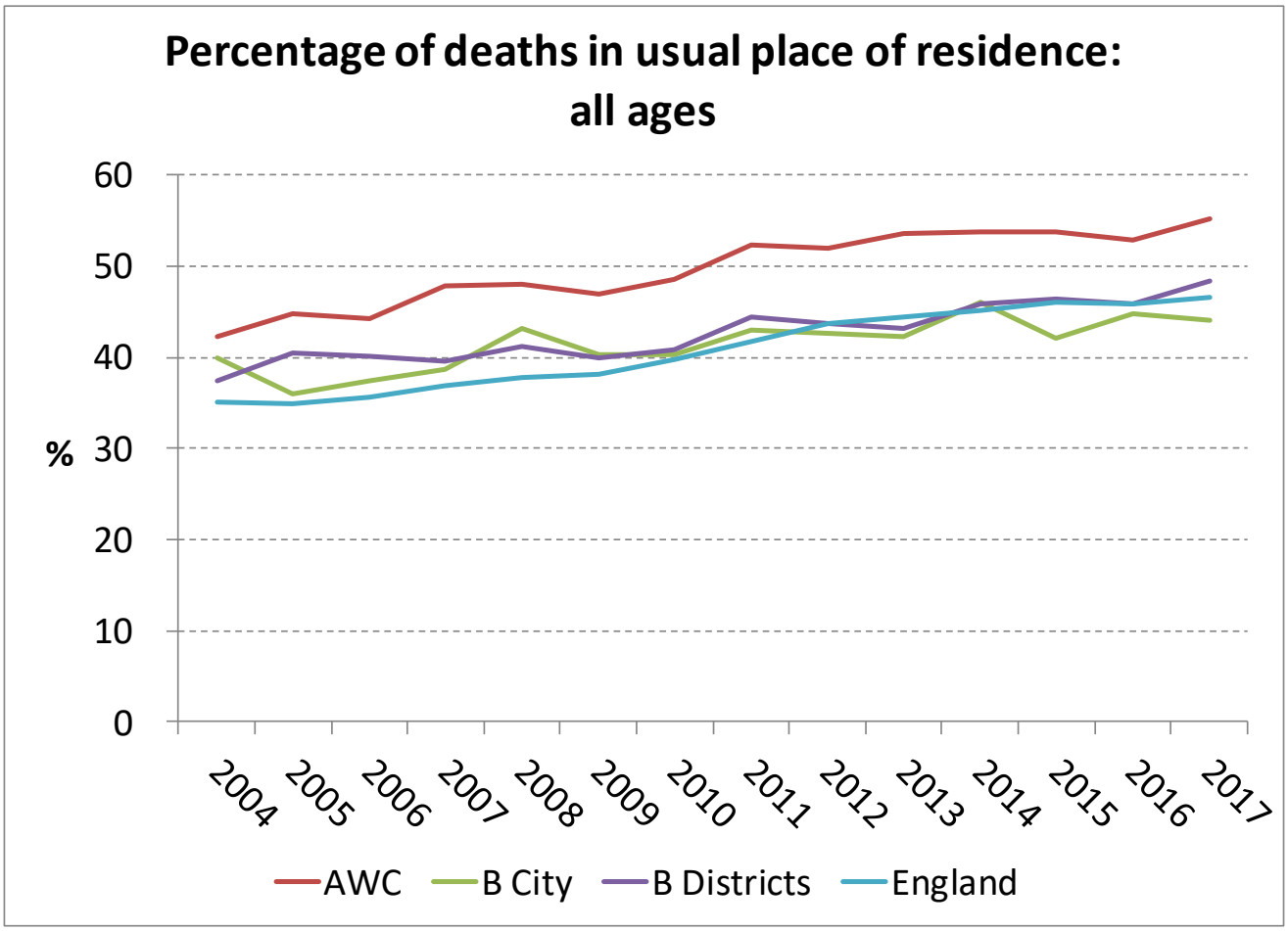


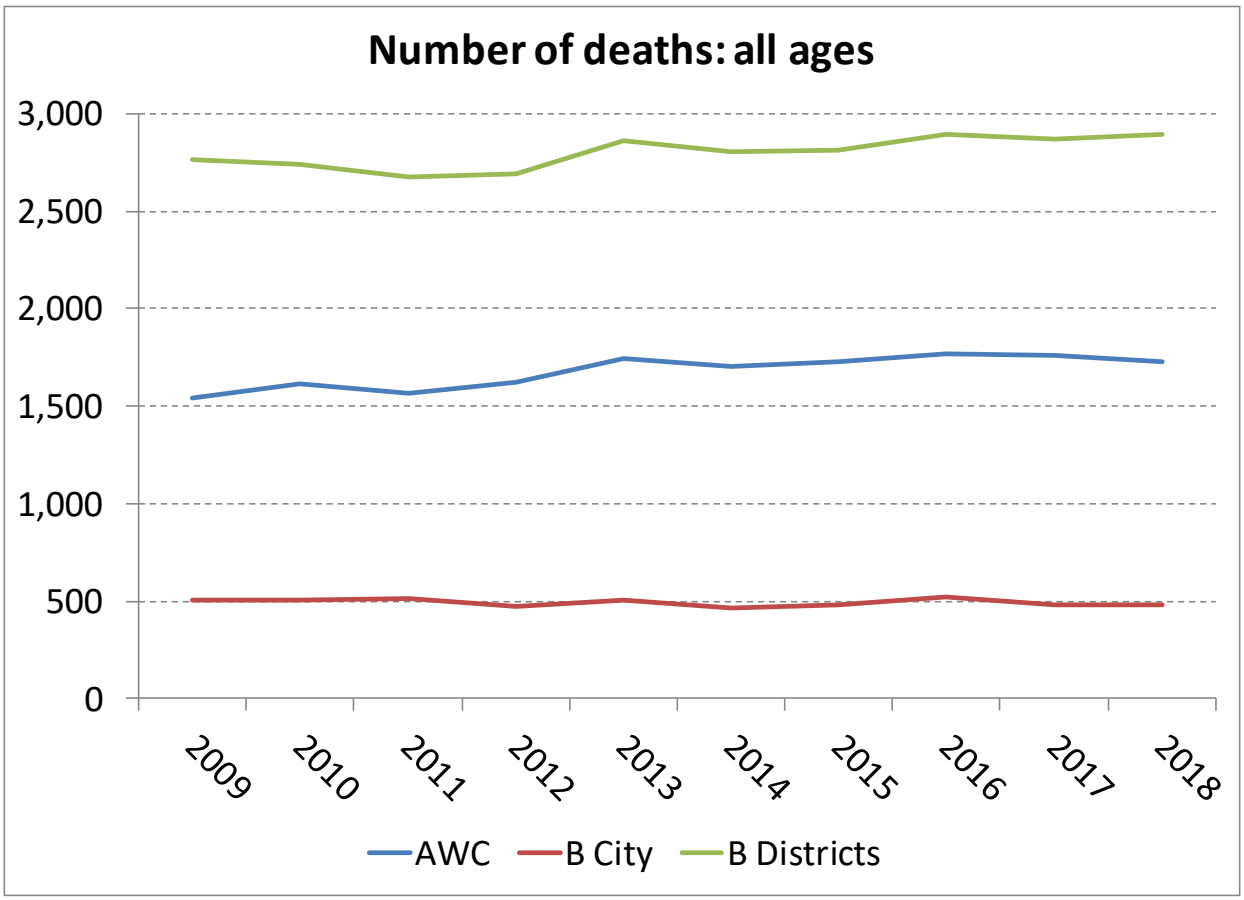
Source: provided by WY H ICS (2020)

On a local level data and intelligence on EOLC in Bradford district and Craven, drawn from a number of sources including the Public Health Mortality database and the Public Health England Atlas of Variation on End of Life Care helps paint a picture of our local population and the key findings are captured below

- Around 5000 people (adults and children) die each year in Bradford district and Craven
- Around 3,750 people are thought to need access to end of life care in any given year
- It is suggested that around 1in 4 deaths are unexpected and 3 in 4 could be predicted
- It is suggested that a third of people with EOL care need specialist palliative care, a third need more general support and the remaining third could be supported with community support (at any given time)
- The main causes of death in adults, are cancer, cardiovascular disease, and respiratory disease, similar to in other parts of the country. However in Bradford we are outliers for under 65s respiratory disease and have high all age mortality for circulatory disease
- Adult place of death changes depending on recorded cause of death e.g. there are more cancer deaths in hospices, most dementia deaths occur in care homes, whereas most deaths due to cardiovascular disease occur in hospital.
- Approximately 1 person in every 100 dies every year, however this will have increased during COVID- 19 pandemic. Figure 5 demonstrates the number of COVID deaths broken down by setting.
- 4 in 10 die in hospital, 2 in 10 home, 2 in 10 care home, 1 in 10 hospice and 1 in 10 other.
- The trend has been towards reducing deaths in hospital and increasing them in a person's usual place of residence.




Percentage of deaths in usual place of residence: all ages
60
50
40
30
20
10
0
%
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
AWC
B City
B Districts
England


Number of deaths: all ages
3,000
2,500
2,000
1,500
1,000
500
0
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
AWC
B City
B Districts

Impact of COVID –19 and deaths in Bradford compared with the national picture

ONS (2021) data demonstrates that since the start of the pandemic up until the 15th January, there have been 1001 registered COVID deaths in Bradford across all settings. Below shows the figures by setting compared to national Covid deaths.

Place of Death	Number of COVID Deaths Bradford (%)	Number of COVID Deaths Nationally (%)
Care Home	262 (26.2)	24059 (24.1)
Elsewhere	5 (0.5)	349 (0.3)
Home	73 (7.3)	4887 (4.9)
Hospice	16 (1.6)	1278 (1.3)
Hospital	644 (64.3)	68895 (69)
Other Communal Establishment	1 (0.1)	424 (0.4)
Total	1001	99892

All data is taken from the ONS Death Registrations by Local Authority.

What changed during Covid?

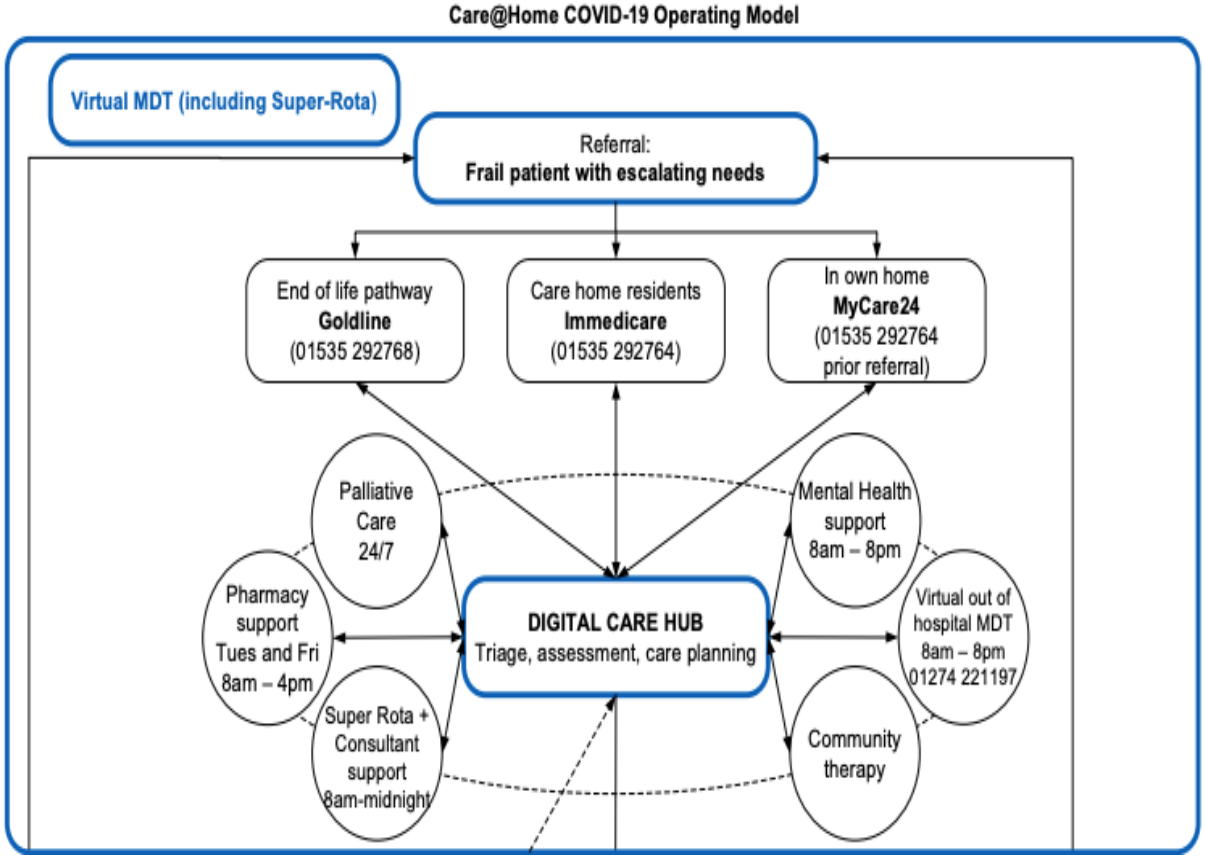
The COVID-19 pandemic raised particular challenges for the frail elderly and vulnerable people living in our community. In recognition of the need to keep people safe and enable them to be cared for in their preferred place, Bradford & Craven CCG and system partners came together early on in the pandemic to establish Care@Home digital response to COVID-19 for frail elderly with escalating need living in their own homes and for all residents living in a care home across the district. Building on the existing Airedale Digital Hub we have enhanced digital support services locally, including:

- Immedicare (telemedicine) to all Care Home residents;
- MyCare 24 for frail elderly or housebound living in their own home;
- Introduced a super-rota to provide access to a Multi-Disciplinary-Team including: GPs, Palliative Care and Care of the Elderly Consultants, Mental Health, Pharmacy and Allied Health Professionals. This was available 8-8pm 7/7 with flexibility to increase hours during peaks
- Reinforced Goldline services which is a dedicated 24/7 telephone line for people who may be in their last year of life and their families and is an integral service within our care@home COVID-19 operating model. Often calls raise a concern or a need for reassurance that the patient or their family has in order to be supported to continue managing their condition in their preferred place at home.
- Created an Integrated Community Response to COVID-19; and Integrated approach-One System to ensure that people receive the right care and support at the right time supported by all teams

This included access and support for both virtual and face to face End of life and Palliative Care and to ensure that people receive effective and compassionate care and support and that people were empowered through sensitive discussions and advanced care planning to make choices about what matters to them and what care and treatment they would like to receive or not if they became unwell.

Figure 1 demonstrates the Care Home operating model to support frail elderly with escalating need living in their own homes and for all residents living in a care home across the district which includes access to 24/7 palliative care advice and support.

Figure 1: Care Home operating model to support frail elderly with escalating need living in their own homes and for all residents living in a care home across Bradford district and Craven



In addition, to the enhanced digital hub the Care@home met 3 x week with all partners to review all new guidance, develop clinical pathways, review services that have been established, troubleshoot and provide training and development to health and social care staff. Some examples of the resources and learning we have supported to enhance EOLC in Bradford District during the pandemic include:

- Advance Care Planning resource for professionals, patients and families A 'My Future Wishes Conversation' Starter Pack commissioned by WY & H ICS and developed by the Alzheimer Society to help patients and families to start conversations https://www.wyhpartnership.co.uk/our-priorities/mental-health/mental-health/advance-care-planning
- This resource has also been utilised across WY & H ICS to look at meeting the needs of the BAME population to have good conversations
- A resource pack and template for Primary Care on how to support individualised DNACPR conversations
- A monthly newsletter for Primary Care and Care Homes sharing best practice
- Bradford Care Homes resource to support best practice

We also established a daily huddle through the multi-disciplinary team for any escalating need of a resident/patient or care home that may need additional support which included

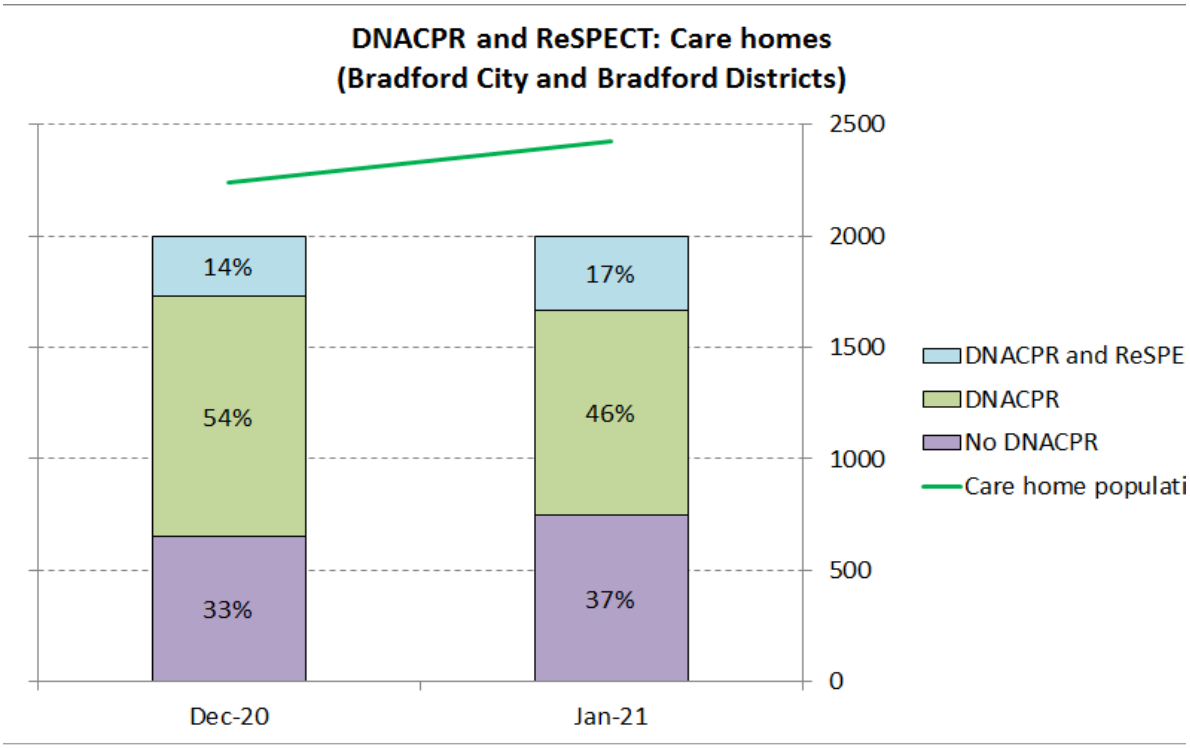
shared daily learning MDT's across Primary & Secondary care with Palliative Care GPs, Community Matrons, Pharmacist, Mental Health and Digital Care nurses.

In hospital despite the restrictions on visits we established a relative's line and prioritised visiting for patients in their final days. Chaplaincy and palliative care support was provided 7 days a week to support people and their loved ones at this difficult time.

Qualitative and quantitative data was also collated and analysed on a regular basis to review themes and trends, how we are doing against were we need to be and agreed actions for how we can continuously improve. This included a month by month comparison of the DNACPR status of residents in care homes and those that are house bound to ensure that the approach was person centered rather than a blanket approach that has been suggested by CQC occurred in some areas across the country.

Figure 2 demonstrates current percentages of people with a DNACPR status in care homes and in their own home across Bradford and Craven for December 2020 and January 2021 and includes progress of ReSPECT discussions.

Figure 2: DNACPR and RePECT status across Bradford district



Source: Bradford and Craven CCG (2021)

Feedback from providers across the system notes that the learning and resources and new ways of integrated working and shared best practice have enabled a 'one system' approach to EOLC.

4. Recommendations

The committee is asked to note the contents of this presentation

5. Background documents

- Ambitions for Palliative and End of Life Care: a national framework for local action 2015 – 2020. Available online at: http://endoflifecareambitions.org.uk/
- Bradford Palliative care website. Available on line at: http://www.palliativecare.bradford.nhs.uk/Pages/Home.aspx
- British Medical Council et al (2016) Decisions relating to cardiopulmonary resuscitation. Available online at: https://www.bma.org.uk/media/1816/bma-decisions-relating-to-cpr-2016.pdf
- British Medical Council (2020) physician assisted dying. Available online at: https://www.bma.org.uk/media/2353/bma-physician-assisted-dying-info-pack-april-2020.pdf
- CQC (2020) Review of DNACPR decisions during the coronavirus pandemic. available online at: https://www.cqc.org.uk/publications/themes-care/review-dnacpr-decisions-during-coronavirus-pandemic-methodology
- General Medical Council (2020) Cardio Pulmonary Resuscitation. Available online at: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-and-care-towards-the-end-of-life/cardiopulmonary-resuscitation-cpr
- Gold Standards Framework. Available online at: https://www.goldstandardsframework.org.uk/cd-content/uploads/files/PIG/NEW%20PIG%20-%20%20%2020.1.17%20KT%20vs17.pdf
- Hempsons (2020) DNACPR Orders and COVID-19. Available online at: https://www.hempsons.co.uk/news-articles/dnacpr-orders-and-covid-19/
- NICE (2019) End of life care for adults service delivery. Available on line at: https://www.nice.org.uk/guidance/ng142/resources/end-of-life-care-for-adults-service-delivery-pdf-66141776457925
- NHS Long Term Plan (2019) https://www.england.nhs.uk/long-term-plan/
- https://www.resus.org.uk/library/publications/publication-decisions-relating-cardiopulmonary
- Resuscitation Council UK (2020)ReSPECT advice for professionals and the public. Available online at: https://www.resus.org.uk/respect/respect-healthcare-professionals
- World Health Organization (2013) WHO Definition of Palliative Care. Available online at: http://www.who.int/cancer/palliative/definition/en
- WY & H ICS (2020) Our priorities for advanced care planning. Available online at: https://www.wyhpartnership.co.uk/our-priorities/mental-health/mental-health/advance-care-planning

6. Not for publication documents

None

7. Appendices

None.

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Strategic Director, Health and Wellbeing to the meeting of the Health and Social Care Overview and Scrutiny Committee to be held on 16 February 2021 V

Subject:

Public Health Outcomes Framework (PHOF) Performance Report

Summary statement:

This report provides an overview of the health and wellbeing of the population of Bradford District, based on the indicators and sub indicators within the Public Health Outcomes Framework (PHOF). The report summarises how indicators and sub indicators compare against the England average and provides a summary of some of the key areas of Public Health relevant to the District.

Sarah Muckle
Director of Public Health

Report Contact: Jonathan Stansbie
Senior Public Health Intelligence Specialist
Phone: (01274) 436031
E-mail: jonathan.stansbie@bradford.gov.uk

Portfolio:
Healthy People and Places

Overview & Scrutiny Area:
Health and Social Care

1. SUMMARY

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

1.2 The report summarises how indicators and sub indicators within the Framework compared against the average for England along with general trends.

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

2. BACKGROUND

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

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

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

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

3. REPORT ISSUES

3.1 A full list of all indicators and sub indicators along with their current figures are available in **Appendix A**. This shows current values, provides an indication of recent or previous years trends where available and benchmarks our performance against the England average. These indicators are up to date as of the 18th January 2021

3.2 Of the 132 indicators and sub indicators where significance against the England average has been tested, 70 are significantly worse, 40 are not significantly different and 22 are significantly better. **Table 1** shows a breakdown of this information by domain.

Table 1 – Bradford District in comparison to England across all indicators where significance has been tested

Domain	Number of indicators	Significantly worse	Not significantly different	Significantly better
Overarching Indicators	12	10	2	0
Wider determinants of health	24	10	7	7
Health Improvement	47	28	11	8
Health protection	28	14	12	2
Healthcare and premature mortality	21	8	8	5

3.3 Of the 132 indicators and sub indicators, 22 are 'getting worse' – the gap between the district and England is widening; 14 are 'getting better' – the gap between the district and England is narrowing; and 88 show no significant change over recent years (**Table 2**).

Table 2 – Changes in trend in recent years for indicators within each domain

Domain	Number of indicators	Getting worse / gap is widening	No significant change	Getting Better / gap is narrowing	No trend data available
Overarching Indicators	12	0	12	0	0
Wider determinants of health	24	2	16	6	0
Health Improvement	47	7	33	4	3
Health protection	28	13	10	2	3
Healthcare and premature mortality	21	0	17	2	2

3.4 Because there are more than 100 indicators in PHOF it is not possible in this report to provide a detailed overview of all indicators. Therefore this report focuses on specific indicators within the PHOF that are of particular interest to the District. Charts showing trends over time for these specific indicators can be found in **Appendix B**. Accordingly, a number of indicators across the four specific domains, in addition to the main overarching indicators, have been selected, and a more detailed analysis has been provided.

3.5 **Overarching indicators**:

3.5.1 **Life expectancy at birth**

Males – **Significantly worse**, **no significant change**
Females - **Significantly worse**, **no significant change**

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

Life expectancy at birth is measured separately for males and females. Life expectancy at birth for ***males*** in Bradford District has followed an upward trend although in recent years this increase has slowed. In 2017-19 life expectancy increased to the highest recorded (78.0 years compared to the England average of 79.8 years).

Life expectancy at birth for ***females*** in Bradford District has followed a similar trend as for males. In 2017-19 life expectancy at birth for females rose to 81.9 years compared to 83.4 years for England.

District figures mask variation in life expectancy across Bradford, particularly relating to deprivation. A male in Bradford District living in the most deprived decile of deprivation can expect to live 9.1 years less than a male from the least deprived area. This inequality gap has been narrowing whereas the England average has been widening. Although the gap in life expectancy is narrower for females (8.0 years), the gap has been widening in recent years, which is following the average trend for England.

3.5.2 **Healthy life expectancy at birth**:
Males – **Significantly worse**, **no significant change**
Females - **Significantly worse**, **no significant change**

Healthy life expectancy is the average number of years a person would expect to live in good health. It is an important summary measure of the health and wellbeing of a population on its own, and also when combined with other information, for example on life expectancy. The measure of good health is derived from responses to a survey question on general health from the Annual Population Survey.

Latest available data on healthy life expectancy shows that healthy life expectancy has continued to fall for males but has risen for females. In 2016-18 healthy life expectancy at birth in males fell to 60.1 years in Bradford District, the lowest recorded and remains below the average for England (63.4 years). For females, healthy life expectancy at birth increased to 60.0 years in 2016-18 but remains below the average for England (63.9 years).

3.5.3 **Disability-free life expectancy at birth**:
Males – **Significantly worse**, **no significant change**
Females – **Not significantly different**, **no significant change**

This new overarching has been introduced to provide more information on healthy ageing to complement the existing PHOF indicator on healthy life expectancy. It is a measure of the average number of years a person would expect to live without a long lasting physical or mental health condition or disability that limits daily activities.

As this is a new data set only three years of data is currently available. Latest figures show males can expect 60.8 years of disability free life compared to an England average of 62.9 years. This value is the same for females, though nationally this figure is lower (61.9 years). For both males and females this value is generally higher than our statistical neighbours.

3.6 **Wider determinants of health:** The wider determinants or social determinants of health are a range of social, economic and environmental factors which influence health and wellbeing. As defined by Public Health England, they determine the extent to which people have the physical, social and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances. There are 24 indicators in the PHOF which relate to the wider determinants of

health.

3.6.1 **Child poverty (**proportion of children in absolute low income families)
Significantly worse, **no significant change**

Childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy. There is also a wide variety of evidence to show that children who live in poverty are exposed to a range of risks that can have a serious impact on their mental health.

The indictor on child poverty has changed and is now based on the proportion of children in absolute low income families. Absolute low income is defined as a family in low income Before Housing Costs (BHC) in the reference year in comparison with incomes in 2010/11. A family must have claimed one or more of Universal Credit, Tax Credits or Housing Benefit at any point in the year to be classed as low income in these statistics.

Bradford District has one of the highest proportions of child poverty in the country, with 30.4% of children in absolute low income families compared to the England average of 15.3%.

3.6.2 **Fuel poverty**
Significance not tested, **no significant change**

Fuel poverty exists when a household cannot afford to heat their home to an adequate level. The drivers of fuel poverty (low income, poor energy efficiency, and energy prices) are strongly linked to cold homes, with evidence showing that living in cold homes is associated with poor health outcomes and an increased risk of morbidity and mortality for all age groups. Fuel poverty in the district has been falling each year since 2015 and is currently at its lowest level recorded (12.4% in 2018). However fuel poverty remains above the average for England (10.3%).

The District's fuel poverty response includes a yearly Warm Homes-Healthy People programme from October to March. This is co-ordinated by a lead provider who triages referrals and c-ordinates practical support through 4-5 local organisations. The programme provides people living in fuel poverty with energy checks, minor repairs and measures to reduce heat loss and draughts, emergency heaters, debt advice, income maximisation (through support to switch providers and claim applicable grants and benefits) and with food, bedding and clothing in crisis situations.

3.6.3 **16-17yr olds not in education, employment or training (NEET)**
Significantly worse, **no significant change**

Young people who are not in education, employment or training are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood. Latest data (2018) shows 6.1% of 16-17yr

olds in Bradford District are not in education, employment or training compared to 5.5% nationally.

3.6.4 **Domestic abuse related incidents and crimes**
Significance not tested, **trend data not calculated**

Tackling domestic abuse as a public health issue is vital for ensuring that some of the most vulnerable people in our society receive the support, understanding and treatment they deserve. Values for this indicator are allocated a value based on the police force area they are part of. West Yorkshire has one of the highest Domestic abuse related incidents and crimes rates in England; 38.9 incidents per 1,000 population compared to an England average of 27.4 incidents per 1,000 population.

3.6.5 **Social isolation – adult social care users**
Not significantly different, **no significant change**

There is a link between loneliness and poor mental and physical health and tackling loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family will help to improve this. This has been slowly improving both in Bradford District and nationally, with 48.6% of adult social care users in in Bradford District feeling as though they have had as much social contact as they want, compared to the England average of 45.9%.

3.6.6 **Utilisation of outdoor space for exercise / health reasons**
Not significantly different, **no significant change**

There is strong evidence to suggest that green spaces have a beneficial impact on physical and mental wellbeing and cognitive function through both physical access and usage. Data is based on the Monitor of Engagement with the Natural Environment (MENE) survey and shows that 12.4% of Bradford District residents spend some time out doors for exercise or health reasons compared to the England average of 17.9%

3.6.7- **Children achieving a good level of development at the end of Reception**
Significantly worse, **significantly increasing**
Children from poorer backgrounds are more at risk of poorer development and the evidence shows that differences by social background emerge early in life. School readiness in Reception aged children has been increasing year on year both in Bradford District and generally in England. In Bradford District 68.0% (the highest value recorded) of children are achieving a good level of development at the end of Reception, compared to the England average of 71.8%

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

3.7.1 **Child excess weight**

Reception – **Not significantly different, no significant change**
Year 6 - **Significantly worse**, **significantly increasing**

All children are weighed and measured in reception and year 6 as part of the National Childhood Measurement Programme. The proportion of reception aged children who are either overweight or obese has fluctuated over time but has generally remained below or in line with the England average. The most recent measurement shows the increasing but remaining below the average for England. In 2019/20 the value for Bradford District rose to 22.3% from 21.9% in 2018/19.

The increase between reception and year 6 remains. After reducing last year the proportion of children in year 6 who are overweight or obese increased again to 40.8% in 2019/20. This is following the national trend where the England average increased to 35.2%. Bradford has the highest proportion of children in year 6 who are overweight or obese in the region.

3.7.2 **Smoking prevalence in adults**

Not significantly different, no significant change

Although smoking prevalence in adults remains high in the District, improvement continues. In 2019, the proportion of the population smoking fell to 16.5%, which is the lowest level recorded in Bradford District, and compares to 22.8% in 2013. Prevalence remains above the average for England, which was 13.9% in 2019.

Public Health continues to commission and provide stop smoking advice and support, currently through the integrated Living Well Service. In a bid to reduce health inequalities, a comprehensive smoking cessation needs analysis was conducted in 2020 which helped to identify and assess where effective action should be taken. Key findings highlighted that health inequalities are disproportionately experienced by high risk groups living in deprived areas. New referral pathways have since been developed that prioritises high prevalence groups, such as routine and manual workers, who are at greater risks of tobacco-related harm. More work is underway with our maternity services to further understand barriers to service uptake, particularly across BAME groups.

3.7.3 **Cancer Screening uptake**

Bowel Cancer – **Significantly worse**, **significantly increasing**
Breast Cancer – **Significantly worse**, **significantly decreasing**
Cervical Cancer - **Significantly worse**, **significantly decreasing**

Screening is important because it helps identify people with some types of cancer in its earliest stages. There are three indicators relating to screening

uptake in the PHOF (breast cancer, cervical cancer and bowel cancer). Screening uptake has been a challenge in the District for many years. The District performs worse than England on all three of these indicators, however improvement has been seen in all screening types in the last year.

The screening programme providers continue to work with NHS England, CBMDC Public Health department and the various stakeholders to promote the screening programmes locally. The local Screening BAME sub group is also working to improve engagement and awareness within the hard to reach communities across the Bradford area.

3.8 **Health protection**: There are 28 indicators included in the health protection domain, which includes the control of infectious diseases through a number of different vaccinations. There are a number of indicators relating to immunisations where, although the District performs either better or similar to the average for England, over recent years uptake has been falling. These include:

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

2 year olds; one dose – **Significantly worse**, **significantly decreasing**
5 year olds; one dose – **Not significantly different**, **significantly decreasing**
5 year olds; two doses – **Significantly worse**, **no significant change**

The MMR is offered as part of the childhood immunisation programme. Children receive the first dose at 12/13 months and a second dose as part of the pre-school booster. There are three indicators relating to MMR – MMR for one dose (two year olds), MMR for one dose (five year olds) and MMR for two doses (five year olds). It is recommended that all children receive two doses for maximum protection. Uptake is below the average for two year olds but is above the England average for five year olds

In 2019/20, 89.9% (90.6% for England) of two year olds had received one dose of the MMR; this compares to 94.6% in 2013/14. Of all five year olds, 95.0% received one dose of the MMR in 2019/20 (94.5% for England) compared to 97.2% in 2013/14. The proportion of children had received two doses of the MMR at age five also fell – 89.6% (86.8% for England) compared with 93.2% in 2013/14

3.8.2 **Dtap / IPV / Hib vaccination**

One year old – **Not significantly different**, **significantly decreasing**
Two year old – **Not significantly different**, **significantly decreasing**

The combined DTaP/IPV/Hib is the first in a course of vaccines offered to babies to protect against diphtheria, pertussis (whooping cough), tetanus, Haemophilus influenzae type b (an important cause of childhood meningitis and pneumonia) and polio (IPV is inactivated polio vaccine).

Uptake of vaccination for both the one year old and two year old Dtap / IPV / Hib vaccination fell in 2019/20 where uptake was 91.8% for one year olds and 93.2% for two year olds. Uptake is below the average for England for

both ages.

3.8.3 Flu vaccination

2-3 year olds – **Significantly worse**, **no significant change**
Primary school – **Significantly worse**, **trend data not calculated**
At risk individuals – **Significantly worse**, **no significant change**
Aged 65+ – **Significantly worse**, **no significant change**

The seasonal flu vaccination programme covers a number of population groups, including children, the over 65s and at risk individuals. Flu vaccination coverage is below the England average for 2-3 year olds, primary school aged children and for at risk individuals but is above the England average for the over 65s.

With respect to all the above immunisations, Public Health continue to work with local stakeholders to improve uptake of immunisations across the our area. Through the NHS England Screening and Immunisation Operational Group there is a sustained local focus on promoting immunisation uptake and ensuring access to immunisations despite the restrictions which have been in place as a result of the current Coronavirus pandemic.

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

3.9.1 **Premature mortality due to cancer, respiratory and cardiovascular conditions**

Cancer – **Significantly worse**, **no significant change**
Respiratory – **Significantly worse**, **no significant change**
Cardiovascular – **Significantly worse**, **no significant change**

The main causes of early death in under 75 year olds are circulatory disease (including heart disease and stroke), cancer and respiratory disease. These conditions can be linked to a variety of different factors including people's lifestyle and wider determinants of health including economic, social and environmental factors which can impact a person's health. The District has followed national trends in seeing a general decline in premature morality rates in general; however rates have remained above the average for England for all three of these indicators.

3.9.2 **Infant mortality**
Significantly worse, **no significant change**

The high levels of infant mortality have long been recognised in the District. Whilst substantial progress has been made over the last decade, the infant mortality rate remains higher than in England (6.1 per 1,000 live births compared to 3.9 per 1,000 live births in England). After year on year decreases since 2001-2003, the infant mortality rate has remained relatively static for the last five years. There is, however, variation across the District, with rates remaining highest in the most deprived areas of the District.

Work led by the Every Baby Matters Steering Group to reduce the risk of babies dying during the first year of life continues, focusing on the three main causes of infant mortality; genetics, nutrition and maternal smoking. Reducing infant mortality continues to be a priority work programme for the District and working towards this target is recognised within the Bradford District Partnership, Children's Trust and Children and Young People's Plan, and within the three CCGs strategies and plans.

3.9.3 **Premature mortality in adults with a severe mental illness (SMI)**
Significantly worse, **trend data not calculated**

People with a long-standing mental health problem are twice as likely to smoke, with the highest rates among people with psychosis or bipolar disorder and are more likely to suffer from a long-term condition. In 2015-17 the premature mortality rate in adults with a severe mental illness was 102.8 deaths per 100,000 population compared to the England average of 90.5 deaths per 100,000 population.

3.9.4 **Suicide rate**
Not significantly worse, no significant change

Although latest data shows an increase on the previous year (both for the district and nationally), for the last 4 years Bradford's suicide rate has remained below the average for England. The rate for 2017-19 for Bradford District was 9.4 deaths per 100,000 compared to 10.1 for England. Bradford also has the lowest suicide rate in the region. Real time surveillance data from West Yorkshire Police of suspect suicides shows there were 54 suspected suicides recorded, up from 44 in the previous year. Due to the small numbers involved is and we will need to wait for next year's data to see if this is a local issue or more of a national problem.

4. FINANCIAL & RESOURCE APPRAISAL

4.1 Tackling public health issues requires long term commitment and investment. Much of this already exists and is directed towards activity which will positively influence the indicators in the PHOF. There are no financial issues arising from this PHOF performance report.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

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

6. LEGAL APPRAISAL

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

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

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

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

7.2 SUSTAINABILITY IMPLICATIONS

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

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

7.3.1 Some of the indicators in the PHOF have a direct impact on reducing the impact of climate change. For example, actions taken to reduce fuel poverty aim to improve housing and heat/light and power systems for vulnerable households. These make

a direct difference for the occupants, creating warm and safer environments and in the process reduce carbon emissions from poor housing.

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

7.3.3 It is, however, important to recognise that energy and emissions can be linked with better standards of living - such as car ownership, domestic energy, good diet and flights abroad. Work needs to take place to ensure that improvements in wellbeing do not therefore automatically lead to increased carbon emissions.

7.4 COMMUNITY SAFETY IMPLICATIONS

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

7.5 HUMAN RIGHTS ACT

None

7.6 TRADE UNION

None

7.7 WARD IMPLICATIONS

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

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

N/A

7.9 IMPLICATIONS FOR CORPORATE PARENTING

N/A

7.10 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

None

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

9.1 That members examine and comment on the report content

10. RECOMMENDATIONS

That the Committee acknowledges the content of the report and seeks a further performance report on PHOF indicators in 2021

11. APPENDICES

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

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

12. BACKGROUND DOCUMENTS

Bradford Joint Strategic Needs Assessment https://jsna.bradford.gov.uk/

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Public Health England

Public Health Outcomes Framework - at a glance summary

Bradford

Key

Significance compared to goal / England average:

Significantly worse	Significantly lower	↑ Increasing / Getting worse	↑ Increasing / Getting better
Not significantly different	Significantly higher	↓ Decreasing / Getting worse	↓ Decreasing / Getting better
Significantly better	Significance not tested	↑ Increasing	↓ Decreasing
		→ No significant change	– Could not be calculated

Notes

- Indicators that are shaded blue rather than red/amber/green are presented in this way because it is not straightforward to determine for these indicators whether a high value is good or bad.
- In the change columns, prev refers to the change in value compared to the previous data point. Statistically significant changes highlighted in this column have been calculated by comparing the confidence intervals for the respective time points. If the confidence intervals do not overlap, the change has been flagged as significant.
- Recent trend refers to the analysis done in the Fingertips tool which tests for a statistical trend. Changes in this column are calculated using a chi-squared statistical test for trend. This is currently only available for certain indicator types; full details are available in the tool.
- Increases or decreases are only shown if they are statistically significant. Where no arrow is shown, no comparison has been made. This may be due to the fact that the required data to make the comparison is not available for the time point, or that no confidence interval values are available for the indicator.

A. Overarching indicators

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
A01a - Healthy life expectancy at birth	All ages	Male	2016 - 18	60.1	61.5	63.4	Years	-	→
A01a - Healthy life expectancy at birth	All ages	Female	2016 - 18	60.0	62.1	63.9	Years	-	→
A01b - Life expectancy at birth	All ages	Male	2017 - 19	78.0	78.8	79.8	Years	-	→
A01b - Life expectancy at birth	All ages	Female	2017 - 19	81.9	82.5	83.4	Years	-	→
A01c - Disability-free life expectancy at birth	All ages	Male	2016 - 18	60.8	61.0	62.9	Years	-	→
A01c - Disability-free life expectancy at birth	All ages	Female	2016 - 18	60.8	60.0	61.9	Years	-	→
A02a - Inequality in life expectancy at birth	All ages	Male	2016 - 18	9.10	10.4	9.50	Years	-	→
A02a - Inequality in life expectancy at birth	All ages	Female	2016 - 18	8.00	8.50	7.50	Years	-	→
A02c - Inequality in healthy life expectancy at birth LA	All ages	Male	2009 - 13	19.1	-	-	Years	-	-
A02c - Inequality in healthy life expectancy at birth LA	All ages	Female	2009 - 13	22.1	-	-	Years	-	-
A01a - Healthy life expectancy at 65	65	Male	2016 - 18	9.25	10.1	10.6	Years	-	→
A01a - Healthy life expectancy at 65	65	Female	2016 - 18	9.60	10.6	11.1	Years	-	→
A01b - Life expectancy at 65	65	Male	2017 - 19	17.8	18.4	19.0	Years	-	→
A01b - Life expectancy at 65	65	Female	2017 - 19	20.4	20.7	21.3	Years	-	→
A01c - Disability-free life expectancy at 65	65	Male	2016 - 18	8.08	8.98	9.90	Years	-	→
A01c - Disability-free life expectancy at 65	65	Female	2016 - 18	9.91	9.27	9.82	Years	-	→
A02a - Inequality in life expectancy at 65	65	Male	2016 - 18	5.10	5.20	5.00	Years	-	→
A02a - Inequality in life expectancy at 65	65	Female	2016 - 18	4.80	5.30	4.60	Years	-	→

B. Wider determinants of health

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
B01b - Children in absolute low income families (under 16s)	<16 yrs	Persons	2018/19	30.4	20.4	15.3	%	→	↑
B01b - Children in relative low income families (under 16s)	<16 yrs	Persons	2018/19	34.7	23.4	18.4	%	↑	↑
B02a - School readiness: percentage of children achieving a good level of development at the end of Reception	5 yrs	Persons	2018/19	68.0	70.0	71.8	%	↑	→
B02a - School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception	5 yrs	Persons	2018/19	55.4	54.1	56.5	%	→	→
B02b - School readiness: percentage of children achieving the expected level in the phonics screening check in Year 1	6 yrs	Persons	2018/19	80.9	80.2	81.8	%	↑	→
B02b - School readiness: percentage of children with free school meal status achieving the expected level in the phonics screening check in Year 1	6 yrs	Persons	2018/19	73.3	68.2	70.1	%	↑	→
B02c - School readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception	5 yrs	Persons	2018/19	81.4	82.1	82.2	%	↑	→
B02d - School readiness: percentage of children achieving at least the expected level of development in communication, language and literacy skills at the end of Reception	5 yrs	Persons	2018/19	68.4	70.6	72.6	%	↑	→
B03 - Pupil absence	5-15 yrs	Persons	2018/19	5.42	4.96	4.73	%	↑	→
B04 - First time entrants to the youth justice system	10-17 yrs	Persons	2018	330.3	244.7	238.5	per 100,000	↓	↓
B05 - 16-17 year olds not in education, employment or training (NEET) or whose activity is not known	16-17 yrs	Persons	2018	6.13	5.98	5.53	%	-	→
B06a - Adults with a learning disability who live in stable and appropriate accommodation	18-64 yrs	Persons	2018/19	86.3	79.5	77.4	%	→	→
B06b - Adults in contact with secondary mental health services who live in stable and appropriate accommodation	18-69 yrs	Persons	2018/19	72.0	70.0	58.0	%	-	→
B08a - Gap in the employment rate between those with a long-term health condition and the overall employment rate	16-64 yrs	Persons	2019/20	11.0	10.9	10.6	Percentage points	-	→
B08b - Gap in the employment rate between those with a learning disability and the overall employment rate	18-64 yrs	Persons	2018/19	63.9	68.0	69.7	Percentage points	-	→
B08c - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	18-69 yrs	Persons	2018/19	58.0	63.7	67.6	Percentage points	-	→
B08d - Percentage of people aged 16-64 in employment	16-64 yrs	Persons	2019/20	66.2	74.0	76.2	%	→	→
B09a - Sickness absence - the percentage of employees who had at least one day off in the previous week	16+ yrs	Persons	2017 - 19	1.72	2.07	2.08	%	-	→
B09b - Sickness absence - the percentage of working days lost due to sickness absence	16+ yrs	Persons	2017 - 19	1.00	1.18	1.09	%	-	→
B11 - Domestic abuse-related incidents and crimes	16+ yrs	Persons	2018/19	38.9 x	32.7	27.4	per 1,000	-	-
B12a - Violent crime - hospital admissions for violence (including sexual violence)	All ages	Persons	2016/17 - 18/19	64.6	54.3	44.9	per 100,000	-	→
B12b - Violent crime - violence offences per 1,000 population	All ages	Persons	2019/20	53.2 ~	37.8 ~	29.5 ~	per 1,000	↑	→
B12c - Violent crime - sexual offences per 1,000 population	All ages	Persons	2019/20	3.89 ~	3.00 ~	2.52 ~	per 1,000	↑	↓
B13a - Re-offending levels - percentage of offenders who re-offend	All ages	Persons	2017/18	31.0	30.8	29.1	%	-	-
B13b - Re-offending levels - average number of re-offences per re-offender	All ages	Persons	2017/18	4.57	4.27	4.05		-	-
B13c - First time offenders	10+ yrs	Persons	2018	249.2	204.4	210.7	per 100,000	↓	→

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
B14a - The rate of complaints about noise	All ages	Persons	**2018/19**	**4.44**	**6.43 @**	**6.83 @**	per 1,000	–	→
B14b - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	All ages	Persons	**2016**	**4.60**	**4.11**	**5.50**	%	–	–
B14c - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	All ages	Persons	**2016**	**5.83**	**6.48**	**8.48**	%	–	–
B16 - Utilisation of outdoor space for exercise/health reasons	16+ yrs	Persons	**Mar 2015 - Feb 2016**	**12.4 $**	**17.5**	**17.9**	%	–	→
B17 - Fuel poverty	Not applicable	Not applicable	**2018**	**12.4**	**10.1**	**10.3**	%	→	–
B18a - Social Isolation: percentage of adult social care users who have as much social contact as they would like	18+ yrs	Persons	**2018/19**	**48.6**	**48.0**	**45.9**	%	–	→
B18b - Social Isolation: percentage of adult carers who have as much social contact as they would like	18+ yrs	Persons	**2018/19**	**40.5**	**35.8**	**32.5**	%	–	→
1.01i - Children in low income families (all dependent children under 20)	0-19 yrs	Persons	**2016**	**23.8**	**19.5**	**17.0**	%	→	↑
1.10 - Killed and seriously injured (KSI) casualties on England's roads	All ages	Persons	**2016 - 18**	**34.3**	**49.1**	**42.6 ~**	per 100,000	–	–
1.15i - Statutory homelessness - Eligible homeless people not in priority need	Not applicable	Persons	**2017/18**	**0.45**	**1.04**	**0.79**	per 1,000	→	→
1.15ii - Statutory homelessness - households in temporary accommodation	Not applicable	Persons	**2017/18**	**0.56**	**0.38**	**3.40**	per 1,000	↑	↑

C. Health improvement

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
C01 - Total prescribed LARC excluding injections rate / 1,000	All ages	Female	2018	48.6	56.9	49.5	per 1,000	→	↓
C02a - Under 18s conception rate / 1,000	<18 yrs	Female	2018	18.4	19.6	16.7	per 1,000	↓	→
C02b - Under 16s conception rate / 1,000	<16 yrs	Female	2018	2.27	3.17	2.50	per 1,000	↓	→
C03a - Obesity in early pregnancy	Not applicable	Female	2018/19	24.1	24.0	22.1	%	–	–
C03c - Smoking in early pregnancy	Not applicable	Female	2018/19	16.5	17.4	12.8	%	–	–
C04 - Low birth weight of term babies	=37 weeks gestational age at birth	Persons	2018	4.16	3.14	2.86	%	→	→
C05a - Baby's first feed breastmilk	Newborn	Persons	2018/19	59.3	56.4	67.4	%	–	→
C06 - Smoking status at time of delivery	All ages	Female	2019/20	14.1	14.0 ~	10.4	%	→	→
C07 - Proportion of New Birth Visits (NBVs) completed within 14 days	<14 days	Persons	2018/19	99.3	85.7	88.8 [c]	%	–	→
C08a - Child development: percentage of children achieving a good level of development at 2-2½ years	2-2.5 yrs	Persons	2018/19	92.6	87.9	84.1 [c]	%	–	↑
C08b - Child development: percentage of children achieving the expected level in communication skills at 2-2½ years	2-2.5 yrs	Persons	2018/19	90.8	92.0	90.0 [c]	%	–	↓
C08c - Child development: percentage of children achieving the expected level in personal-social skills at 2-2½ years	2-2.5 yrs	Persons	2018/19	95.8	94.9	92.9 [c]	%	–	→
C09a - Reception: Prevalence of overweight (including obesity)	4-5 yrs	Persons	2019/20	22.3 ^	24.1	23.0	%	→	→
C09b - Year 6: Prevalence of overweight (including obesity)	10-11 yrs	Persons	2019/20	40.8 ^	35.8	35.2	%	↑	→
C10 - Percentage of physically active children and young people	5-16 yrs	Persons	2018/19	36.1	45.9	46.8	%	–	→
C11a - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	<15 yrs	Persons	2018/19	125.2	103.2	96.1	per 10,000	→	→
C11a - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	0-4 yrs	Persons	2018/19	162.5	127.0	123.1	per 10,000	→	→
C11b - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	15-24 yrs	Persons	2018/19	198.7	144.2	136.9	per 10,000	→	↑
C12 - Percentage of looked after children whose emotional wellbeing is a cause for concern	5-16 yrs	Persons	2018/19	32.3	40.6	38.6	%	–	→
C14b - Emergency Hospital Admissions for Intentional Self-Harm	All ages	Persons	2018/19	266.2	205.8	193.4	per 100,000	→	↑
C15 - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)	16+ yrs	Persons	2018/19	47.2	52.2	54.6	%	–	→
C16 - Percentage of adults (aged 18+) classified as overweight or obese	18+ yrs	Persons	2018/19	65.6	65.4	62.3	%	–	→
C17a - Percentage of physically active adults	19+ yrs	Persons	2018/19	62.4	66.2	67.2	%	–	→
C17b - Percentage of physically inactive adults	19+ yrs	Persons	2018/19	25.5	22.7	21.4	%	–	→
C18 - Smoking Prevalence in adults (18+) - current smokers (APS)	18+ yrs	Persons	2019	16.5	15.7	13.9	%	–	→
C19a - Successful completion of drug treatment - opiate users	18+ yrs	Persons	2018	3.73	4.70	5.82	%	→	↓
C19b - Successful completion of drug treatment - non-opiate users	18+ yrs	Persons	2018	27.8	29.6	34.4	%	→	↓
C19c - Successful completion of alcohol treatment	18+ yrs	Persons	2018	20.0	35.2	37.6	%	↓	↓
C19d - Deaths from drug misuse	All ages	Persons	2017 - 19	6.30	6.20	4.70	per 100,000	–	→
C20 - Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison	18+ yrs	Persons	2019/20	39.1	39.0	34.5	%	→	→
C21 - Admission episodes for alcohol-related conditions (Narrow)	All ages	Persons	2018/19	805.3	729.0	663.7	per 100,000	→	→

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
C22 - Estimated diabetes diagnosis rate	17+ yrs	Persons	2018	85.1	81.9	78.0	%	–	→
C24a - Cancer screening coverage - breast cancer	53-70 yrs	Female	2019	69.5	75.2 ~	74.5 ~	%	↓	↑
C24b - Cancer screening coverage - cervical cancer (aged 25 to 49 years old)	25-49 yrs	Female	2019	67.0	72.8 ~	69.8 ~	%	↓	→
C24c - Cancer screening coverage - cervical cancer (aged 50 to 64 years old)	50-64 yrs	Female	2019	76.8	77.8 ~	76.2 ~	%	↓	→
C24d - Cancer screening coverage - bowel cancer	60-74 yrs	Persons	2019	56.2	61.7 ~	60.1 ~	%	↑	→
C24e - Abdominal Aortic Aneurysm Screening - Coverage	65	Male	2018/19	81.2	83.5 ~	81.3 ~	%	→	→
C26a - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check	40-74 yrs	Persons	2015/16 - 19/20	75.0	78.9	87.7	%	–	
C26b - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	40-74 yrs	Persons	2015/16 - 19/20	48.0	45.9	47.1	%	–	→
C26c - Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check	40-74 yrs	Persons	2015/16 - 19/20	36.0	36.2	41.3	%	–	↓
C27 - Percentage reporting a long term Musculoskeletal (MSK) problem	18+ yrs	Persons	2020	18.0	19.9	18.5	%	–	→
C28a - Self-reported wellbeing - people with a low satisfaction score	16+ yrs	Persons	2018/19	5.01	5.11	4.29	%	–	→
C28b - Self-reported wellbeing - people with a low worthwhile score	16+ yrs	Persons	2018/19	- &	4.34	3.61	%	–	–
C28c - Self-reported wellbeing - people with a low happiness score	16+ yrs	Persons	2018/19	10.9	9.41	7.81	%	–	→
C28d - Self-reported wellbeing - people with a high anxiety score	16+ yrs	Persons	2018/19	21.4	20.6	19.7	%	–	→
C29 - Emergency hospital admissions due to falls in people aged 65 and over	65+ yrs	Persons	2018/19	2438	2105	2198	per 100,000	→	→
C29 - Emergency hospital admissions due to falls in people aged 65-79	65-79 yrs	Persons	2018/19	1246	997.9	1044	per 100,000	→	→
C29 - Emergency hospital admissions due to falls in people aged 80+	80+ yrs	Persons	2018/19	5897	5314	5543	per 100,000	→	→
2.02ii - Breastfeeding prevalence at 6-8 weeks after birth - current method	6-8 weeks	Persons	2018/19	42.3	- [b]	46.2 [c]	%	–	–
2.19 - Cancer diagnosed at early stage (experimental statistics)	All ages	Persons	2017	51.8	50.6	52.2	%	→	→

D. Health protection

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
D01 - Fraction of mortality attributable to particulate air pollution	30+ yrs	Persons	2018	4.60	4.48	5.15	%	–	–
D02a - Chlamydia detection rate / 100,000 aged 15 to 24	15-24 yrs	Persons	2019	1252 *	2200 *	2043 *	per 100,000	↓	→
D02b - New STI diagnoses (exc chlamydia aged <25) / 100,000	15-64 yrs	Persons	2019	576.9	644.4	900.3	per 100,000	↑	↑
D03c - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	1 yr	Persons	2019/20	91.8 *	93.6 *	92.6 *	%	↓	→
D03d - Population vaccination coverage - MenB (1 year)	1 yr	Persons	2019/20	91.4 *	93.8 *	92.5 *	%	–	→
D03e - Population vaccination coverage - Rotavirus (Rota) (1 year)	1 yr	Persons	2019/20	87.9 *	91.4 *	90.1 *	%	–	→
D03f - Population vaccination coverage - PCV	1 yr	Persons	2019/20	92.5 *	94.2 *	93.2 *	%	↓	→
D03g - Population vaccination coverage - Hepatitis B (2 years old)	2 yrs	Persons	2019/20	90.0	- [a]	- [a]	%	–	
D03h - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2 yrs	Persons	2019/20	93.2 *	95.3 *	93.8 *	%	↓	↓
D03i - Population vaccination coverage - MenB booster (2 years)	2 yrs	Persons	2019/20	88.3 *	91.2 *	88.7 *	%	–	↓
D03j - Population vaccination coverage - MMR for one dose (2 years old)	2 yrs	Persons	2019/20	89.9 *	92.6 *	90.6 *	%	↓	↓
D03k - Population vaccination coverage - PCV booster	2 yrs	Persons	2019/20	90.0 *	92.8 *	90.4 *	%	↓	↓
D03l - Population vaccination coverage - Flu (2-3 years old)	2-3 yrs	Persons	2019/20	27.0 *	39.7 ~ *	43.8 *	%	→	↓
D03m - Population vaccination coverage - Hib / MenC booster (2 years old)	2 yrs	Persons	2019/20	89.9 *	92.5 *	90.5 *	%	↓	↓
D04a - Population vaccination coverage - DTaP/IPV booster (5 years)	5 yrs	Persons	2019/20	89.3 *	88.9 *	85.4 *	%	↓	↓
D04b - Population vaccination coverage - MMR for one dose (5 years old)	5 yrs	Persons	2019/20	95.0 *	95.8 *	94.5 *	%	↓	↓
D04c - Population vaccination coverage - MMR for two doses (5 years old)	5 yrs	Persons	2019/20	89.6 *	89.8 *	86.8 *	%	→	↓
D04d - Population vaccination coverage - Flu (primary school aged children)	4-11 yrs	Persons	2019	44.9 *	60.8 ~ *	60.4 ~ *	%	–	–
D04e - Population vaccination coverage - HPV vaccination coverage for one dose (females 12-13 years old)	12-13 yrs	Female	2018/19	87.2 *	91.5 *	88.0 *	%	↓	↓
D04f - Population vaccination coverage - HPV vaccination coverage for two doses (females 13-14 years old)	13-14 yrs	Female	2018/19	88.6 *	88.4 *	83.9 *	%	–	→
D04g - Population vaccination coverage - Meningococcal ACWY conjugate vaccine (MenACWY) (14-15 years)	14-15 yrs	Persons	2018/19	79.0 *	89.5 *	86.7 *	%	–	↑
D05 - Population vaccination coverage - Flu (at risk individuals)	6 months-64 yrs	Persons	2019/20	42.2 *	45.0 ~ *	44.9 *	%	→	↓
D06a - Population vaccination coverage - Flu (aged 65+)	65+ yrs	Persons	2019/20	72.7 *	73.8 ~ *	72.4 *	%	→	→
D06b - Population vaccination coverage - PPV	65+ yrs	Persons	2019/20	74.0 *	71.2 *	69.0 *	%	↓	→
D06c - Population vaccination coverage - Shingles vaccination coverage (70 years old)	70	Persons	2017/18	44.2 *	46.8 *	44.4 *	%	–	–
D07 - HIV late diagnosis (%)	15+ yrs	Persons	2017 - 19	46.3 *	51.3 *	43.1 *	%	–	→
D08a - Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months	All ages	Persons	2018	83.1	88.7	83.6	%	→	→
D08b - TB incidence (three year average)	All ages	Persons	2017 - 19	14.4	6.41	8.58	per 100,000	–	→
D09 - NHS organisations with a board approved sustainable development management plan	Not applicable	Not applicable	2015/16	50.0	67.1	66.2	%	–	→
D10 - Adjusted antibiotic prescribing in primary care by the NHS	All ages	Persons	2019	0.96 *	1.00 *	0.95 *	per STAR-PU	–	↓

E. Healthcare and premature mortality

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
E01 - Infant mortality rate	<1 yr	Persons	2017 - 19	6.09	4.23	3.95	per 1,000	–	→
E02 - Percentage of 5 year olds with experience of visually obvious dental decay	5 yrs	Persons	2018/19	36.0	28.7	23.4	%	–	→
E04a - Under 75 mortality rate from all cardiovascular diseases	<75 yrs	Persons	2017 - 19	101.2	80.2	70.4	per 100,000	–	→
E05a - Under 75 mortality rate from cancer	<75 yrs	Persons	2017 - 19	137.6	137.5	129.2	per 100,000	–	→
E06a - Under 75 mortality rate from liver disease	<75 yrs	Persons	2017 - 19	21.5	19.9	18.5	per 100,000	–	→
E07a - Under 75 mortality rate from respiratory disease	<75 yrs	Persons	2017 - 19	48.0	41.2	34.2	per 100,000	–	→
E08 - Mortality rate from a range of specified communicable diseases, including influenza	All ages	Persons	2017 - 19	8.33	11.4	11.2	per 100,000	–	→
E09a - Premature mortality in adults with severe mental illness (SMI)	18-74 yrs	Persons	2015 - 17	102.8	-	90.5	per 100,000	–	–
E09b - Excess under 75 mortality rate in adults with severe mental illness (SMI)	18-74 yrs	Persons	2015 - 17	324.6	-	355.1	%	–	–
E10 - Suicide rate	10+ yrs	Persons	2017 - 19	9.35	12.0	10.1	per 100,000	–	→
E11 - Emergency readmissions within 30 days of discharge from hospital	All ages	Persons	2018/19	17.0	14.1	14.3	%	–	→
E12a - Preventable sight loss - age related macular degeneration (AMD)	65+ yrs	Persons	2018/19	68.0	130.7 ~	112.3	per 100,000	↓	→
E12b - Preventable sight loss - glaucoma	40+ yrs	Persons	2018/19	7.08	16.2 ~	13.2	per 100,000	→	→
E12c - Preventable sight loss - diabetic eye disease	12+ yrs	Persons	2018/19	1.82	4.01 ~	3.10	per 100,000	→	→
E12d - Preventable sight loss - sight loss certifications	All ages	Persons	2018/19	30.2	52.3 ~	43.4	per 100,000	↓	→
E13 - Hip fractures in people aged 65 and over	65+ yrs	Persons	2018/19	538.7	544.5	558.4	per 100,000	→	→
E13 - Hip fractures in people aged 65-79	65-79 yrs	Persons	2018/19	214.5	224.3	237.5	per 100,000	→	→
E13 - Hip fractures in people aged 80+	80+ yrs	Persons	2018/19	1479	1473	1489	per 100,000	→	→
E14 - Excess winter deaths index	All ages	Persons	Aug 2018 - Jul 2019	19.2	17.8	15.1	%	–	→
E14 - Excess winter deaths index (age 85+)	85+ yrs	Persons	Aug 2018 - Jul 2019	28.1	19.6	18.2	%	–	→
E15 - Estimated dementia diagnosis rate (aged 65 and over)	65+ yrs	Persons	2020	78.7 *	70.2 *	67.4 *	%	–	→

Accompanying indicator value notes

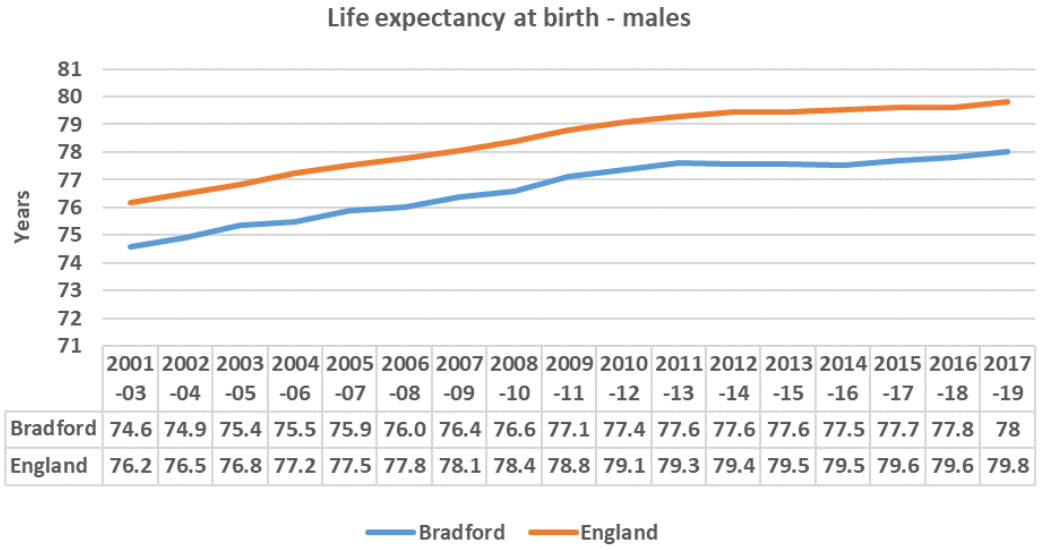
symbols	Data note
*	Value compared to a goal (see below)
~	Aggregated from all known lower geography values
$	Value based on effective sample size <100
^	Interpret with caution - see Notes section in Definitions for details
&	Value cannot be calculated as number of cases is too small
x	LAs are allocated the rate of the police force area within which they sit
@	Value is modelled or synthetic estimate
[a]	Value suppressed due to incompleteness of source data
[b]	Value not published for data quality reasons
[c]	Annual figure includes constituent area(s) with annual figure scaled up data from three quarters' data

Thresholds for indicators that are compared against a goal

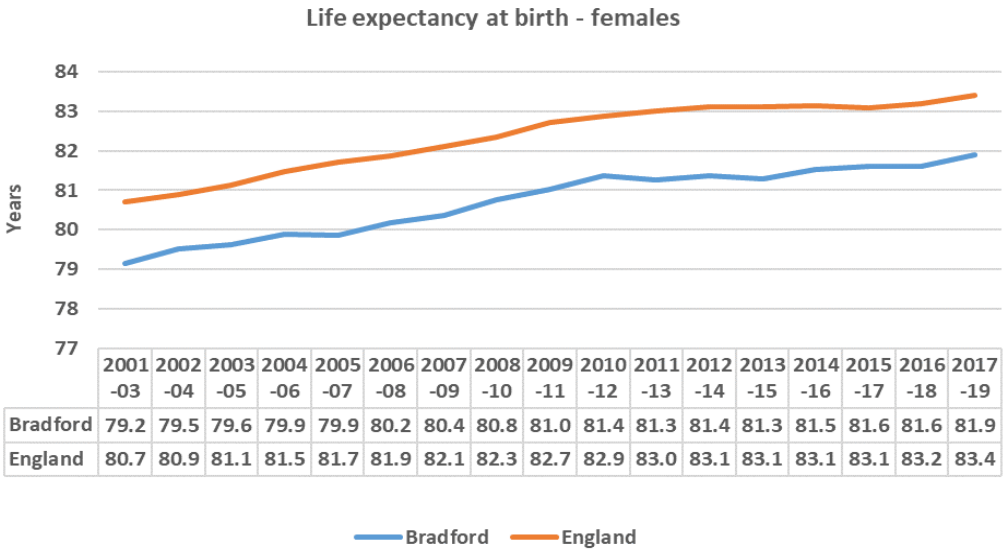
Indicator Name	Green	Amber	Red
D02a - Chlamydia detection rate / 100,000 aged 15 to 24	>= 2,300	1,900-2,300	< 1,900
D03c - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	>= 95%	90-95%	< 90%
D03d - Population vaccination coverage - MenB (1 year)	>= 95%	90-95%	< 90%
D03e - Population vaccination coverage - Rotavirus (Rota) (1 year)	>= 95%	90-95%	< 90%
D03f - Population vaccination coverage - PCV	>= 95%	90-95%	< 90%
D03h - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	>= 95%	90-95%	< 90%
D03i - Population vaccination coverage - MenB booster (2 years)	>= 95%	90-95%	< 90%
D03j - Population vaccination coverage - MMR for one dose (2 years old)	>= 95%	90-95%	< 90%
D03k - Population vaccination coverage - PCV booster	>= 95%	90-95%	< 90%
D03l - Population vaccination coverage - Flu (2-3 years old)	>= 65%	40-65%	< 40%
D03m - Population vaccination coverage - Hib / MenC booster (2 years old)	>= 95%	90-95%	< 90%
D04a - Population vaccination coverage - DTaP/IPV booster (5 years)	>= 95%	90-95%	< 90%
D04b - Population vaccination coverage - MMR for one dose (5 years old)	>= 95%	90-95%	< 90%
D04c - Population vaccination coverage - MMR for two doses (5 years old)	>= 95%	90-95%	< 90%
D04d - Population vaccination coverage - Flu (primary school aged children)	>= 65%		<65%
D04e - Population vaccination coverage - HPV vaccination coverage for one dose (females 12-13 years old)	>= 90%	80-90%	< 80%
D04f - Population vaccination coverage - HPV vaccination coverage for two doses (females 13-14 years old)	>= 90%	80-90%	< 80%
D04g - Population vaccination coverage - Meningococcal ACWY conjugate vaccine (MenACWY) (14-15 years)	>= 90%	80-90%	< 80%
D05 - Population vaccination coverage - Flu (at risk individuals)	>= 55%		< 55%
D06a - Population vaccination coverage - Flu (aged 65+)	>= 75%		< 75%
D06b - Population vaccination coverage - PPV	>= 75%	65-75%	< 65%
D06c - Population vaccination coverage - Shingles vaccination coverage (70 years old)	>= 60%	50-60%	< 50%
D07 - HIV late diagnosis (%)	< 25%	25-50%	>= 50%
D10 - Adjusted antibiotic prescribing in primary care by the NHS	<= mean England prescribing (2013/14)		> mean England prescribing (2013/14)
E15 - Estimated dementia diagnosis rate (aged 65 and over)	>= 66.7% (significantly)	Similar to 66.7%	< 66.7% (significantly)

Appendix B – Charts relating to specific indicators

3.5.1 Life expectancy at birth

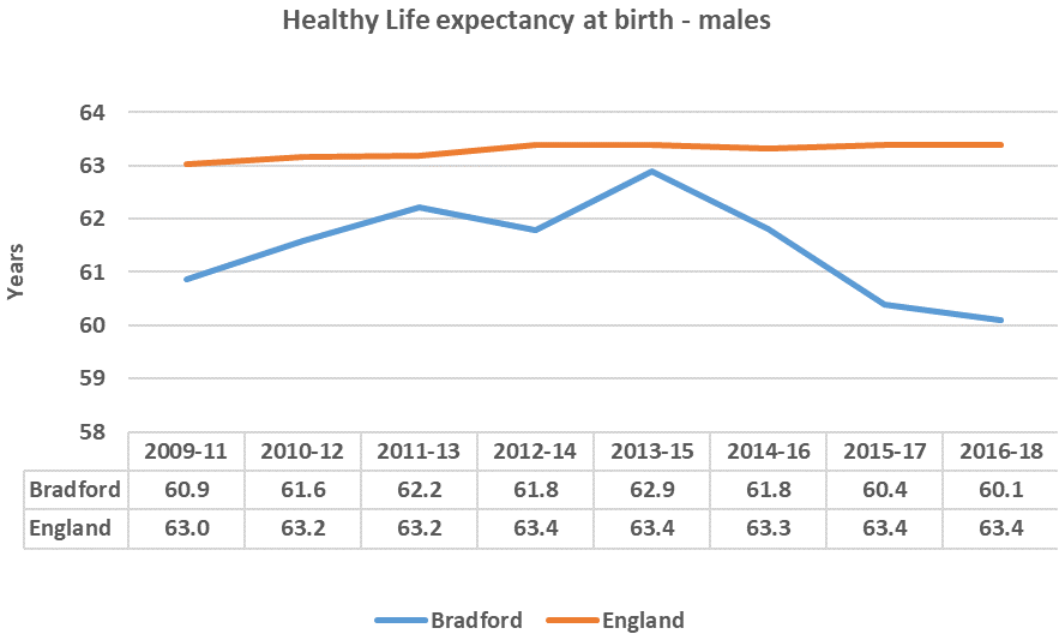


	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16	2015-17	2016-18	2017-19
Bradford	74.6	74.9	75.4	75.5	75.9	76.0	76.4	76.6	77.1	77.4	77.6	77.6	77.6	77.5	77.7	77.8	78
England	76.2	76.5	76.8	77.2	77.5	77.8	78.1	78.4	78.8	79.1	79.3	79.4	79.5	79.5	79.6	79.6	79.8

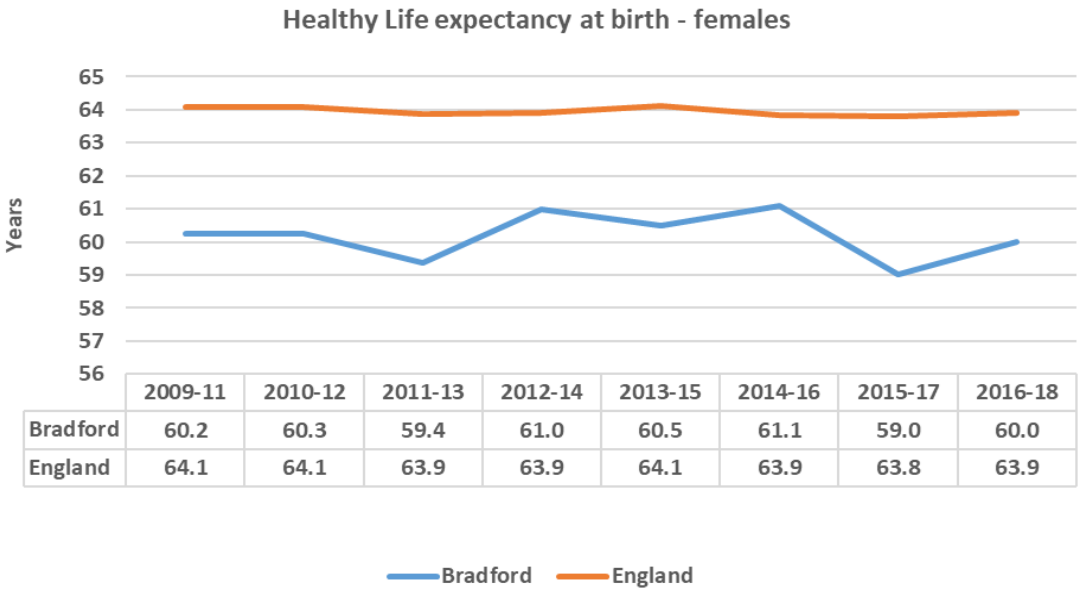


	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16	2015-17	2016-18	2017-19
Bradford	79.2	79.5	79.6	79.9	79.9	80.2	80.4	80.8	81.0	81.4	81.3	81.4	81.3	81.5	81.6	81.6	81.9
England	80.7	80.9	81.1	81.5	81.7	81.9	82.1	82.3	82.7	82.9	83.0	83.1	83.1	83.1	83.1	83.2	83.4

3.5.2 Healthy Life expectancy at birth

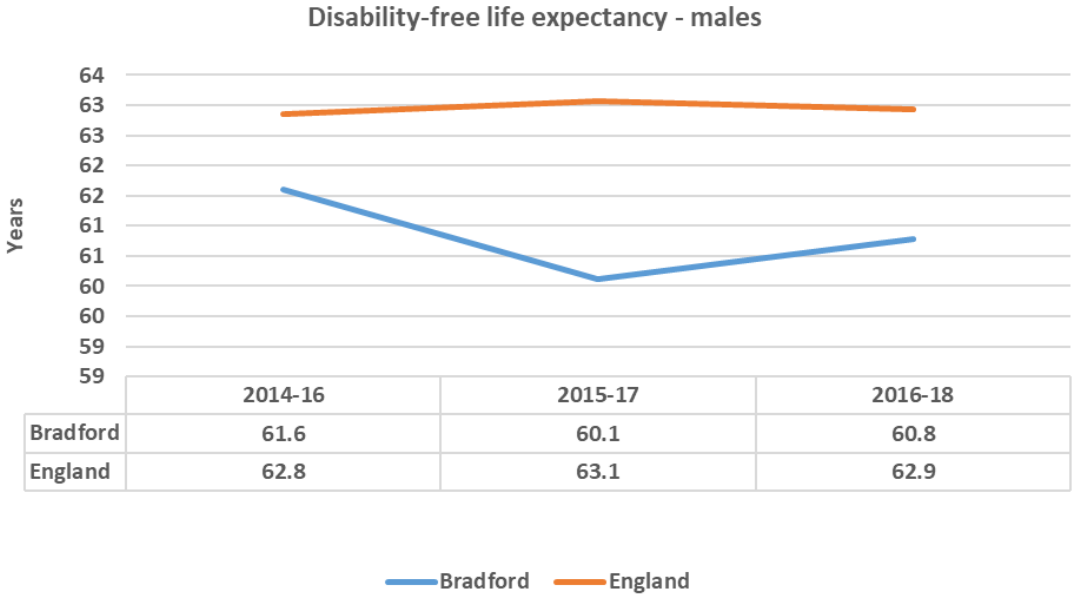


	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16	2015-17	2016-18
Bradford	60.9	61.6	62.2	61.8	62.9	61.8	60.4	60.1
England	63.0	63.2	63.2	63.4	63.4	63.3	63.4	63.4

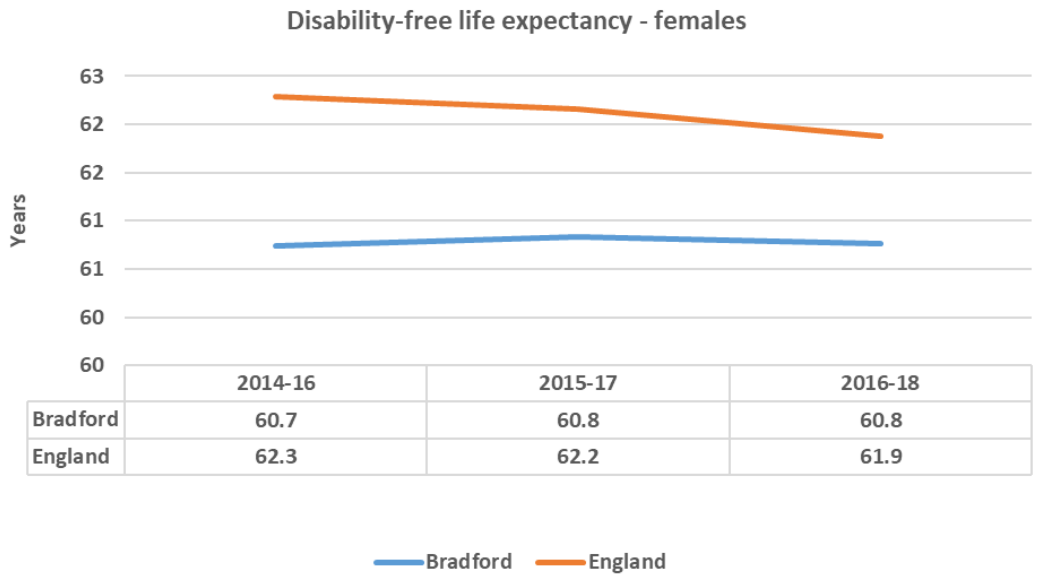


	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16	2015-17	2016-18
Bradford	60.2	60.3	59.4	61.0	60.5	61.1	59.0	60.0
England	64.1	64.1	63.9	63.9	64.1	63.9	63.8	63.9

3.5.3 Disability Free Life Expectancy

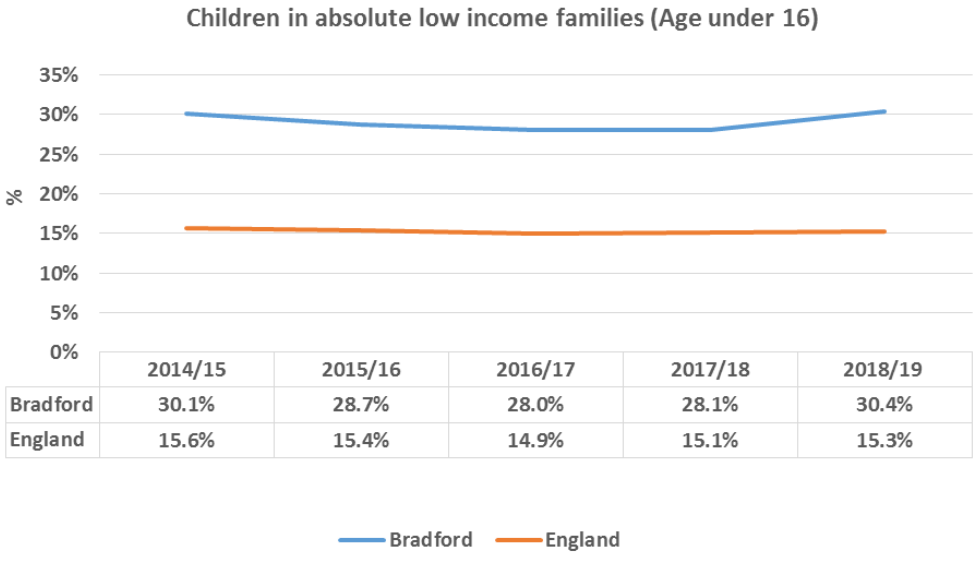


	2014-16	2015-17	2016-18
Bradford	61.6	60.1	60.8
England	62.8	63.1	62.9



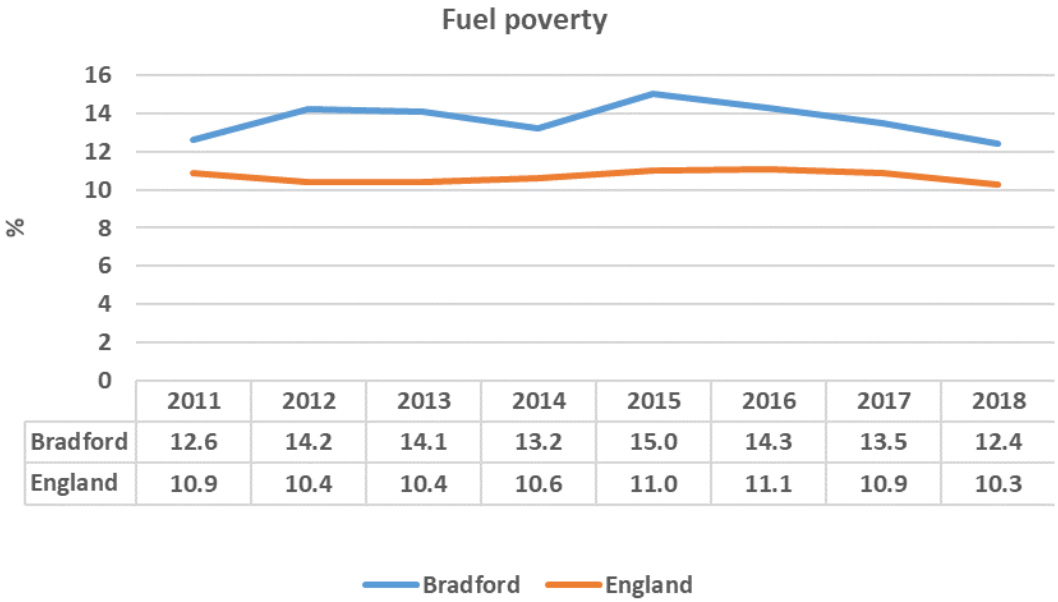
	2014-16	2015-17	2016-18
Bradford	60.7	60.8	60.8
England	62.3	62.2	61.9

3.6.1 Child Poverty



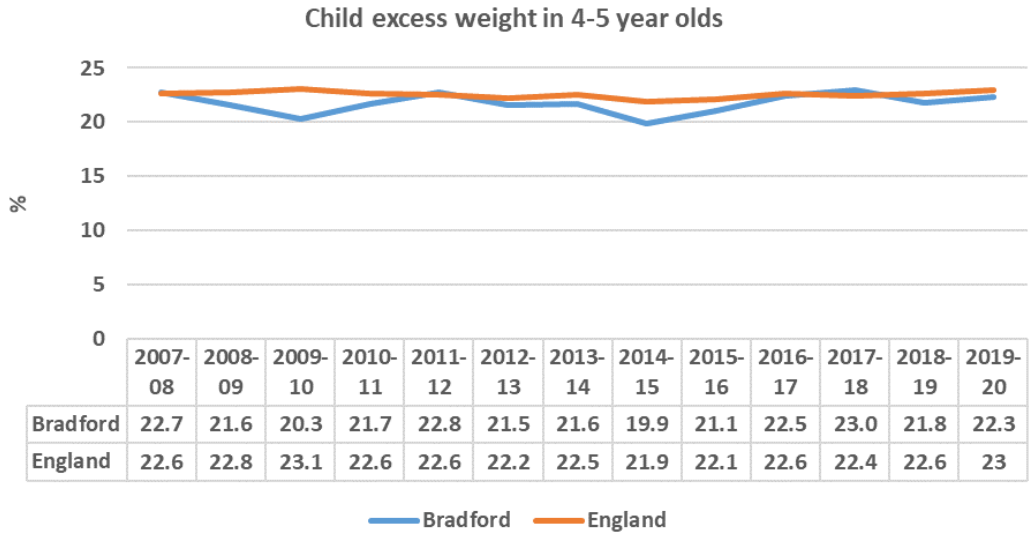
	2014/15	2015/16	2016/17	2017/18	2018/19
Bradford	30.1%	28.7%	28.0%	28.1%	30.4%
England	15.6%	15.4%	14.9%	15.1%	15.3%

3.6.2 Fuel poverty

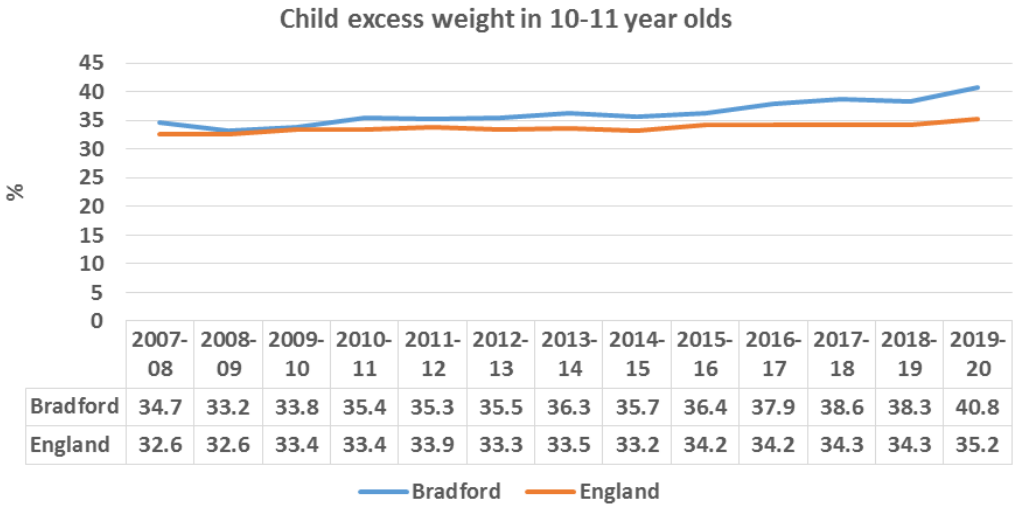


	2011	2012	2013	2014	2015	2016	2017	2018
Bradford	12.6	14.2	14.1	13.2	15.0	14.3	13.5	12.4
England	10.9	10.4	10.4	10.6	11.0	11.1	10.9	10.3

3.7.1 Child excess weight

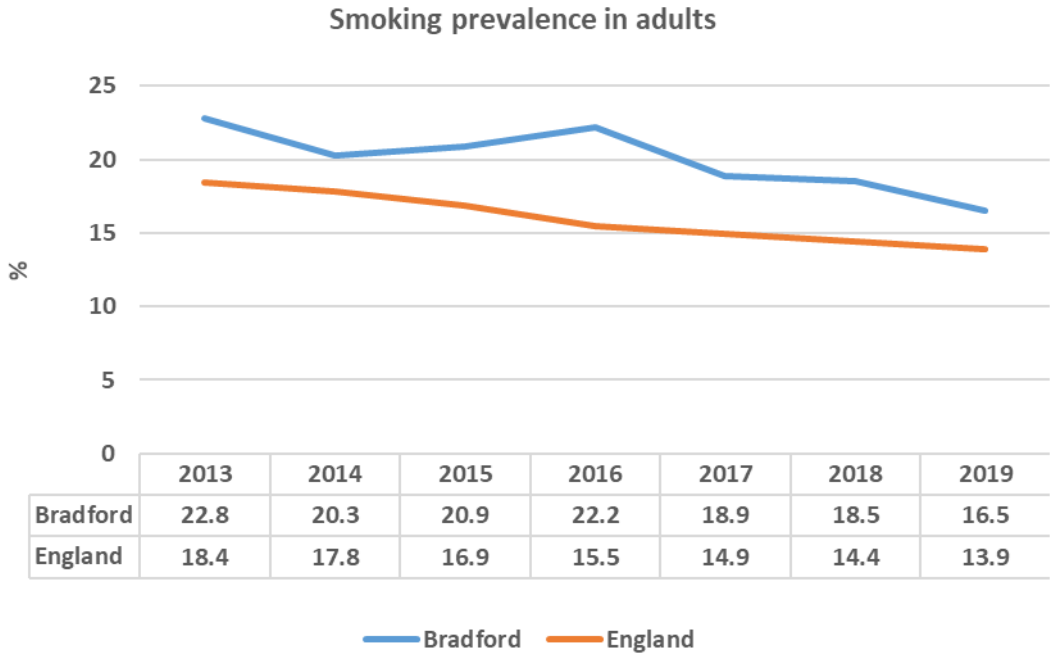


	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Bradford	22.7	21.6	20.3	21.7	22.8	21.5	21.6	19.9	21.1	22.5	23.0	21.8	22.3
England	22.6	22.8	23.1	22.6	22.6	22.2	22.5	21.9	22.1	22.6	22.4	22.6	23



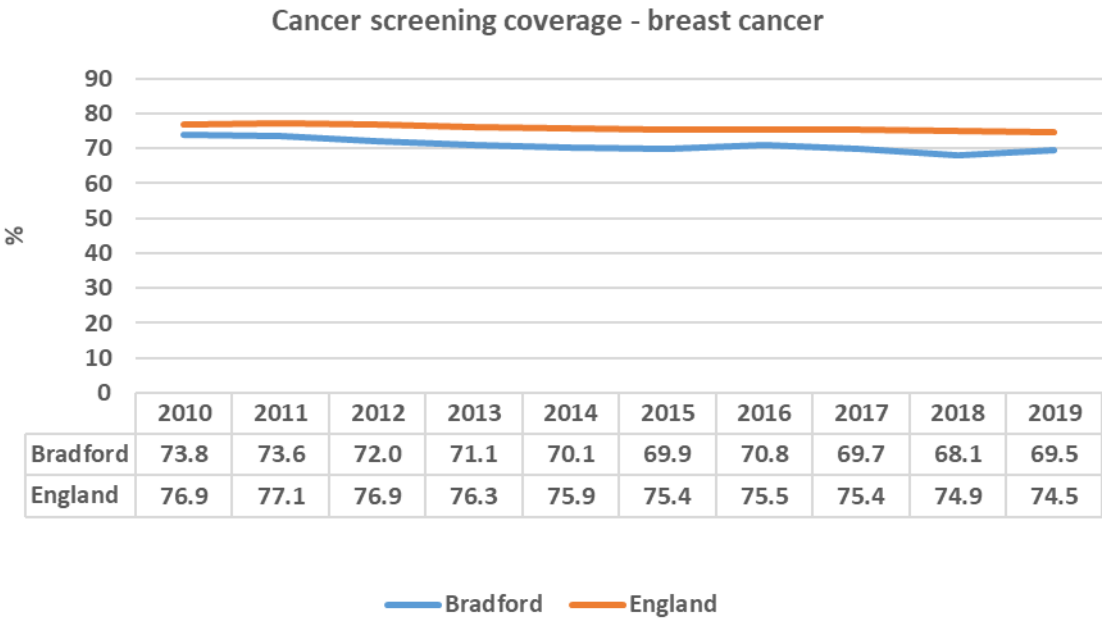
	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Bradford	34.7	33.2	33.8	35.4	35.3	35.5	36.3	35.7	36.4	37.9	38.6	38.3	40.8
England	32.6	32.6	33.4	33.4	33.9	33.3	33.5	33.2	34.2	34.2	34.3	34.3	35.2

3.7.2 **Smoking prevalence in adults**

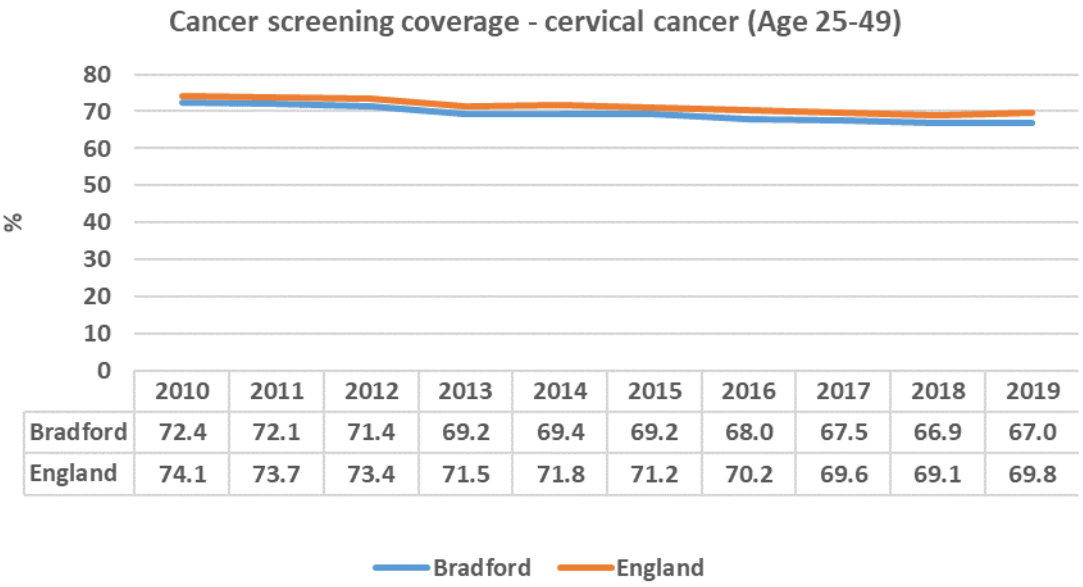


	2013	2014	2015	2016	2017	2018	2019
Bradford	22.8	20.3	20.9	22.2	18.9	18.5	16.5
England	18.4	17.8	16.9	15.5	14.9	14.4	13.9

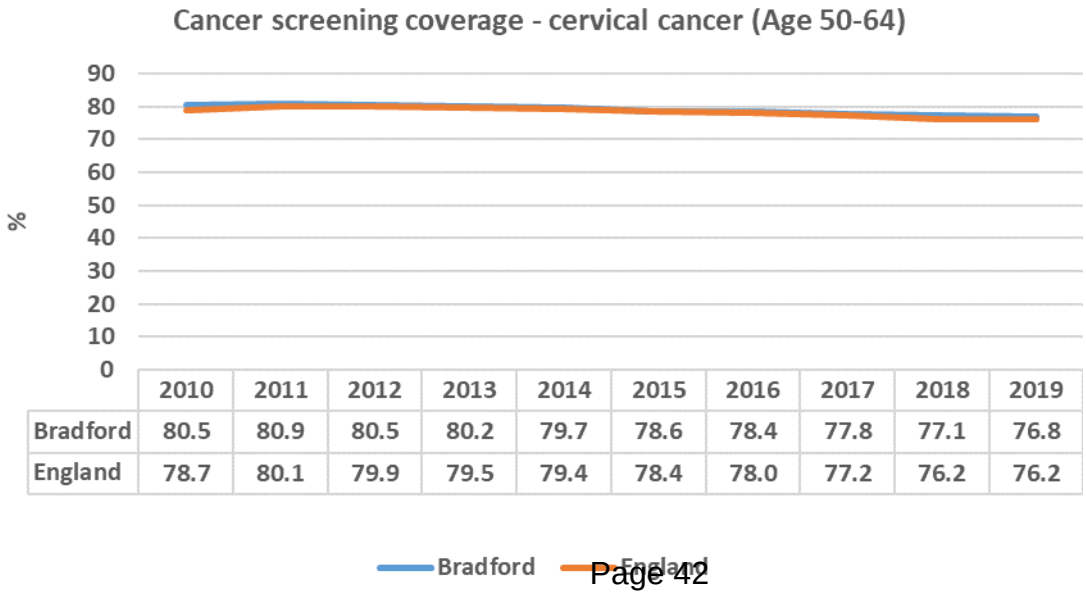
3.7.3 **Cancer Screening coverage**



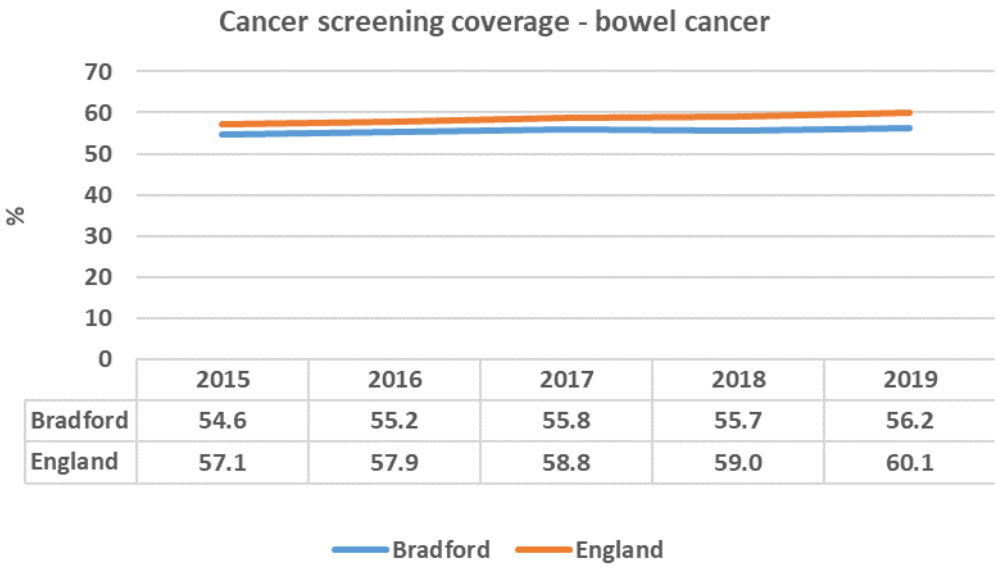
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Bradford	73.8	73.6	72.0	71.1	70.1	69.9	70.8	69.7	68.1	69.5
England	76.9	77.1	76.9	76.3	75.9	75.4	75.5	75.4	74.9	74.5



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Bradford	72.4	72.1	71.4	69.2	69.4	69.2	68.0	67.5	66.9	67.0
England	74.1	73.7	73.4	71.5	71.8	71.2	70.2	69.6	69.1	69.8

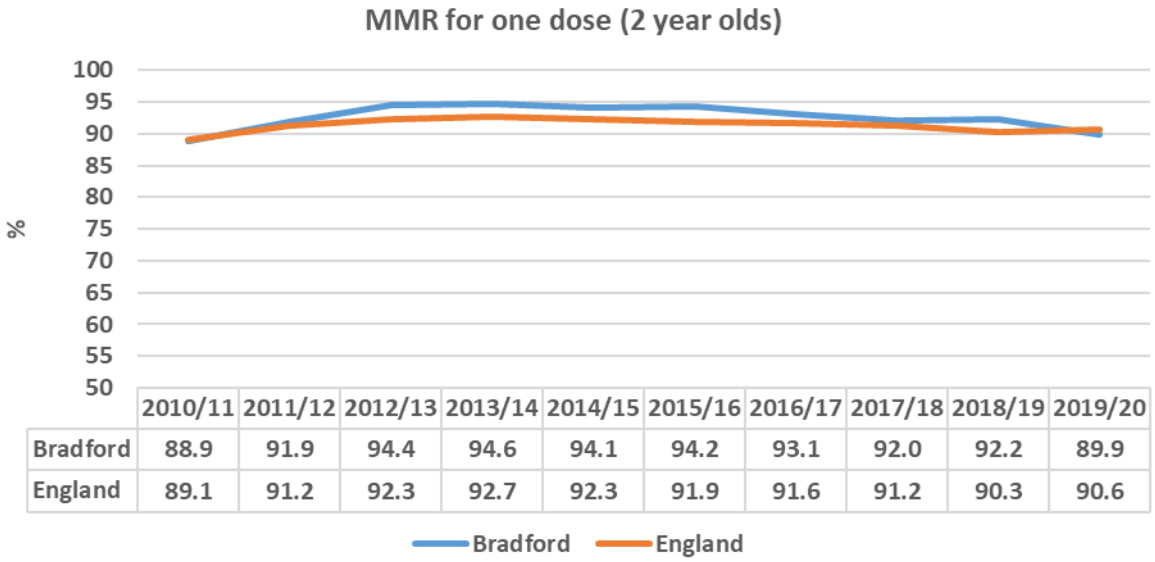


	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Bradford	80.5	80.9	80.5	80.2	79.7	78.6	78.4	77.8	77.1	76.8
England	78.7	80.1	79.9	79.5	79.4	78.4	78.0	77.2	76.2	76.2

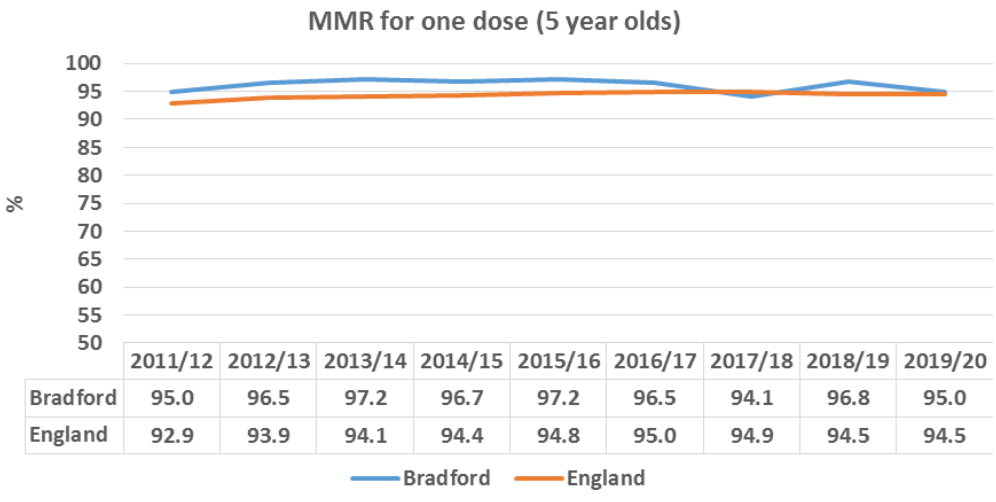


	2015	2016	2017	2018	2019
Bradford	54.6	55.2	55.8	55.7	56.2
England	57.1	57.9	58.8	59.0	60.1

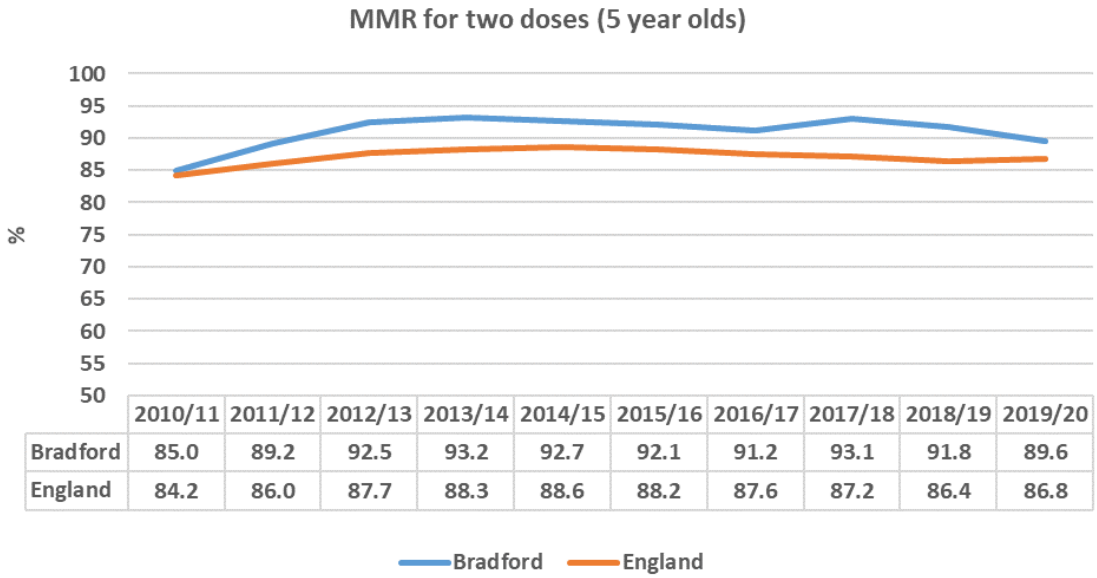
3.8.1 **Measles, mumps and rubella (MMR) vaccination**



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Bradford	88.9	91.9	94.4	94.6	94.1	94.2	93.1	92.0	92.2	89.9
England	89.1	91.2	92.3	92.7	92.3	91.9	91.6	91.2	90.3	90.6

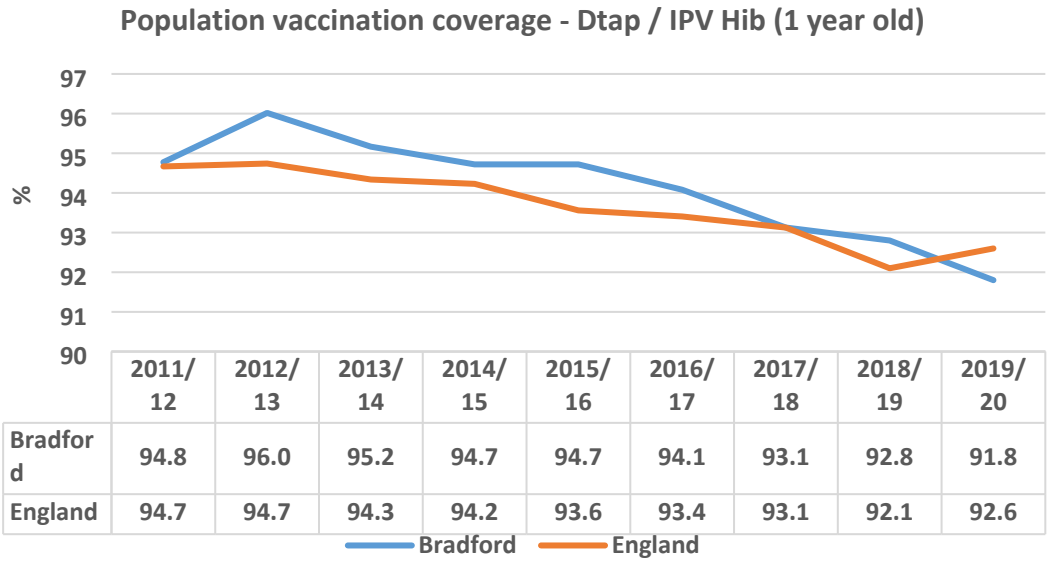


	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Bradford	95.0	96.5	97.2	96.7	97.2	96.5	94.1	96.8	95.0
England	92.9	93.9	94.1	94.4	94.8	95.0	94.9	94.5	94.5

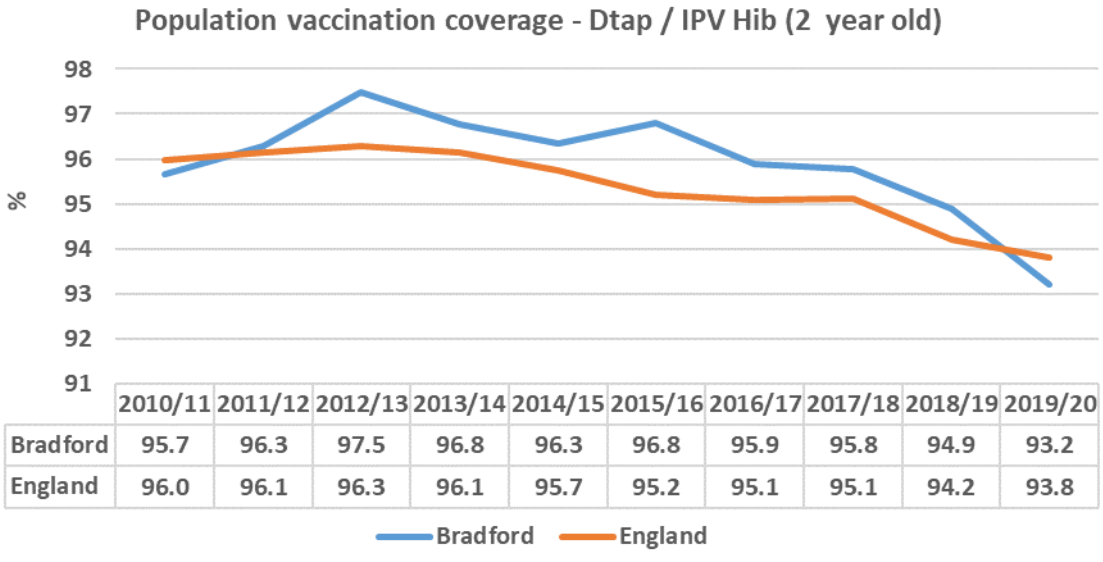


	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Bradford	85.0	89.2	92.5	93.2	92.7	92.1	91.2	93.1	91.8	89.6
England	84.2	86.0	87.7	88.3	88.6	88.2	87.6	87.2	86.4	86.8

3.8.2 Dtap / IPV / Hib vaccination

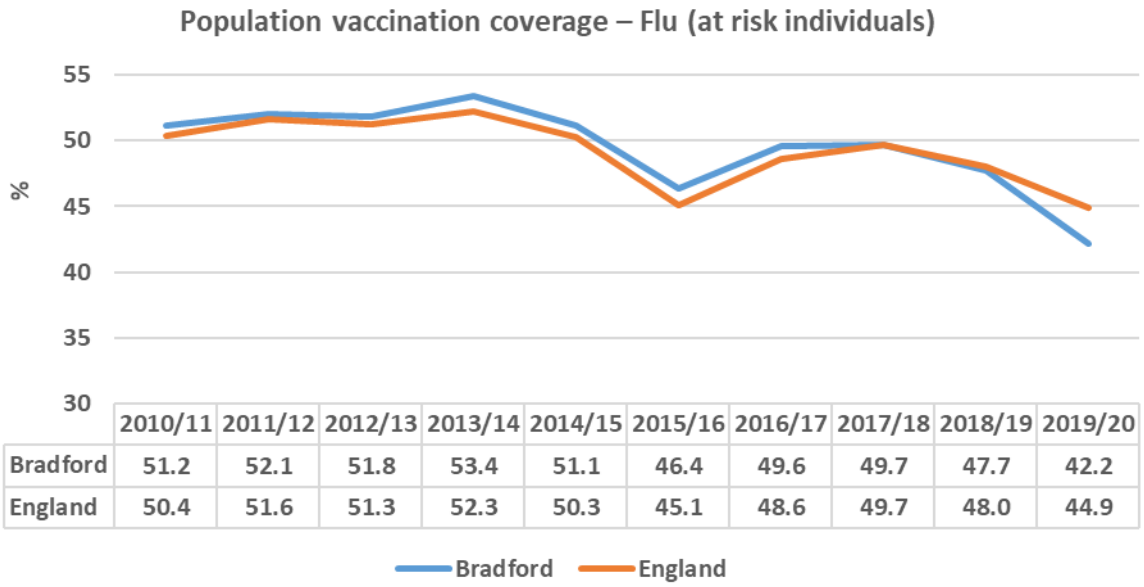


	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Bradford	94.8	96.0	95.2	94.7	94.7	94.1	93.1	92.8	91.8
England	94.7	94.7	94.3	94.2	93.6	93.4	93.1	92.1	92.6

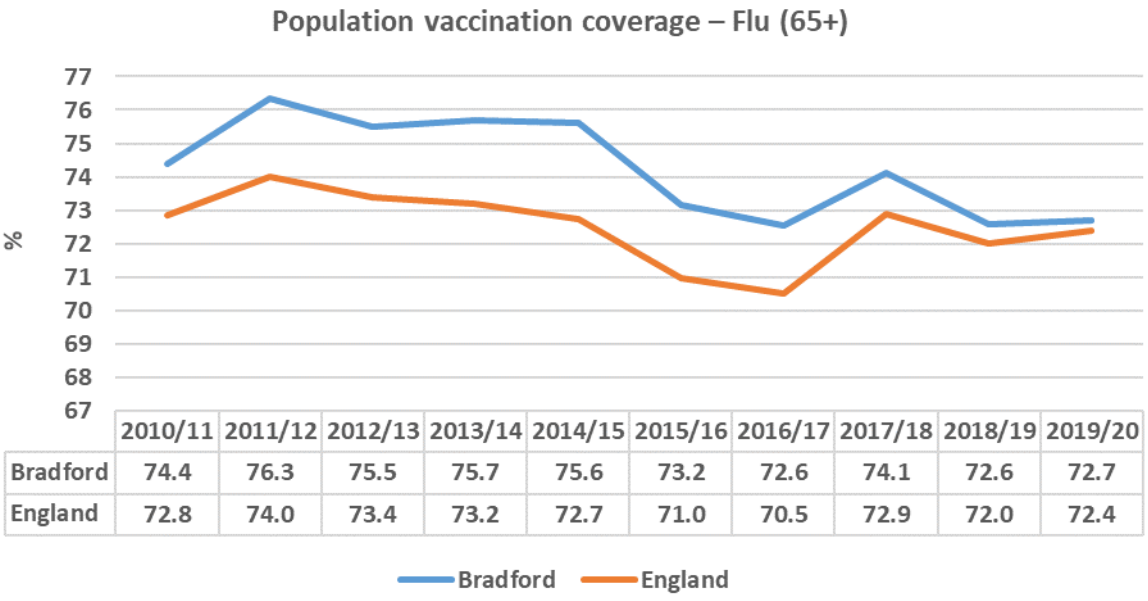


	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Bradford	95.7	96.3	97.5	96.8	96.3	96.8	95.9	95.8	94.9	93.2
England	96.0	96.1	96.3	96.1	95.7	95.2	95.1	95.1	94.2	93.8

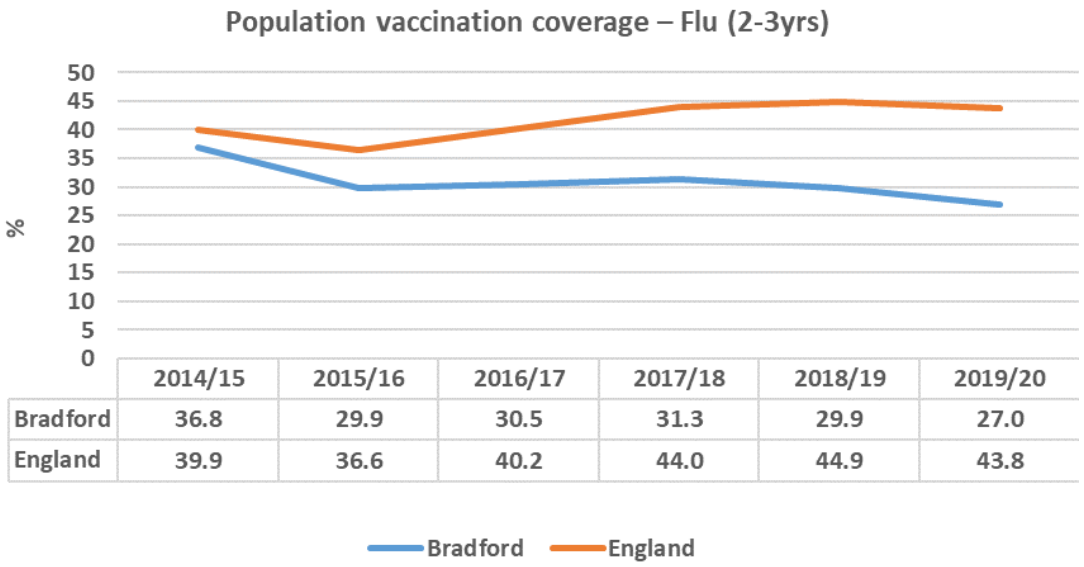
3.8.3 **Flu vaccination**



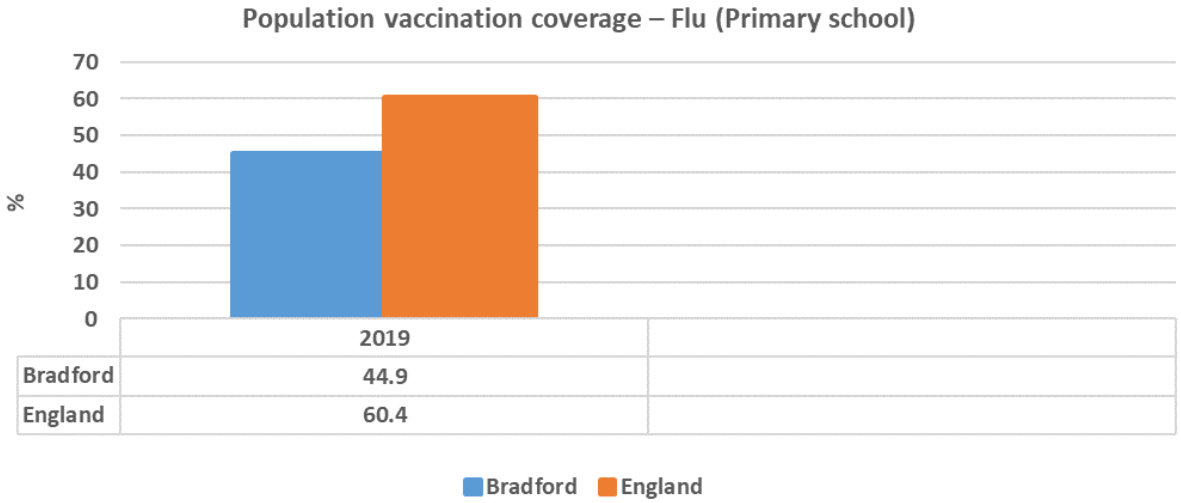
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Bradford	51.2	52.1	51.8	53.4	51.1	46.4	49.6	49.7	47.7	42.2
England	50.4	51.6	51.3	52.3	50.3	45.1	48.6	49.7	48.0	44.9



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Bradford	74.4	76.3	75.5	75.7	75.6	73.2	72.6	74.1	72.6	72.7
England	72.8	74.0	73.4	73.2	72.7	71.0	70.5	72.9	72.0	72.4

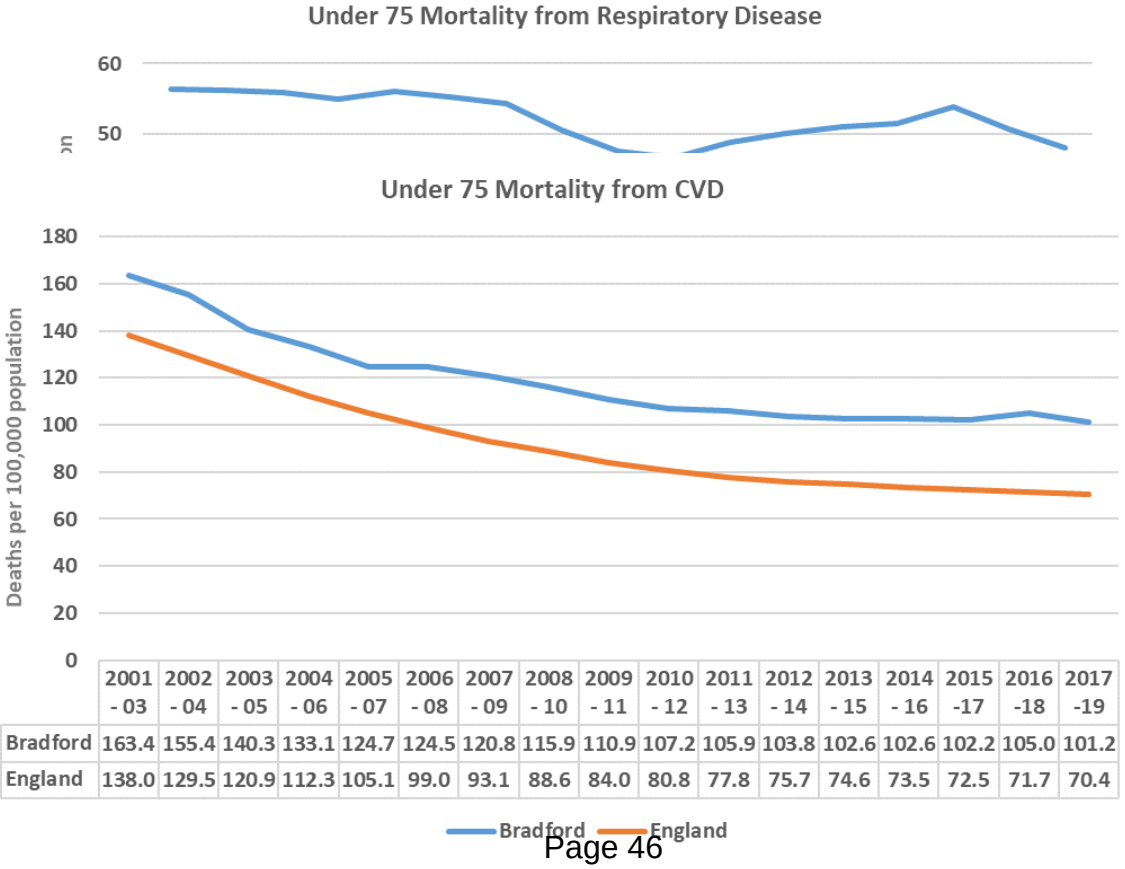


	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Bradford	36.8	29.9	30.5	31.3	29.9	27.0
England	39.9	36.6	40.2	44.0	44.9	43.8

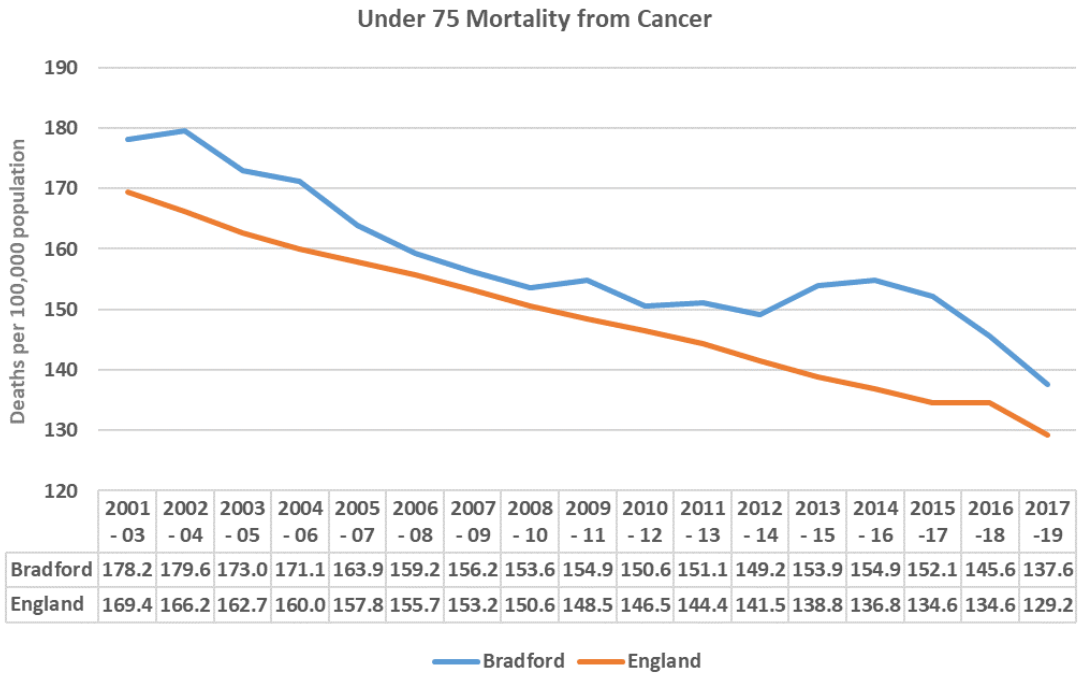


	2019	
Bradford	44.9	
England	60.4	

3.9.1 **Premature Mortality**

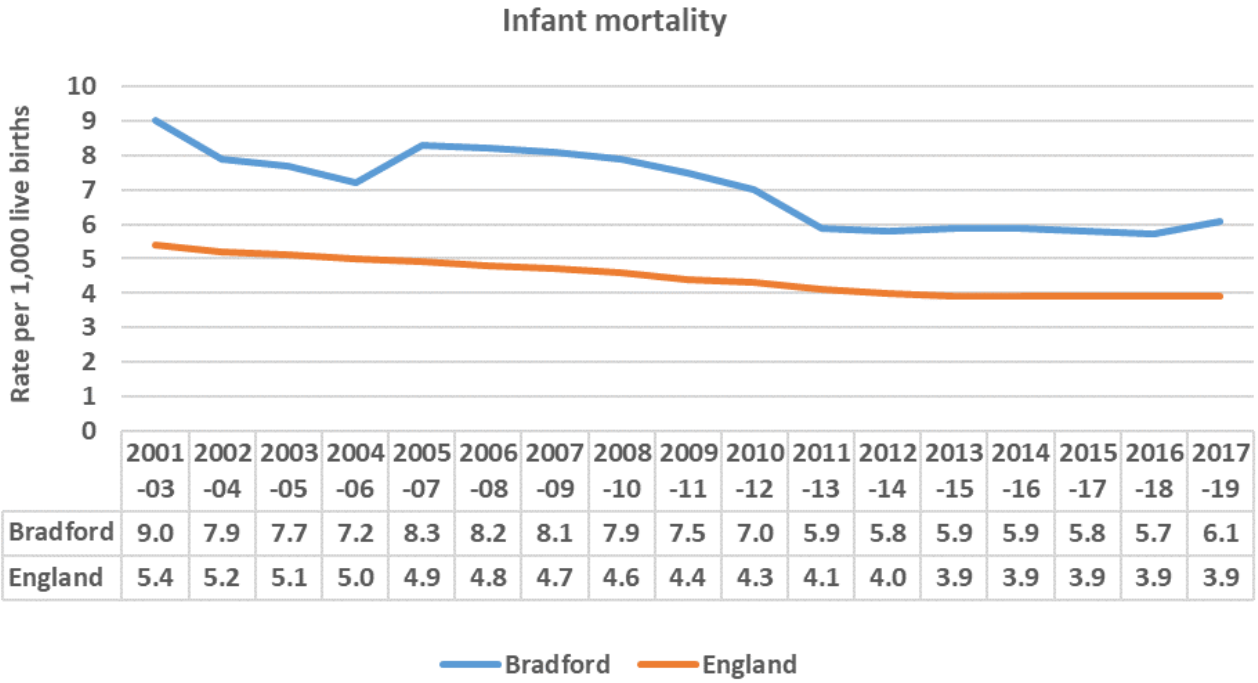


	2001 - 03	2002 - 04	2003 - 05	2004 - 06	2005 - 07	2006 - 08	2007 - 09	2008 - 10	2009 - 11	2010 - 12	2011 - 13	2012 - 14	2013 - 15	2014 - 16	2015 -17	2016 -18	2017 -19
Bradford	163.4	155.4	140.3	133.1	124.7	124.5	120.8	115.9	110.9	107.2	105.9	103.8	102.6	102.6	102.2	105.0	101.2
England	138.0	129.5	120.9	112.3	105.1	99.0	93.1	88.6	84.0	80.8	77.8	75.7	74.6	73.5	72.5	71.7	70.4



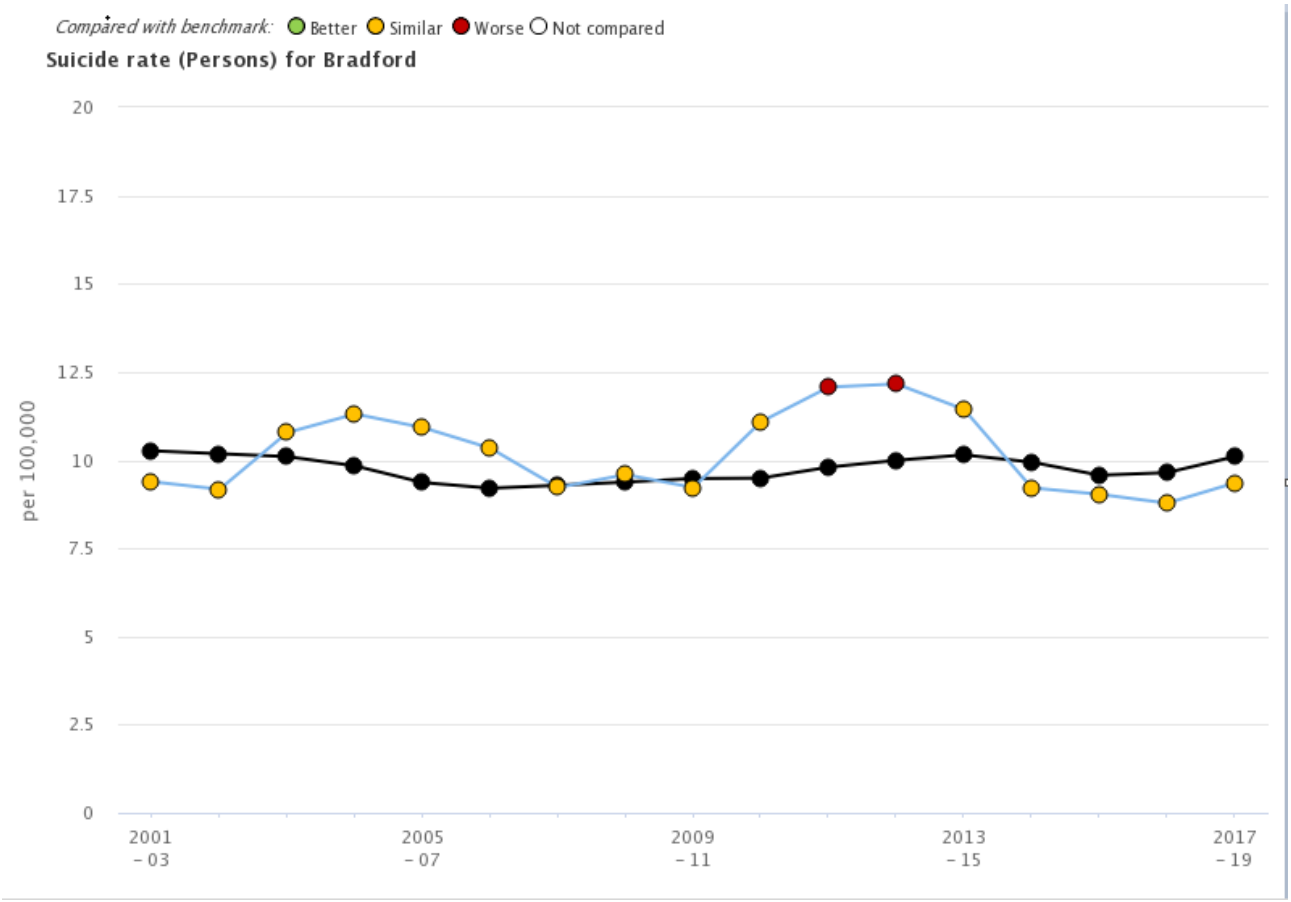
	2001 - 03	2002 - 04	2003 - 05	2004 - 06	2005 - 07	2006 - 08	2007 - 09	2008 - 10	2009 - 11	2010 - 12	2011 - 13	2012 - 14	2013 - 15	2014 - 16	2015 -17	2016 -18	2017 -19
Bradford	178.2	179.6	173.0	171.1	163.9	159.2	156.2	153.6	154.9	150.6	151.1	149.2	153.9	154.9	152.1	145.6	137.6
England	169.4	166.2	162.7	160.0	157.8	155.7	153.2	150.6	148.5	146.5	144.4	141.5	138.8	136.8	134.6	134.6	129.2

3.9.2 **Infant mortality**



	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16	2015-17	2016-18	2017-19
Bradford	9.0	7.9	7.7	7.2	8.3	8.2	8.1	7.9	7.5	7.0	5.9	5.8	5.9	5.9	5.8	5.7	6.1
England	5.4	5.2	5.1	5.0	4.9	4.8	4.7	4.6	4.4	4.3	4.1	4.0	3.9	3.9	3.9	3.9	3.9

3.9.3 **Suicide rate (all age)**



City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Strategic Director, Health and Wellbeing to the meeting of the Health and Social Care Overview and Scrutiny Committee to be held on 16 February 2021 W

Subject:

Health & Wellbeing Commissioning Strategy and Intentions – Adult Social Care 2021 update

Summary statement:

This report is to provide an update and to advise members on the progress of the 2019-21 adult social care commissioning strategy and intentions of the Bradford Council's Health and Wellbeing department

EQUALITY & DIVERSITY:
As part of the commissioning processes Equality Impact Assessments are undertaken at key points in the process, where requirements necessitate. All work undertaken will be address issues of equality and diversity as they apply to protected characteristic groups.

The team will contribute to the Council's equalities objectives in the following ways:

- **Leadership and commitment:** Through promoting discussion at Commissioning SMT meetings regularly
- **Workforce:** Positive recruitment of staff with the right values-base to work in social care and who are representative of Bradford's communities.
- **Service Design/Delivery:** We will develop our approach to co-production. We will design, commission and deliver services that are accessible, inclusive and responsive to the needs of people and communities. We will 'Keep it Local' and contracts will deliver meaningful social value.
- **Communities:** We will further develop our relationship with community networks, and harder to reach groups, to ensure their voice informs our commissioning approach; equalities data collection will be reviewed to ensure we're getting the right intelligence to inform our work.

Iain McBeath
Strategic Director of Health & Wellbeing

Report Contact: Jane Wood/Holly Watson, Commissioning Team
Phone: 07812 490 705
E-mail: holly.watson@bradford.gov.uk

Portfolio:
Healthy People and Places

Overview & Scrutiny Area:
Health and Social Care and Wellbeing

1. SUMMARY

1.1 This report is to provide an update and to advise members on the progress of the 2019-21 adult social care commissioning strategy and intentions of the Bradford Council's Health and Wellbeing department.

2. BACKGROUND

2.1 The Health & Wellbeing department (the department) commission a wide range of services for vulnerable people across the district. This is achieved through an on-going programme of commissioning and procurement activity.

2.2 This work is aligned to the key priorities of the department and the shared system vision *Happy, Healthy and at Home* and where appropriate, is carried out in partnership with colleagues from the NHS Clinical Commissioning Group (CCG).

2.3 The team works with corporate procurement colleagues to design and deliver good, fit for purpose and proportionate procurement practices and processes and which aims to support smaller local VCS and not for profit organisations to be able to deliver adult social care support offers by championing the 'keep it local' agenda.

2.4 In September 2019 the department presented to the Committee a report setting out the commissioning strategy and intentions for 2019-21 and the five key commissioning priorities of:

- Increasing early help & prevention services/offers
- Developing further approaches to support personalisation, choice and control
- Redesigning and recommissioning a range of statutory accommodation and support services
- Reviewing and developing contract and quality management and financial administration services arrangements
- Undertaking effective market shaping and facilitation and ensuring a sustainable and vibrant market

2.5 A link to a copy of the full document and previous committee report is provided at paragraph 12 (*Background Documents*).

2.6

2.7 The Commissioning Intentions document attached at Appendix 2 sets out where procurement activity with a value of over £2m will be carried out in the life time of the commissioning strategy (2019-2021). As a consequence of the delays to delivery as a result of the COVID-19 pandemic, the commissioning intentions work programme in relation to this strategy will continue until mid-2022. During 2021/22 the department will develop a refreshed Commissioning Strategy and Intentions aligned to the new Council Plan, the Health and Wellbeing Department plan and the Health and Care System Strategy 'Happy Healthy and at Home' which is in the process of being reviewed.

3. OTHER CONSIDERATIONS

Impact of COVID-19

3.1 Since March 2020 the majority of the commissioning team resource has been redirected to focus on supporting independent care and support providers in the response to the COVID-19 pandemic.

3.2 This has included regular communication with all providers, through bulletins, emails and calls, care home liaison delivered by commissioning and contracting officers, support to access PPE, support to ensure appropriate staff cover was in place, implementation of additional financial support to the sector, access to testing and latterly vaccination roll out. From August 2020 funding from Council Covid support grants enabled the recruitment of additional staff to form a dedicated team to undertake this work.

3.3 All business as usual commissioning and procurement activity was put on hold for the initial wave of the pandemic. As pressures eased slightly in late summer a review was undertaken and where reasonable to do so, some commissioning work was restarted. Consideration was given not only to the capacity within the department but also the potential impact of commissioning on providers who continue to work under exceptionally difficult circumstances.

3.4 Delivery of the commissioning strategy and intentions is continually monitored and timescales and targets are adapted as needed in response to the demands placed on the department and whole care and support sector due to COVID-19.

Priority one update: Adult Social Care Early Help & Prevention

3.5 Grants to the voluntary and community sector (VCS) which support the provision of early help and prevention service across the district were extended during the pandemic in order to offer financial stability and ensure the continuation of services.

3.6 Work re-started over the summer includes:

- The award of new Alternative to Respite funding. This service aims to provide alternative options to respite in care homes for people with identified social care needs and their carers using personal budgets. The service also supports people and their carers who can self-fund, to plan for holidays.
- The award of innovation grants to promote and support user-led organisations
- The launch new innovation grants to promote and support services for carers

3.7 Commissioning work will recommence in the spring on the post diagnostic dementia support service and the housing related support multiple needs and young people services. Work will include comprehensive service reviews in 2021/22.

Priority two update: Personalisation, Choice and Control

3.8 Work to bring home support providers on the Individual Service Fund 1 (ISF1) programme continued in 2020 but was significantly delayed.

3.9 The approach to the delivery of the main ISF pilot has been reviewed. A small scale pilot project within learning disability services is being established to look at how to progress ISFs going forward.

Priority three update: Statutory Accommodation and Support Services

3.10 Work on the commissioning and procurement of day opportunities was restarted in autumn 2020 and the procurement process for the new day opportunities provider list was launched in December 2020. This work aims to improve the range of service available and increase choice for service users.

3.11 Planned reviews of accommodation and support models for people with learning disabilities, mental health, Autism and acquired brain injuries, respite services and extra care have all been delayed until 2021/22.

3.12 The recommissioning of the residential and nursing framework has been re-started with the procurement process expected to commence in early summer 2021. This sector had been heavily impacted by the pandemic and the current focus is providing ongoing support to the sector.

Priority Four update: Contract Management and Financial Administration Services

3.13 The work on reviewing and developing a proportionate risk based contract management approach was initially diverted to focusing on supporting providers with the early stages of the pandemic.

3.14 As resource has moved back, focus has been on provider sustainability as the financial implications of the pandemic are felt by the social care market.

3.15 Processes are being reviewed and new approaches adapted to take on board learning from the pandemic and how this will shape contract management in the future.

3.16 A review of the financial administration current processes and procedures is underway which aims to enhance the use of digital systems to automate and streamline processes.

Priority five update: Market shaping, facilitation and sustainability

3.17 It is recognised that the COVID-19 pandemic has had a significant impact on the shape and sustainability of the care and support sector market which will last well beyond the end of any social restrictions. The department has led on providing resources and financial support to the sector to maintain providers throughout the stages of the pandemic so far. This work is regularly reviewed to ensure the Council is providing the right support at the right level to promote sustainability and mitigate the risk of provider failure. Significant work will be required over 2021/22 to understand if and how future need and demand has shifted in the longer-term as a result of the pandemic.

3.18 A significant and positive outcome of the pandemic has been the development of a closer and more co-productive working relationship between the Council and the independent sector care market. The links forged will continue to be nurtured.

3.19 The Market Position Statement was published over the summer setting out the current state of the social care and support market in Bradford, and how the department intends to work with the market in the future.

Development of the Commissioning, Contract Management & Quality Assurance team

3.20 The Council's proposed Financial Plan and Budget for 2021/22 includes £500,000 to improve commissioning of services for vulnerable adults. If approved, this funding will be used to expand and develop the commissioning, contract management and quality assurance work carried out by the team. There will be a particular focus on increasing joint working with the CCG and other partners in the Bradford Health and Care System.

4. FINANCIAL & RESOURCE APPRAISAL

4.1 Commissioning activity is undertaken in line with Contract Standing Orders. Budgets are set in each area of the department and financial and performance monitoring routinely takes place. There is no direct impact on the budget but as the commissioning strategy and intentions are embedded, specific monitoring will take place to ensure that the spend remains within budget.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

5.1 Each commissioning project is managed by a team that includes commissioners, operational, finance, procurement and legal staff. To manage activities and timescales there is a formal project plan, which includes a risk register and a communication plan which is monitored by the project team.

5.2 The project team reports progress to the Assistant Director and the departmental management team. Jointly commissioned projects report to the relevant joint boards.

6. LEGAL APPRAISAL

6.1 All procurements will be carried out in accordance with Contract Standing Orders.

7. OTHER IMPLICATIONS

7.1 SUSTAINABILITY IMPLICATIONS

7.1.1 Each commissioning project will take into consideration what contribution services can make towards achieving sustainability strategies in the District.

7.2 GREENHOUSE GAS EMISSIONS IMPACTS

7.2.1 Providers of commissioned services will be required to support the Council's commitment to reduce CO2 emissions through the standard contracting arrangements it enters into with Council.

7.3 COMMUNITY SAFETY IMPLICATIONS

7.3.1 There are no community safety implications arising from this report.

7.4 HUMAN RIGHTS ACT

7.4.1 The Human Rights Act 1998 provides a legal basis for concepts fundamental to the rights of people. The fundamental rights include rights that impact directly on service provision in the health and social care sector.

7.4.2 Where services are commissioned, providers of services will be required to comply with the Human Rights Act through the contracting arrangements it enters into with the Council.

7.5 TRADE UNION

7.5 1 Future changes in commissioned service may change the roles of staff and offer new and different opportunities to work together.

7.5.2 The proposed increased investment in Commissioning will result in changes to the structure of the Commissioning team will require involvement and consultation with Trade Unions.

7.6 WARD IMPLICATIONS

7.6.1 There are no direct implications in respect of any specific Ward.

7.7 IMPLICATIONS FOR CORPORATE PARENTING

7.7.1 The implementation of an adult social care commissioning strategy and intentions will have positive implications for corporate parenting. The Council's ability to fulfil its legal and moral duty to safeguard and promote outcomes for its Looked after Children, will be considered in the detailed commissioning intentions.

7.9 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

7.9.1 A full Privacy Impact Assessment will be undertaken to determine specific areas of UK General Data Protection Regulation (UK GDPR) and information security as part of the commissioning process. It is recognised that the potential for transfer of personal data might be significant when commissioning and procuring services.

7.9.2 There may be a need for partner agencies to share data however this would only be with the express permission of individual affected in the full knowledge of why and what it would be used for. UK GDPR principles relating to any individual's data and rights under the Data Protection Act 2018 will be respected.

8. NOT FOR PUBLICATION DOCUMENTS

8.1 None

9. OPTIONS

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

10. RECOMMENDATIONS

10.1 That the Committee note the report

11. APPENDICES

11.1 Appendix 1 Health & Wellbeing – (Adult Social Care) Updated Commissioning Intentions

12. BACKGROUND DOCUMENTS

12.1 Health & Wellbeing – (Adult Social Care) Commissioning Strategy and Intentions 2019-2021
https://bradford.moderngov.co.uk/documents/s27380/Hlth26SeptDocG.pdf
https://bradford.moderngov.co.uk/documents/s27381/Hlth26SeptDocGAppendix%201.pdf
https://bradford.moderngov.co.uk/documents/s27382/Hlth26SeptDocGAppendix%202.pdf

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Appendix 2
Health Wellbeing - (Adult Social Care)
Commissioning Intentions 2019-2021

Title	Description	Position in September 2019	Procurement over £2m required	Estimate Annual Value of Procurement	Timescales for Procurement	Recommended Procurement Approach
Adult Social Care Early Help & Prevention						
Re-imagining days small grants (Combating loneliness)	Day Opportunities grants	Completed				
Mental Health Grants	Employment, day time activities and support services	See- reimagining days under Accommodation & support Services	Yes - See Re-imagining days	Yes - See Re-imagining days	Yes - See Re-imagining days	Yes - See Re-imagining days
Learning Disability Employment support	Supported employment service to be procured	See re-imagining days				
Joint carers support service and Joint Carers Strategy	Strength based approach to support carers & promote their views through contracting arrangements and development of Joint Carers strategy. Use of Better Care Fund to develop respite for carers	Contract awarded. On going contract monitoring. Joint strategy to be completed Oct 2019.				
Carers services	Range of provision to enhance and develop support to carers across the district	New work started in 2020				
Advocacy services	Statutory & non statutory and self & group advocacy	Contracts awarded				
Art of Commissioning	NDTi project looking at innovation in commissioning home support	New work started in 2020		TBC	TBC	TBC

Title	Description	Position in September 2019	Procurement over £2m required	Estimate Annual Value of Procurement	Timescales for Procurement	Recommended Procurement Approach
Alternatives to respite	Alternative to respite in a care homes for people with identified social care needs and their carers using personal budgets. Support for people and their carers who can self fund to plan for holidays	New work started in 2020				
Review of community connectors pathway	Review of community connectors pathway (incl. MAST, support navigators)	New work started in 2020				
Innovation grants for User Led Organisations	Support for user led organisation	New work started in 2020				
Capital grants for improving disabled access	Funding for community organisations to improve access to services	New work started in 2020				
Housing Related Support	Multiple needs and young people's housing related support. Working jointly with Housing in relation to the Short term housing needs assessment being carried to inform future commissioning	2019/2021	Yes	£2.7m	2020/2021	Public Contracts Regulations 2015 Light Touch Regime
Post diagnostic dementia support service	VSC provided dementia advice and support service	On going	Yes	£2.0m	2022/2023	Public Contracts Regulations 2015 Light Touch Regime
Personalisation, Choice and Control						
Individual Service Funds (ISF)	Development of ISF model	2019/2020	Yes	Unknown due to service user choice and take up of ISF's		Public Contracts Regulations 2015 Light Touch Regime
Accommodation and Support Services						
Home Support retender	Procurement completed. Implementation phase. Personal budgets (ISF & Direct Payments) options for existing service users wishing to remain with current providers.	2018/2019 contract awarded. 2019/2020 implementation				
Residential and nursing care home contract renewal	Re-commissioning of framework contract for residential and nursing care homes	2019/2020	Yes	£36m	2019/2020	Public Contracts Regulations 2015 Light Touch Regime

Title	Description	Position in September 2019	Procurement over £2m required	Estimate Annual Value of Procurement	Timescales for Procurement	Recommended Procurement Approach
Flexible accommodation and support models for people with Learning disabilities, mental health, autism and acquired brain injuries	Develop a model to provide a range of flexible services to support people with different needs, to live their lives	2020/2021	Yes	£25m	2020/2021	Public Contracts Regulations 2015 Light Touch Regime
Re-imagining days	Commission and procure day opportunities and personalised offers	2019/2020	Yes	£6.8m	2019/2020	Public Contracts Regulations 2015 Light Touch Regime
Respite services	Review and remodel Strategy for all client groups. Review and consult on current model, developing new non-residential options and responding to accommodation related issues	2020/2021	Yes	Once the strategy and scope has been determined value will be calculated	2020/2021	Recommendation following development of strategy and commissioning model
Extra care	Strategy and market engagement to be undertaken. Review of existing support provider contracts.	2020/2021	Yes	Current arrangements £1.6m but future commissioning intentions to be scoped in once strategy is determined	2020/2021	Public Contracts Regulations 2015 Light Touch Regime
Market Shaping - facilitation and sustainability						
Market briefings and MPS	Clear direction and plans shared with the care market. Demand and needs assessment modelling. Sharing implications of Healthy, Happy and at Home, working with the voluntary and community sector	On going				

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