City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Bradford District and Craven Health and Care Partnership to the meeting of Health and Social Care Overview and Scrutiny Committee to be held on 27th January 2022

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Subject:

UPDATE ON THE LOCAL HEALTH AND CARE SYSTEM'S STRATEGY, TRANSFORMATION PROGRAMMES, AND THE DEVELOPMENT OF PARTNERSHIP ARRANGEMENTS

Summary statement:

Following updates to the Committee in 2021, this report summarises the strategy of the local health and care partnership; and highlights the benefits for local people which are being achieved through the partnership's transformation programmes.

The report also provides an update on the implementation of local delivery and decision making arrangements which will support the partnership to make a difference as part of the West Yorkshire Integrated Care System.

EQUALITY & DIVERSITY:

Equality assessments - Please consider and comment on the equality impacts of any new, review, or removal of policies, practices, strategies, services or functions. In some instances this may require the completion of an equality impact assessment form. Full guidance is available on BradNet.

Equality objectives – if the work presented contributes to one of the Council's equality objectives a statement must be provided to explain what and how (more detail available in the report guide).

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Portfolio:

Healthy People and Place

Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

Following updates to the Committee in 2021, this report summarises the strategy of the local health and care partnership; and highlights the benefits for local people which are being achieved through the partnership's transformation programmes.

The report also provides an update on the implementation of local delivery and decision-making arrangements which will support the partnership to make a difference as part of the West Yorkshire Integrated Care System.

2. OUR STRATEGY

The Bradford District and Craven Health and Care Partnership Strategy (Appendix 1) sets out our vision, shared purpose, and commitments as a health and care place-based partnership. Its primary audience is those who work in health, care and wellbeing in Bradford District and Craven – our Place.

The partnership has the strategic ambition to reduce health inequalities and improve population health and wellbeing for the people of Bradford District and Craven. We are committed to our partnership vision of keeping people 'Happy, Healthy at Home' through the actions taken to support our population to stay healthy, well, and independent throughout their whole life.

Health and care partners in the District have a strong history of working well together. As we move into formal partnership arrangements, we are confident that the work we have done to date from our strategic partnering agreement, our transformation programmes to our distributed leadership model place us in a strong position to take on the delegated responsibility to 'Place' from the West Yorkshire Integrated Care System.

Our four primary purposes as a new partnership are:

- Improving outcomes in population health, healthcare and wellbeing;
- Tackling inequalities in outcomes, experience and access;
- Enhancing productivity and value for money; and
- Supporting broader social and economic development.

Our Partnership Strategy sets out the commitments that we will use to align our plans and resources to tackle inequality in health, wellbeing, outcomes and access as our shared purpose. Our operating model of 'Act as One' shows our clear commitment to a new model of mutual accountability; collective decision-making with a shared responsibility for managing collective performance, resources, and the totality of population health.

3. TRANSFORMATION PROGRAMME HIGHLIGHTS

3.1 Introduction

There are eight Act as One transformation programmes in place across our partnership. They share the same common aims of addressing inequalities, improving outcomes and driving forward efficiencies and collaboration between partner organisations. In effect these programmes are one of the main ways in which we work together to deliver our strategy and make a difference for people.

The programmes are:

- Access to Care
- Ageing Well
- Better Births
- Care Coordination
- Children & Young People's Wellbeing
- Diabetes
- Healthy Hearts
- Respiratory

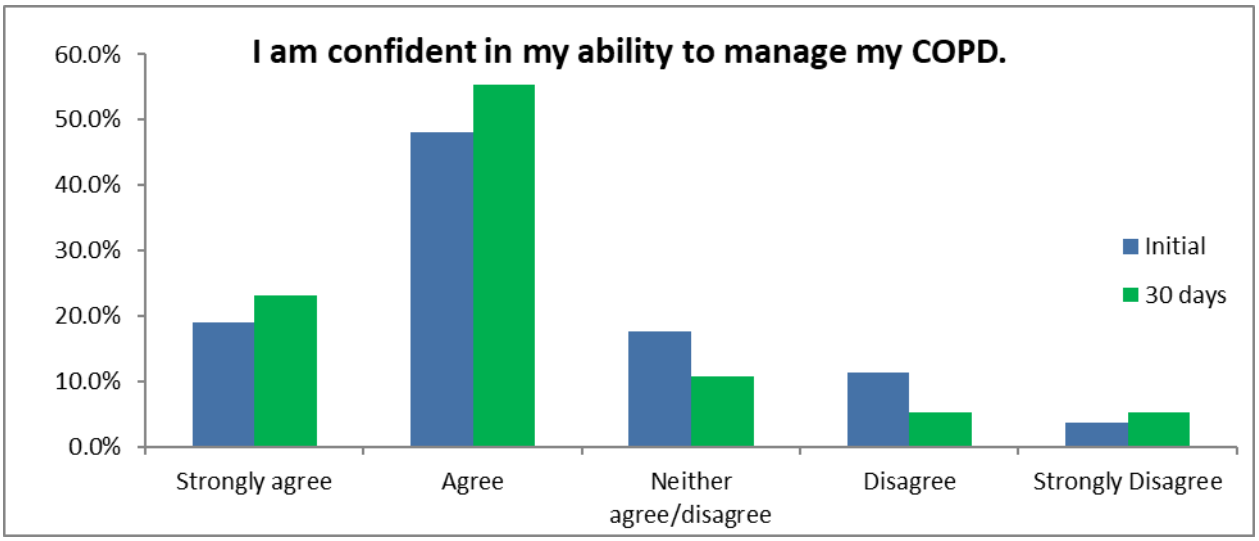
This report does not attempt to summarise all of the work that has happened since the last update was provided to the Committee in January 2021. What follows is a selection of highlights, showcasing the progress that has been made in a number of areas across the portfolio.

3.2 Supporting people with Chronic Obstructive Pulmonary Disease (COPD) via the Digital Care Hub at Airedale Hospital

Chronic Obstructive Pulmonary Disease is a chronic lung condition that results in obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, mucus production and wheezing, and patients can suffer frequent hospital admissions and other exacerbations. For those patients who have uncontrolled COPD, they can get into a cycle of admissions or interactions with other parts of the health sector such as their GP or A&E departments to seek help and support.

The Digital Hub, based at Airedale Hospital, has been running now for in excess of 5 years and undertakes a range of activities from supporting people with end of life care needs to supporting older people in care homes – all by using either phone or video conferencing technology.

A small scale trial (involving around 70 patients initially) was undertaken at the beginning of 2021, whereby patients who had been discharged from hospital, following an admission with COPD were supported by the Hub virtually. The support was agreed with the patient and their clinical team, but could include up to a daily proactive call from staff within the hub, as well as patients being able to contact the hub 24/7 for further support and advice. The chart below shows feedback from the patients involved in the trial at the start and then again after 30 days:



All patients involved in the initial trial completed their evaluation at 30 days, and during that time only one had been re-admitted to the hospital.

Based on the success of that trial, the team sought further funding to expand their operations and the scope and scale of their work. £300k investment was secured from NHSX to rapidly expand the number of COPD patients supported by the hub, hub staffing levels, as well as investing in a new app that would support remote monitoring and self care for patients. The team set a target to recruit 6,000 COPD patients (from all sectors), and as of the 6th December 2021, over 2,000 patients had been referred into the new service.

Of those now registered with the hub, feedback has started to come through and included:

- On average patients give the service 4.6 out of 5 stars
- 84% of patients found that they needed to go to hospital less often compared with before being registered with the hub
- Comments from patients included:
    - “The app helps me stay calm when I struggle with my condition and there's always someone to turn to if I'm not sure about my breathing condition”
    - “I feel listen to and I feel safe knowing that there is someone at the end of the phone if needed. The app makes you aware of your condition and what your normals are it's great”

3.3 Supporting Self Management - Self-Care week & Home Blood Pressure Machines

Self-care week took place in the second week of November 2021 and is a national initiative to support and encourage those living with health conditions to improve how they manage and control it, without the need for interventions from a health or care professional. In Bradford District and Craven this was our opportunity to run our first public facing events since the pandemic took hold.

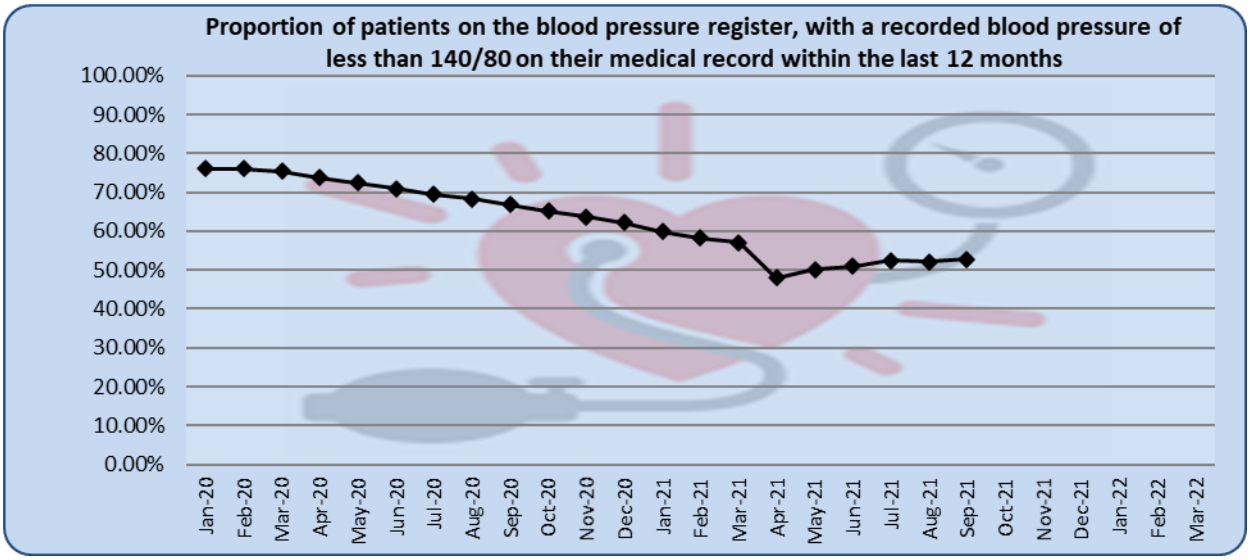
Programme leads from Better Births, Healthy Hearts, Diabetes and the Respiratory programmes worked in partnership with local and national charities (Mind, Diabetes UK), VCS organisations (Hale, Maternity Voices Partnership) and Primary Care Networks to run

six pop-up sites across the District, including in community centres, The Broadway Shopping Centre and the Airedale Shopping Centre.

The feedback from members of the public was overwhelmingly positive, helped cement key relationships with stakeholders and provided the public with comprehensive access to both some health services (in the form of vaccinations and health checks) and top quality advice and links to community organisations for further support. Over 200 health checks were performed over the sessions and an additional 70 people received their covid vaccination.

In the Healthy Hearts Programme, helping people to better manage their long term cardiac conditions has been at the fore of the work undertaken. At the same time as empowering patients, the programmes have supported Primary Care by enabling some routine health checks to be done by people themselves remotely.

The programme was successful in obtaining 7,000 home blood pressure machines. Working with Primary Care, the machines have been distributed across the place to those practices in the most deprived areas and those with the biggest gap between the expected number of people with high blood pressure and those actually on the high blood pressure register. As a result of this, we have started to see a recovery in the number of patients who have a record of their blood pressure on their medical record in the last 12 months – a performance indicator in primary care.



3.4 Bradford District & Craven Innovation Hub – Supported by The Health Foundation

In 2019, The Health Foundation published a report called “The Spread Challenge”. The report queried, why it was that in some parts of the NHS innovative approaches were readily adopted, but that the same innovations in other areas didn’t seem to work. Following on from this, the Health Foundation established a national fund, for four places to bid for to become so called “Innovation Hubs”. Each hub would test the theories arrived at in the original Spread Challenge report by trying to adopt a series of innovations that have been proven to work in other areas of the country.

Out of over 80 applicants, Bradford District and Craven's application to become an Innovation Hub was successful, bringing with it the prestige of being only one of four hubs nationally, and an investment of around £450k into the region over two and a half years. The application involved system partners from across the board, including academic institutions, the NHS, voluntary sector, and the Academic Health Science Network for Yorkshire.

The work is in its initial start up phase at the moment, with a new innovation hub lead person due to come into post in early February 2022.

3.5 Deconditioning and patient optimisation

The Pandemic resulted in people living restricted lives due to the virus, shielding, isolation and lockdowns. For older people in particular, a direct consequence of being less active can be muscle wasting and general deconditioning which in turn causes a decline in ability, reduced independence and increased falls risk. Research across the District shows that there are over 97,000 people aged 65 or over and that a third of them have an illness that limits them a lot in their daily activities of life.

The Ageing Well Programme team worked with Allied Health Professionals (AHPs), local people and community groups to produce a range of self-help resources and education around the impact and prevention of deconditioning across our vulnerable populations. Resources were available both online and in paper format in multiple languages (including English, Urdu, Punjabi, Polish) and also in video formats too, allowing them to be shared across social media platforms. The Race Equality Network (REN) have helped promote and circulate these new resources through their networks, further broadening the reach.

The benefits of exercise and mobility are well understood and proven and this work has helped patients remain active, prevent deconditioning and stay well in their homes and communities during a difficult year.

Through the Access to Care Programme we have been successful in obtaining access to national funds to develop a range of digital resources that will support our population to optimise their health whilst waiting for surgery, or prior to their referral for surgery. This will include resources to help people with nutritional advice, their fitness and lifestyle, and psychological support, as three such examples. For people who have underlying health conditions, surgery can have a significant impact on their physical and mental wellbeing and therefore making lifestyle changes before surgery, supported by our health and care teams, can reduce their length of stay in hospital and improve their long-term outcome from surgery.

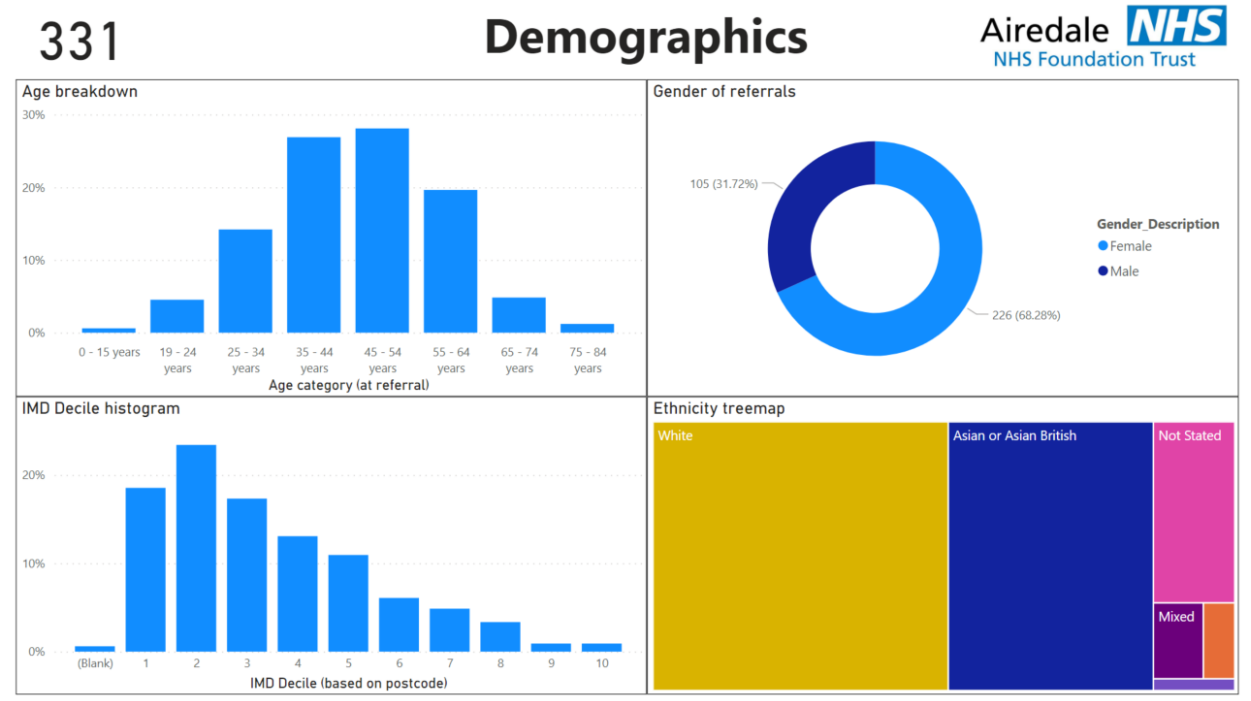
3.6 Long Covid

Long Covid is a term to describe the effects of Covid-19 that continue for weeks or months beyond the initial illness. The National Institute for Health and Care Excellence (NICE) defines Long Covid as lasting for more than 12 weeks following a Covid-19 infection. There are two main types of ongoing symptoms experienced by patients: a smaller group of people with respiratory symptoms (e.g. breathlessness), and a larger group of people with a cluster of more general symptoms, particularly tiredness and fatigue.

Due to the broad range of issues experienced by patients with long covid, a whole system multi-professional approach was required. Working across the NHS, Voluntary sector and

primary care, the team developed a bespoke pathway for our population. For patients who are still displaying long covid symptoms 12 weeks-post infection, they are referred in by their GP, to physiotherapist who takes responsibility for coordinating their care. From there, the coordinator has access to a wide range of other clinical (such as specialist respiratory care) and non-clinical services (such as employee health links, support returning to work and financial advice).

The chart below shows the activity going through the service to date:



The service is now established, and has been receiving 10-15 referrals per week into December 2021. Those running the service have engaged extensively with communities and their local GPs, which has also translated into a high proportion of Asian or British Asian referrals compared to national data and high levels of referrals from patients living in areas with higher levels of deprivation.

3.7 A&E Navigators

Since July 2021 we have been running an initiative from BTHFT's Emergency Department supporting young people under the age of 25 who attend the hospital as a result of a violent incident. Youth Workers (Breaking the Cycle team) and a substance misuse worker support these individuals, who may either be the victim or perpetrator of a violent crime to access support and break the cycle of violence in these vulnerable young people. Over 400 interventions have been delivered in the Emergency Department with a number of young people and their families receiving ongoing support back in the community to enact positive changes to their lifestyle and behaviour.

The public health approach to this initiative looks to address the underlying risk factors and we are providing quarterly data including demographics and outcomes to the West Yorkshire Combined Authority who are evaluating the impact of the scheme.

4. Partnership Development

4.1 Introduction

The local health and care partnership is changing the way it works, to make it easier to implement our strategy and to make improvements for people. These changes to local arrangements also enable us to maximise the effectiveness of our participation in the West Yorkshire Health and Care Partnership, and to prepare for the new Health and Care Act, which is expected to be passed by Parliament in 2022.

An update on the proposed changes was presented to the Overview and Scrutiny Committee in September 2021. This report provides further detail and seeks to address the questions posed by the Committee in that earlier discussion.

4.2 Partnership Governance and Decision Making

Within Bradford District and Craven we have well established health and care partnership arrangements. The Wellbeing Board sets the overall direction, and coordinates action between each of our strategic partnerships to maximise our impact on all the factors that influence our social, economic, and environmental wellbeing. The Health and Care Partnership is recognised as one of the key local partnerships that contribute to the delivery of the overall District Plan as set out by the Wellbeing Board. This well established relationship will remain intact following the implementation of the proposed changes.

Our existing health and care partnership arrangements are underpinned by the Strategic Partnering Agreement (SPA), which documents the way we work together, how we reach decisions collectively, and confirms our shared ambition. The SPA is currently being updated to reflect the proposed partnership governance and decision making arrangements, ensuring alignment with the constitution of the West Yorkshire Integrated Care Board (ICB), and preparing for the anticipated changes in responsibility from the CCG to the ICB.

Our Partnership has long been an inclusive one, with direct participation in decision making groups by the voluntary, community, and social enterprise sector, the independent care sector, primary care, alongside large NHS and local government organisations. As we continue to develop our partnership, we are committed to ensuring we retain this breadth, and add to it, particularly to strengthen the voice of people who use health and care services. Our approach to this will be to connect with existing arrangements for public voice and participation, and to pay particular attention to diversity and inclusion.

The majority of decision making for Bradford District and Craven will be retained locally, with only those matters which we agree to be best discharged once for West Yorkshire being agreed by the ICB, in line with the subsidiarity principle which has underpinned the success of our ICS since its inception. The draft constitution of the West Yorkshire ICB sets out a scheme of reservation and delegation (SORD), which clarifies the decisions that will be taken locally by Bradford District and Craven. The SORD is set out at Appendix 3 and shows that the vast majority of decisions will be taken locally.

Local decision making will be led by the Bradford District and Craven Partnership Board, which will be formally established as a committee of the West Yorkshire Integrated Care Board. This Committee will be chaired by an independent chair (to be appointed). The aim is for this individual to bring objectivity and challenge to the Committee. They will play a key role in ensuring that the Committee takes transparent, efficient, effective and safe decisions that make effective use of NHS resources. The Chair will support the Place Lead in ensuring that the Committee remains continuously able to discharge its duties and responsibilities as set out in the ICB scheme of delegation, in line with the governance standards adopted by the Integrated Care System. They will act in a lay or Non Executive capacity and as a meeting facilitator.

The Committee will meet in public, and provision will be made for the public to raise questions and have them answered. All members will be required to adhere to the Nolan Principles. Participation will include voluntary and community sector and Healthwatch members for both Bradford District and for Craven. Local Authority representation will be provided by Chief Executives and relevant Strategic Directors.

The establishment of this Committee is progressing well, draft Terms of Reference have been produced, a development session was held with members on the 16th December 2021 and meeting dates for 2022 have been agreed. The Committee has agreed to work in shadow arrangements until the Integrated Care Board becomes our local statutory body in July 2022.

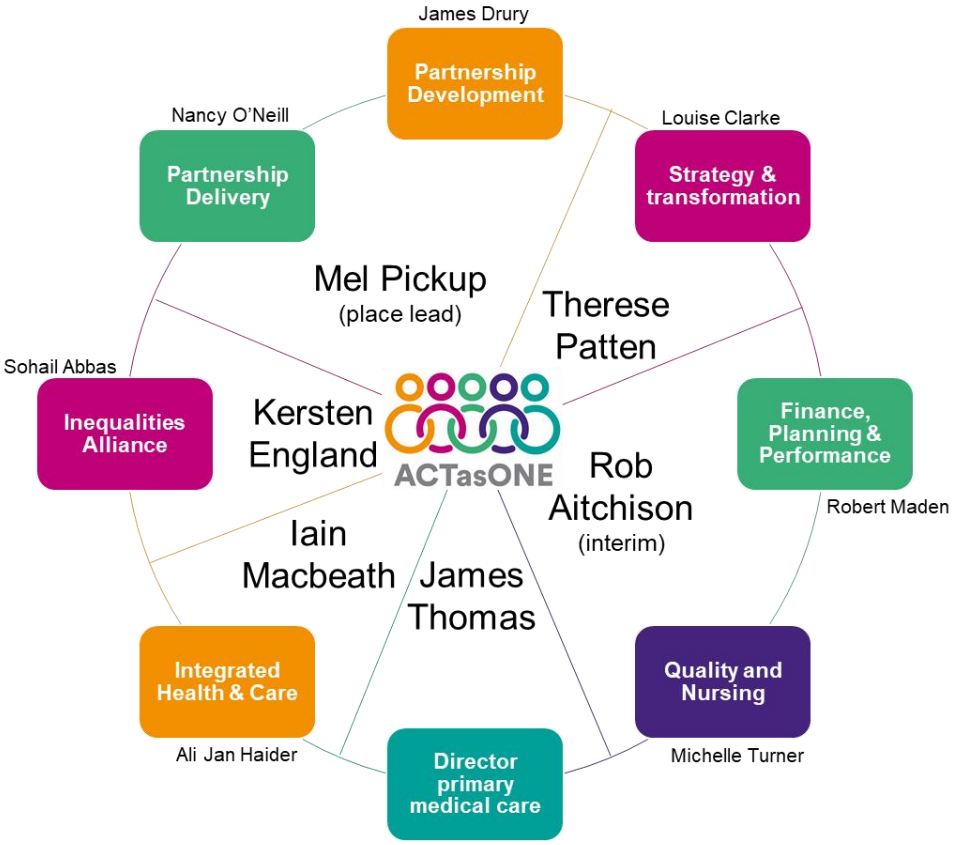
The Partnership Board will be supported by assurance sub-committees for Finance and Performance, Quality, and People (workforce). These sub-committees will be chaired by non-executives who will also be members of the Partnership Board. These arrangements build upon our existing well established system sub-committees.

The Health and Care Partnership will develop an annual plan which will respond to the needs of the community as identified by the Wellbeing Board. An annual report will be published detailing progress made against our objectives, the key decisions taken, and how resources have been used. All these arrangements will remain open to Overview and Scrutiny.

4.3 Partnership Leadership Arrangements

Our proposed leadership arrangements are based upon the principles of distributed leadership as set out in our Strategic Partnering Agreement. As shared previously with the Committee, Mel Pickup, Chief Executive of Bradford Teaching Hospitals NHS FT is the designate place-based lead, subject to confirmation by the West Yorkshire ICB.

Other members of our Partnership Leadership Executive will also provide system leadership supporting a team of directors to deliver each element of our local health and care system. The diagram below demonstrates this distributed leadership model.



5. OTHER CONSIDERATIONS

➢ No other directly or indirectly related matters have been identified.

6. FINANCIAL & RESOURCE APPRAISAL

➢ There are no direct financial issues for the local authority arising from this change. Integrated Care Boards (and their place based committees) will retain equivalent powers and responsibilities as CCGs have currently, to enter into Section 75 arrangements with local authorities. Responsibilities regarding the Better Care Fund will transfer to the new arrangements.

7. RISK MANAGEMENT AND GOVERNANCE ISSUES

The Local Authority may wish to provide its own risk assessment. However the principal risk that decision making becomes a primarily regional rather than local responsibility is addressed by the ICB constitution and scheme of reservation and delegation.

There has been an assessment of the impact of the change in the Parliamentary time table for the passage of the Health and Care Bill (from an expected April ’22 date to commence statutory Integrated Care Boards, to a July ’22 target date). The impact assessment has concluded that this change is entirely manageable for the West Yorkshire ICS and each of the local Place Based Partnerships. The change may require additional financial and governance activity to be undertaken by CCG teams associated with ‘year end’, but this will be planned for. Until the West

Yorkshire ICB is ready to commence in July, the Accountable Officer and Governing Body of the Bradford District and Craven CCG will remain in place.

8. LEGAL APPRAISAL

- The Local Authority may wish to provide its own legal appraisal. However, the West Yorkshire Partnership and the local Bradford District and Craven Health and Care partnership have engaged the support of solicitors in the development of these arrangements.

9. OTHER IMPLICATIONS

- No other implications have been identified.

10. NOT FOR PUBLICATION DOCUMENTS

- 'None'.

11. RECOMMENDATIONS

The views of the Health and Social Care Overview and Scrutiny Committee are requested

12. APPENDICES

Appendix 1 Bradford District and Craven Health and Care Partnership Strategy November 2021 – the document sets out the vision, shared purpose, and commitments of the health and care place-based partnership

Appendix 2 Bradford District and Craven Health and Care Partnership Strategy November 2021 'Plan on a Page' – a one page summary of the partnership strategy

Appendix 3 West Yorkshire Integrated Care Board Scheme of Reservation and Delegation – the document sets out the powers and responsibilities of the Bradford District and Craven Health and Care Partnership Board, as a Committee of the ICB.