Report of the Chair to the meeting of Bradford and Airedale Health and Wellbeing Board to be held on 22nd February 2022.

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Subject: Chairs Highlight report

a. Better Care Fund

Summary statement:

The Health and Wellbeing Board Chair's highlight report summaries key business conducted between Board meetings. February's report includes an update on the District's Better Care Fund submission.

Councillor Susan Hinchcliffe
Chair, Bradford and Airedale Health and Wellbeing Board

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Portfolio:

Health and Wellbeing

Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

The Health and Wellbeing Board Chair's highlight report summaries business conducted between Board meetings. February's report includes the latest submission to the Better Care Fund and the annual report from the Health Protection Comittee.

2. BACKGROUND

Better Care Fund

Appendix A is a copy of Bradford District's submission to the Better Care fund. The Better Care fund was introduced in 2015 and requires Local Authorities and CCG's to enter into pooled budget arrangements and develop a joint spending plan. It is not clear yet how the upcoming changes to the CCG will impact the future development of the Better Care Fund.

The Better Care Fund Policy Framework and subsequent planning guidance included changes to the reported BCF metrics. The original metrics of admissions to residential care homes and effectiveness of reablement remain.
The list of metrics now required is listed below:

- Avoidable admissions - Unplanned hospitalisation for chronic ambulatory care sensitive conditions (an NHS indicator that measures how many people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency)
- Length of stay - Percentage of in patients, resident in the HWB area, who have been an in-patient in an acute hospital for: i, 14 days or more and ii, 21 days or more
- Discharge to normal place of residence - Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence
- Permanent residential admissions
- Effectiveness of Reablement.

Targets for the above metrics have been agreed as a partnership as part of the planning process.

This submission has already been discussed at our local Placed Based Partnership meeting and has received the input of Health and Care Partners. The plan has also been discussed in detail at the Joint Planning and Commissioning Forum, Finance Forum and System Finance and Performance Committee. The appendix documents provide a comprehensive overview of the District's BCF submission and narrative.

3. OTHER CONSIDERATIONS

Please refer to appendix documents

4. FINANCIAL & RESOURCE APPRAISAL

Financial requirements are detailed within the body of the appendix documents.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

The Wellbeing Board currently provides the governance for both the BCF.

6. LEGAL APPRAISAL

None

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

The BCF is strongly underpinned with the ambition to tackle inequalities and promote the aims of the District Plan which include upholding the District's Equality objectives. The appendix documents detail how they set out to achieve this.

7.2 SUSTAINABILITY IMPLICATIONS

No direct implications

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

No direct implications.

7.4 COMMUNITY SAFETY IMPLICATIONS

No direct implications.

7.5 HUMAN RIGHTS ACT

No direct implications.

7.6 TRADE UNION

No direct implications.

7.7 WARD IMPLICATIONS

No direct implications.

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

No direct implications.

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

No options are provided

10. RECOMMENDATIONS

- The District's BCF submission is noted and approved by the Wellbeing Board.

11. APPENDICES

A. BCF Narrative Submission
B. BCF Expenditure Plan

12. BACKGROUND DOCUMENTS

None

Bradford District Health and Wellbeing Board

Better Care Fund Narrative Plan for 2021/22

SUBMISSION SUMMARY

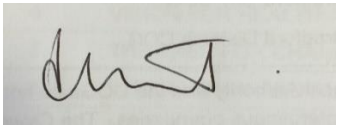
Local Authority	City of Bradford MDC
Clinical Commissioning Groups	Bradford District and Craven CCG
Boundary Differences	The Local Authority and the CCG does not have coterminous boundaries. The Craven locality is part of North Yorkshire County Council.
Date of narrative submission:	16th November 2021
Minimum required value of pooled budget: 2021/22	£69,790,003
Total agreed value of pooled budget: 2021/22	£69,790,003
National Conditions	This plan is compliant with the following national conditions of the BCF planning framework: NC1 – A Jointly agreed plan NC2– NHS contribution to Social Care is maintained in line with inflation NC3– Agreement to invest in NHS-Commissioned out-of-hospital services NC4– Plan for outcomes for people being discharged from hospital

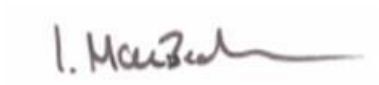
AUTHORISATION AND SIGN OFF OF THE

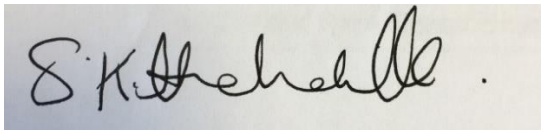
BRADFORD DISTRICT BETTER CARE FUND

The BCF Plan has been produced by officers of Bradford District and Craven Clinical Commissioning Group and City of Bradford Metropolitan District Council with support from the Voluntary Care Sector, Housing and Disabled Facility Grant leads

This plan has been jointly agreed by City of Bradford Metropolitan District Council, Bradford and District Clinical Commissioning Group and the Chair of Bradford Health and Wellbeing Board. The plan will be presented to the Bradford Health and Wellbeing Board at its meeting on 22/02/2022.

Signed on behalf of the CCG 	Bradford and District CCGs
By	Helen Hirst
Position	Chief Officer
Date	16/11/2021

Signed on behalf of the Council 	City of Bradford MDC
By	Iain MacBeath
Position	Strategic Director Health and Wellbeing
Date	16/11/2021

Signed on behalf of the Health and Wellbeing Board 	Bradford and District Health and Wellbeing Board
By	Councillor Susan Hinchcliffe
Position	Chair of the Health and Wellbeing Board
Date	16/11/2021

1. Background and Context

The Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLUHC) have published a Policy Framework for the implementation of the Better Care Fund (BCF) in 2021-22. The Framework forms part of the NHS mandate for 2021-22.

Local areas were not required to submit BCF plans in 2020-21, given the exceptional pressures on systems due to the COVID-19 pandemic, but were required to agree use of the mandatory funding streams locally, to pool these into a joint agreement under section 75 of the NHS Act 2006 and to provide an end of year report.

Use of BCF mandatory funding streams (clinical commissioning group [CCG] minimum contribution, improved Better Care Fund [iBCF] grant and Disabled Facilities Grant [DFG]) must be jointly agreed by CCGs and local authorities to reflect local health and care priorities, with plans signed off by Health and Wellbeing Boards (HWBs).

The BCF Policy Framework sets out four national conditions that all BCF plans must meet to be approved. These are:

- **A jointly agreed plan between local health and social care commissioners**
- **and signed off by the Health and Wellbeing Board.**
- **NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution.**
- **Invest in NHS commissioned out-of-hospital services.**
- **Plan for improving outcomes for people being discharged from hospital**

This narrative alongside the income and expenditure template 2021/22 responds to the BCF Policy Framework and BCF Planning Requirements 2021/22, enabling areas to agree plans for integrated care that support recovery from the pandemic and build on the closer working many systems developed to respond to it.

2. Governance

2.1 Bradford Health and Wellbeing Board

The Health and Wellbeing Board is the lead partnership in the Bradford District Partnership working closely with the other Strategic Delivery Partnerships.

The Health and Wellbeing Board brings together leaders from across the district including the Council, the NHS, the Police, Fire and Rescue, social housing and the Voluntary and Community sector. Our shared ambition is:

> **To create a sustainable health and care economy that supports people to be healthy, well and independent**

The Board provides strategic direction to a wide range of organisations that organise health and wellbeing services, and support people to take good care of their own health and wellbeing; helping more people to take control of their lives and to have more of a say in how their health and wellbeing needs are met. We will lead real improvements in the long-term health and wellbeing of all our population.

2.2 Bradford District and Craven Health and Care System Executive Board

The Executive Board provides the formal leadership for the Bradford District and Craven Health and Care System. The Executive Board is responsible for setting strategic direction and agreeing the broad objectives for our local system. It provides oversight for all system

business, and a forum to make decisions together on those matters which are best tackled collectively.

The Executive Board leads the local place based partnership which is responsible for agreeing and implementing plans that provide:

- a greater focus on population health management
- facilitate integration between providers of services around the individual's needs, and
- a clear focus on improving health and reducing inequalities

Through the Executive Board we will take collective responsibility for:

- Managing collective performance, resources and the totality of population health
- Agreeing ambitious outcomes, and engaging people and communities
- Identifying good practice and innovation and ensuring it is spread and adopted through the system.

Local system oversight and assurance functions provide a mechanism for partner organisations to take ownership of system performance and delivery and hold one another to account.

Our vision

People will be healthier, happier, and have access to high quality care that is clinically, operationally and financially stable. People will take action, and be supported to stay healthy, well and independent through their whole life and will be supported by their families and communities through prevention and early intervention, with greater focus on healthy lifestyle choices and self-care. When people need access to care and support it will be available to them through a proactive and joined up health, social care and wellbeing service designed around their needs and as close to where they live as possible.

In short … Happy, Healthy at Home

Membership

The Executive Board will include the following members:

- Accountable Officer, Bradford District and Craven NHS CCG
- Chief Executive, City of Bradford Metropolitan District Council
- Chief Executive, Airedale NHS Foundation Trust
- Chief Executive, Bradford District Care NHS Foundation Trust
- Chief Executive, Bradford Teaching Hospitals NHS Foundation Trust
- Chair of the Bradford District Assembly, representing the voluntary and community sector
- Chief Executive of the Bradford Care Association, representing independent care sector providers
- Strategic Director of Health and Wellbeing, City of Bradford Metropolitan District Council

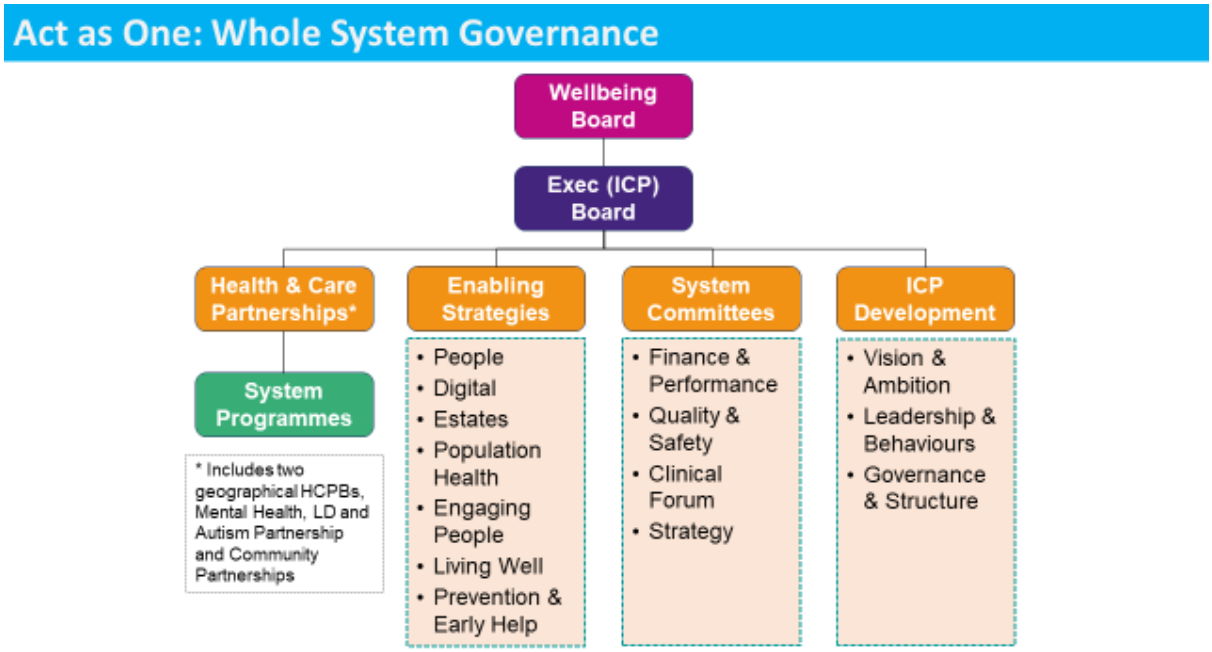
2.3 Systems Leadership through Act as One

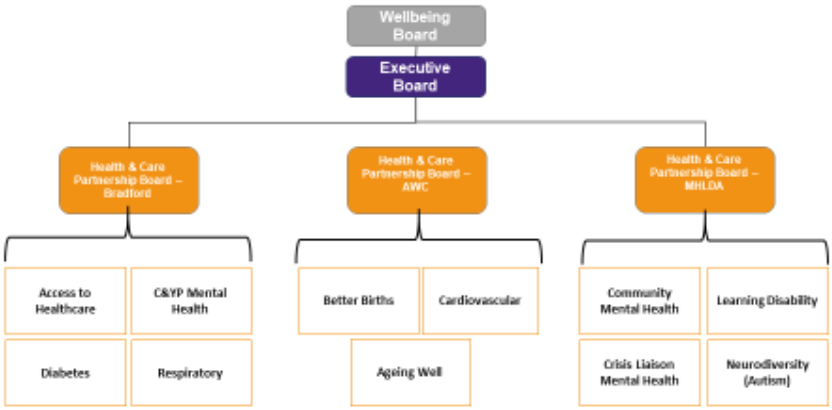
We are committed to transforming our systems and modernising health and social care in our area so that our local communities can enjoy the right quality of service and support at the right place at the right time, provided by the right person(s). Our success in doing so will be determined by local people and depend on our ability to positively fuse and maximise the potential of the different organisational cultures across health and social care. Our approach requires determined and purposeful leadership that recognises and steps up to the challenge of a creating and actualising a new ambition.
Towards the end of 2020, the Health and Care Partnership Boards set out to bring together a number of different areas of work into one programme, which they called 'Act As One'. The aim of this was to encourage partnership working and a joined up approach to health and care.

The idea is that by maximising partnership working, we can better achieve the vision of 'Happy, Health and at Home'. They brought together 10 priority areas of work which are:

1. Access to healthcare
2. Diabetes
3. Children and Young People's mental health
4. Respiratory issues (breathing problems)
5. Better births
6. Cardiovascular issues (heart and blood vessels)
7. Ageing well
8. MH Community Services Transformation
9. MH Acute Crisis & Liaison Services
10. Learning Disability and Neurodiversity strategy delivery

They aim to reduce duplication, bring together support functions, and continue the 'Integrated Care' focus across health and care. The VCS Alliance are supporting the coordination of the work of the voluntary sector across the 'Act as One' programme and are securing delivery opportunities in the priority areas for local groups.





2.4 Management and oversight

Governance of the Better Care Fund Programme is through the Bradford Health and Wellbeing Board which, since April 2013, has functioned as a statutory committee of Bradford Council. The Board operates with major contributions by the Local Authority and the CCGs.

Financial oversight and assurance of the Better Care Fund has been overseen by a dedicated Finance Forum. Since April 2021 the Planning and Commissioning Forum provides system leadership and strategic direction to the joint planning and collaborative commissioning arrangements within the Act as One local framework across Bradford District, including operational oversight of the Better Care Fund, its schemes and the joint commissioning arrangements made under the S.75. This newly established group, replaces the Executive Commissioning Board. During 2021/22 we will work to establish the annual work plan of the group.

2.5 Legal Framework

As will other joint commissioning activities, the Better Care Fund in Bradford is managed through a Section 75 Framework Partnership Agreement between the Council and the CCGs. The Framework approach was agreed to best reflect where the Council and the CCG are in terms of developing an integrated commissioning approach in that it provides for a dedicated lead commissioner for each scheme. In the event of under spends achieved through prudent fund management, these will be managed in line with the Section 75 agreement. The existing Section 75 agreement is currently being refreshed and the new agreement will come into place for the start of the new calendar year.

3. Overall Approach to Integration in Bradford

The Strategic Partnering Agreement (SPA) for the transformation and better integration of health and care services for the population of Bradford District and Craven, is the underpinning memorandum of understanding for our health and care system. The SPA was updated earlier this year to reflect the changes in our ways of working since the original agreement was signed in 2019 and will be updated again to reflect our move to becoming an Integrated Care Partnership/Place Based Partnership through the legislative changes, applicable to Clinical Commissioning Groups.

The SPA will continue to reflect how we work together as a partnership, as well as setting out how we will manage the budget delegated to our place.

Signatories to the Strategic Partnering Agreement (2121) are as follows:

1. NHS BRADFORD DISTRICT AND CRAVEN CLINICAL COMMISSIONING GROUP
2. AIREDALE NHS FOUNDATION TRUST
3. BRADFORD DISTRICT CARE NHS FOUNDATION TRUST
4. BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
5. CITY OF BRADFORD METROPOLITAN DISTRICT COUNCIL
6. BRADFORD CARE ALLIANCE COMMUNITY INTEREST COMPANY
7. BRADFORD VCS ALLIANCE LIMITED
8. LOCAL CARE DIRECT
9. MODALITY PARTNERSHIP
10. WHARFEDALE, AIREDALE AND CRAVEN ALLIANCE
11. BRADFORD CARE ASSOCIATION LIMITED
12. AFFINITY CARE

The NHS Long Term Plan (LTP) published in January 2019 aimed to accelerate the redesign of patient care to future-proof the NHS for the decade ahead including the move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting. It also placed a focus on taking action to strengthen the NHS contribution to prevention and health inequalities**.**

The White Paper published by the Department of Health and Social Care in February 2021 builds on the Long-Term Plan vision and sets out the key components of an Integrated Care System (ICS), which are proposed to be set out in a new Health and Care Bill. The Parties have operated under a Strategic Partnering Agreement since 2019 through which they have developed an effective framework for a place-based partnership for Bradford District & Craven through their 'Act as One' approach.

This framework has been tested in extreme circumstances through the Covid-19 pandemic. The parties recognise that from April 2021 until April 2022 they will need to undertake a programme of work to further develop their partnering arrangements to become an effective Integrated Care Partnership (ICP) from April 2022.

Subject to the Health and Care Bill, it is expected that the CCG will be dissolved, and its functions transferred to the ICP in April 2022, with a mechanism to allow Place Based Partnerships at place level to exercise some functions, reflecting the subsidiarity principle.

The SPA sets out the operating framework values, principles and shared ambition of the Parties in supporting work towards the transformation of health and care and better health and wellbeing outcomes for the people who live in Bradford District and Craven through the ICP model.

It sets out a programme of work (the SPA Work Plan) to be undertaken by the Parties and the Parties have agreed in how the Commissioners and Providers will work together in a collaborative and integrated way on a 'best for Bradford District and Craven' basis.

The Parties have agreed to work towards a common vision that:

- People will be healthier, happier, and have equitable access to high quality care.
- People will be in control of their health and wellbeing, and will be supported to stay healthy, well and independent through their whole life. Communities and the health and care system will coproduce health and wellbeing and will focus on prevention and early intervention.
- Reducing the widening health inequalities in Bradford District and Craven is a priority. We will tackle inequality in access and quality of healthcare, and we will

contribute to addressing the wider causes of inequality by playing a full part in social and economic development and environmental sustainability.

- When people need access to care and support it will be available to them through a proactive and joined up health, social care and wellbeing service designed around their needs. Access to services will include digital options and will be provided as close to where they live as possible.

In short … **Happy, Healthy at Home**

The Parties have agreed a collective way of working – "Act as One" – which they will use to achieve the following objectives:

- deliver the Bradford District and Craven Integrated Care Partnership Plan, and contribute to the delivery of the West Yorkshire Integrated Care System Plan;
- coordinate the local contribution to health, social and economic development to prevent future risks to health and wellbeing;
- share collective responsibility for the management of our collective resources, purposefully deployed to secure better outcomes for our population; including incrementally increasing the proportion of our resource used on prevention;
- develop population health management capabilities to:
  (a) identify, understand and take into account the wider determinants of people's health and wellbeing;
  (b) proactively improve primary and secondary prevention and better target interventions;
  (c) reduce health inequalities;
  (d) use evidence of people's experiences of services and outcomes gathered through involvement and authentic public engagement strategies to inform the co-production of simple, modern, joined-up health and care services; and
  (e) deliver personalised care; and deliver health and care services that are developed in partnership with the communities they seek to serve; and
- recognise, support and develop the collective health and care workforce as a key asset in achieving the vision and objectives.

The governance structure for the SPA in Bradford District and Craven will consist of:

- the ICP Board;
- the Airedale Wharfedale and Craven Health and Care Partnership Board; the Bradford and District Health and Care Partnership Board; and the Mental Health, Learning Disabilities and Neurodiversity Health and Care Partnership Board

(together the "Health and Care Partnerships");

- the Programme Boards; and the System Committees.

The Services that are within the scope of the SPA are be:
(1) all of the health and care services commissioned by the CCG; and
(2) adult social care, children's social care and public health services commissioned by the Council.

The system 'Act as One' programme and partnership boards demonstrate how as a system, we agree and operationalise our approach to integration, with membership representation from our system stakeholders. Joint initiatives such as the joint commissioning road map, development of the system Planning and Commissioning Forum and other key initiatives are leading to sustainable plans for delivery of services and are just a few of the areas that will deliver real improvement. Additionally, the system has begun to utilise resources

collectively through creation of several posts that are at system level and joint posts between the local authority and the CCG.

3.1 Supporting people to remain at home

Bradford Better Care fund continues to play an important role in the transformation and sustained delivery of the requirements of the Care Act. The Happy, Healthy, at Home model has been underpinned in adult social care by a three tier model aiming to prevent reduce and delay the need for social care services. he three tiers describe how Adult Social Care supports people and is set out in the diagram below:

Figure 1: Three Tier Model for Social Care

The Three Tier Model relies on good information being available to people, local communities being central to supporting people, and that when people do need longer term support that they have an active role in achieving this.

To ensure the sustained delivery of the Care Act duties, Better Care funding continues to be used
to:

- encourage more people to live independently across Bradford District
- work with communities to build on resources to support people outside of council funded support
- reduce the need for ongoing support from adult social care
- ensure our support builds on the strengths and abilities of people, their families and their local communities
- tailor the on-going support we provide to individuals through personal budgets, creative support planning and building on people's strengths and resources to meet their aims
- reduce waiting times for people contacting adult care and support
- Prevention & maximising independence in home care

The Maximising Independence (MI) focus is a core part of reablement, home support and intermediate care services commissioned and delivered in Bradford through the Better Care Fund.

The detail in the Planning Template sets out a range of BCF funded services to keep people independent and living in their own homes or community settings. These include core services of home support, reablement

services, the collaborative care team and integrated community equipment services, as well as low level prevention and support services such as Social Prescribers who work with people who feels they need some extra support to improve their emotional health and wellbeing, need support to make new friends or find out about local activities. People accessing Social Prescribing include those who have lost family, have housing or money issues, or are struggling to come to terms with a long-term medical condition. The Social Prescriber meets with the individual to discuss the type of support they need. A plan of action will be discussed and they may be referred or signposted to other community services.

A range of daytime activities are available for people living in the community. 137 community activity groups are funded in local community centres. Of those there are 45 who cater for a specific BAME community of older people and have language skills and cultural awareness to support older people to stay independent, active and linked with their communities. Many are gender specific groups. In addition, there are six other men in sheds groups, and two for the older LGBTQ community, again gender specific.
Carers' Resource provides support for carers, offering a range of services such as Carer's Wellbeing Grants to enable carers to promote their own health and wellbeing and to help carers continue caring. Carer Navigator service supports friends and families who have a loved one admitted to Airedale General Hospital and Bradford Royal Infirmary, the service can support in meetings about discharge from hospital, help to organise social and personal care, support emergency planning, and connect with other Carers' Resource services such as the Carer Card and Advice Line.

3.2 Changes in BCF funded services 2020/21

A business review process was undertaken of the short term social care operating model in the summer of 2020 to ensure we could respond to the increasing demand and implement changes required in the Discharge and Community support operating model. The following changes were made in collaboration with partners (NHS, Care Providers, Community and Voluntary sector providers). BEST, our enablement service, enhanced the reviewing team function (HSRT) to include increased reviewing of packages of support including those placed with independent home support providers and for placements back to a person's existing provider after a transfer home. BEST place packages with home support providers and work to support them after transfer from hospital. This has allowed us to respond to the unprecedented demand for home support from both hospitals and community. In 2020/21 57% of people discharged from BEST were discharged either without the need for a long term care package, or with a reduced package of care, this figure has increased up to 65% in 2021/22. In the same time period we have also seen the length of stay in BEST fall from 3.6 weeks, down to 3.3 weeks.
Enablement coordinators from BEST have been included in both hospital Multi Agency Integrated Discharge Team's (MAIDTs) this year which has allowed social workers to assess out of hospital in line with the guidance and improved flow out of hospital. Carer Navigators commissioned from the VCS and part of the jointly funded Carers Resource Service across the district have worked with enablement coordinators, as trusted assessors, to support local authority managed short term care beds and have been recruited and introduced into the hospital MAIDT this year. This has improved the flow into beds or back to the Enablement Coordinators if wrongly signposted (for local authority managed short term bed) and social workers to support carers in the assessment process.
Pathway O has been enhanced by a multi-agency social team (MAST) commissioned from the VCS jointly by the local authority with the NHS. It provides support for substance misuse (alcohol particularly), mental health support and social prescribing and links people to

services in their communities. This is in addition to home from hospital, supported discharge. Equipment provision from BACES has been reviewed and enhanced as well as local authority occupational therapy provision. Tech enabled care has been enhanced over the past year and will be embedded in enablement over the next year.
The development of an integrated urgent community response service in line with the NHS plan is being progressed building on the partnership working between BEST, Tapid Response and Virtual Ward and Airedale Collaborative Care Team, alongside these services the in house residential service is growing a Community Outreach Support Team to further enhance the ability to be more responsive.

3.3 BCF Metrics

Plans have been set for each of the BCF key metrics for 2021/22, in line with other plans and priorities across the Bradford health and social care system, and are shown in the table below.

Metric	Plan	All England Av/CIPFA Comp
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions – 2021/22 plan 1,064.2	Bradford ranks 120 out of 152 Local Authority areas, based on 19/20 data (latest data available on BCF Exchange).
Length of Stay	Proportion of inpatient resident for more than 14 days – 21/22 Q3 plan 9.5% – 21/22 Q4 plan 9.5% Proportion of inpatient resident for more than 21 days – 21/22 Q3 plan 5.5% – 21/22 Q4 plan 5.5%	Bradford ranks 19 out of 152 Local Authority areas, for Los 14+ days and 51 out of 152 Local Authority areas, for LoS 21+ days.
Discharge to normal place of residence	2021/22 plan - 95.0%	Bradford 30 out of 152 Local Authority areas
Reablement	2021/22 plan – 79.1%	Bradford ranks 8 out of 15 within the CIPFA nearest neighbour comparator group and 91 out of 152 Local Authority areas.
Residential and Nursing Placements	2021/22 plan- 547	Bradford ranks 8 out of 15 within the CIPFA nearest neighbour comparator group and 90 out of 152 Local Authority areas.

3.3.1 Avoidable admissions

Data provided via BCF Exchange 19/20 = 1097.1 (rank 120/150). The 20-21 actual is an

FOT using CCG data uplifted to reflect variation with BCF (BCF figures approx. 14% higher) 2020/21 data is not reflective of reality due to covid. Plan assumes 3% reduction on 2019/20, which is in line with M1-M6 reduction in admissions according to CCG data (2019/20 Vs 2018/19)

3.3.2 Length of Stay (LoS)

Performance against other LAs on both Length of Stay metrics is strong. 14+ - Bradford 9.4%, (rank 19/150) and 21+ - Bradford 5.3%, (rank 51/150) National Av 16.38%. LoS targets have been set to maintain this good performance - 14+ days target set to remain at top quartile performance and 21+ days upper middle quartile performance. Given the backdrop of an anticipated challenging winter period these targets represent a stretched position for the Bradford system.

3.3.3 Discharge to normal place of residence

Latest data provided via BCF Exchange - Bradford 94.2%, (rank 30/150) National Av 92.6%. This target places Bradford in the top quartile and above national average and given the breath of schemes to support discharge, maintain and regain individual's independence we anticipate this will be a realistic target.

3.3.4 Reablement

This metric is a long standing metric within the BCF plan. The target of 79.1% has been set in line with England average. Currently, Bradford ranks 8th out of 16 in the CIPFA comparator group. The regional average is 76.4 and All England is 79.1. Discharge to Assess has been running since March 20 and due to covid many older people being discharged have a higher acuity and more complex needs, resulting in fewer people being at home 91 days after discharge than seen in pre-covid years.

3.3.5 Residential and Nursing Placements

Bradford ranks 8th out of 16 in the CIPFA comparator group. The regional average is 549.8 and All England average is 498.2. Home First is the standard approach unless a person's needs are so great that it is not possible for them to remain in their own home or an alternative community setting. Through both discharge and intermediate care services, the individual's independence is maximised in a community setting prior to any decision on long term care options that may subsequently be taken. Maintaining the 20/21 numbers for admissions to permanent care against a background of high Covid 19cases and a growing population, is a stretched position for Bradford.

A range of BCF schemes support the ambitions set in these key metrics. BCF commissioned services continue to underpin the discharge process, keeping people independent and in their own homes. National data shows that Bradford remains in the top quartile for length of stay ensuring that people do not remain in hospital longer than in necessary and are discharged promptly back to their normal place of residence and supported to recover.

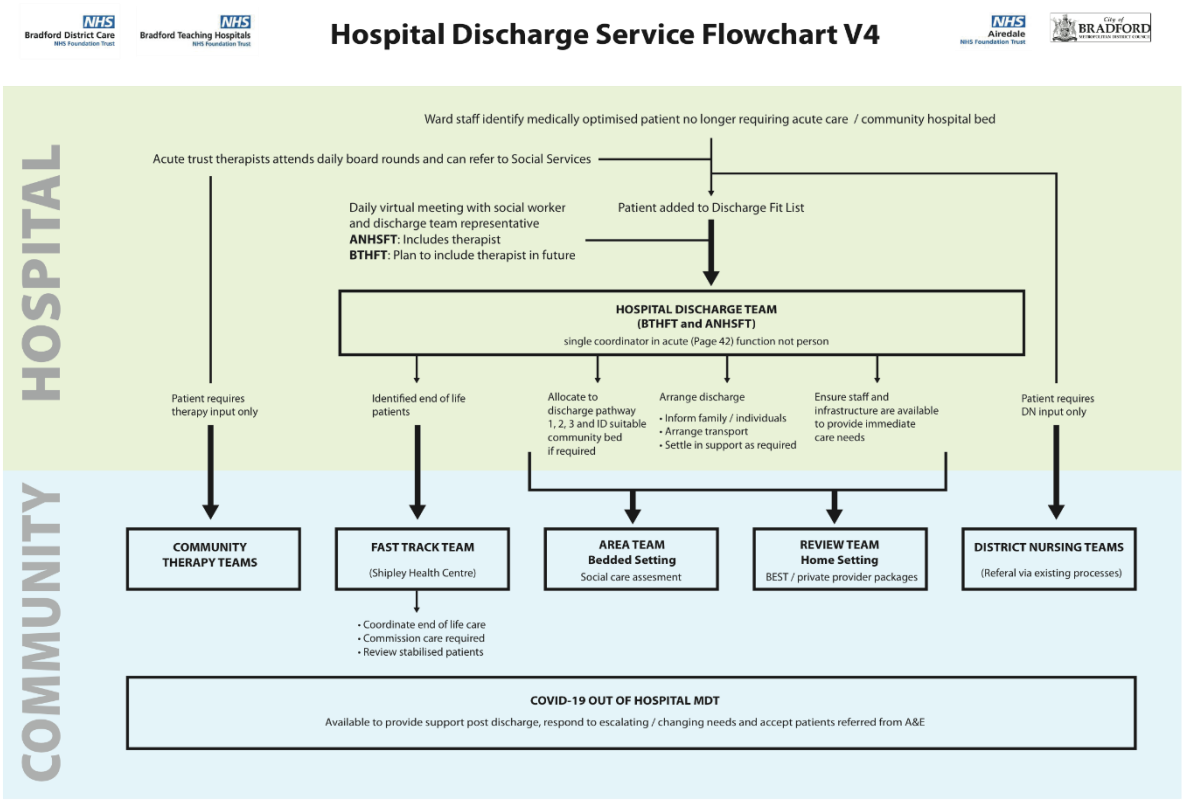
People are supported to recover in their own homes with packages of care relevant to their needs and carers are supported with breaks and a range of resources through the integrated Carers Resource Service. Data from April 2019 to August 2021 shows that 95% of people were discharged back to their usual place of residence. Residential and nursing placements are only used where the persons needs are such that they cannot be supported in an alternative setting. The robust choice of intermediate care services funded through BCF allows people to be supported back to independence following discharge. Our Virtual Ward and Early Supported Discharge Services also provide an alternative to extended hospital stays allowing people to be discharged earlier, back to the community.

4. Supporting Discharge (national condition four)

4.1 Discharge to Assess

The Discharge to Assess model has been implemented in Bradford since March 2020 with an intention to support more people to be discharged to their own home or normal place of

residence. A range of services have been out of hospital service have been funded through the Better Care Fund since 2017, and these have been grown and strengthened during the C19 pandemic. Figure 1 shows the interface between these services at a hospital and community level.



4.2 Multi-Agency Integrated Discharge Team (MAIDT)

The MAIDT team (Hospital Discharge Team) is a multi-agency team operating a discharge to assess model.

The BCF in Bradford continues to support the interface via a range of intermediate care services including a Virtual Ward. The Elderly and Intermediate Care Service in Bradford strives to provide safe, high-quality care to the older population of the region, and is a leader in the development of safe alternatives to acute care, including the Virtual Ward.

The Multi-Agency Integrated Discharge Team (MAIDT) brings together dedicated health and social care professionals and members of the voluntary sector who work to ensure patients with complex needs can be discharged from our hospitals on the correct pathway in a safe and timely way.

20 per cent of hospital discharges are more complex and are referred to the MAIDT.

The MAIDT was established to bring about a number of step changes in the way we care for our patients when they are ready to leave us, including:

- A single referral process
- System change
- Co-ordinated discharge plans
- Joint assessment process
- Effective discharge
- Better overall outcomes for patients

The team's key stakeholders include Bradford Teaching Hospitals NHS Foundation Trust (BTHFT), Bradford District Care NHS Foundation Trust (BDCFT), City of Bradford

Metropolitan District Council (CBMDC) and the voluntary and community sector (VCS), primarily Home from Hospital.
MAIDT supports the above organisations' commitment to working with common objectives and shared principles which aim to deliver better co-ordination of services for people being discharged from our hospitals.
The MAIDT aims to practice person-centred care planning and support for eligible adults with complex needs. We are committed to home-first discharge wherever possible. The key principles of this service are:

- To maximise wellbeing
- Maximise choice and control
- Maximise independence, function and self-care
- To help people receive the right care at the first time of asking
- To maximise opportunities to enable safe discharge from hospital by working with the individual and, with their consent, their families to understand their needs prior and post hospital admission

Interventions provided by the service include:

- Joint (health and social care) triage of referrals and support for ward-based assessments as required of individuals and goal planning
- The lead MAIDT team member will devise a multi-agency discharge plan which will support the person and their carers to allow for a safe and effective discharge and prevent hospital re-admission due to poor discharge planning
- The lead MAIDT team member will ensure referral to appropriate community-based services for patients who require individual complex packages of care, including community complex care teams.
- The MAIDT work with carers and families to establish their ability to engage with their discharge and the support they need.

4.3 Strategy and priorities for supported discharge

Within scope of the Act as One Ageing Well programme, a system wide Discharge to Assess working group was established in January 2021. The group is chaired by colleagues within Adult Social Care at Bradford Local Authority and consists of key partners from Airedale NHS Foundation Trust, Bradford Teaching Hospital's Foundation Trust, Bradford District Care Trust, North Yorkshire County Council and VCS.
The aim of the group is to develop a more integrated health and social care Discharge to Assess model across Bradford district & Craven to improve flow and support our strategic vision of 'Home First' for all people.

Priorities of the working group

- Education and awareness of pathways 0-3
- Developing a system wide dashboard which provides one version of the truth
- Process mapping to identify gaps/pressures and creating opportunities for shared learning across Bradford and Airedale
- Utilising NHSE/I Service Development Funds (£300K NR) to support flow and prepare for Winter
- Alignment to national guidance

Work undertaken so far

- Designed and developed pathway posters to be displayed on the wards to support staff in understanding the different pathways (0-3)

- Established a working group with BI leads to explore how we develop a system wide dashboard
- A series of workshops involving all system partners (with facilitative support from ECIST) are taking place. The first workshop focussed on pre-discharge planning
- A series of process mapping sessions with Airedale to work through the gaps and pressures
- Currently planning how to utilise NHSE/I SDF non-recurrent monies to support flow through Winter

4.4 BCF Schemes supporting discharge

The detail in the Planning Template clearly sets out the number of schemes funded through the Better Care Fund including:

- A range of intermediate care beds, which support safe, timely and effective discharge;
- The Home from Hospital (HFH) service, provided by our VCS partners supports discharge from the acute setting. Home from Hospital in Bradford, Airedale & Wharfedale is a VCS service for adults who are being discharged home and need extra support, including, patients at risk of readmission to hospital; people worried about how they will cope when they get home; people with dementia and long term conditions; people living alone and people living with someone. The Home from Hospital team and volunteers ease the process of settling back home, enabling people to regain confidence and independence, they support residents by delivering a basic hamper, give weekly calls for up to six weeks, liaise with health and social care professional, help to access appropriate benefits and help to set up ongoing support eg domiciliary services and telephone befriending;
- The Virtual Ward has been established as an enabling multi-disciplinary team to support older people at home. It has largely been a step-down model with a 'discharge to assess' mentality linked to our older people assessment unit. Moving forward we are hoping to offer a comprehensive geriatric assessment to all patients, with a view to preventing admissions from primary care.
- Bradford Enablement Support Team (BEST) provides reablement support for 6 weeks following discharge.

5. Recruitment and Retention of staff in social care

Staff recruitment and retention within the care workforce remains a challenge for Bradford and remains part of our priority planning for 2021/22. In 2020/21 we increased the fee rate for home support by 7.2%. This increase was in recognition of the desire to improve the terms and conditions of the wider workforce, including enabling providers to fulfil more aspects of the Unison Ethical Care Charter.

A number of skills and recruitment campaigns have been held, supported by the Workforce Capacity Fund with our partner Skills House. Skills House offer a bespoke training offer which enables individuals to gain care certificate training and then be supported to gain employment in the Bradford care sector. Other initiatives in development include a 'Care Academy' in partnership with local colleges in order to create pathways in care that give people a genuine career path and progression in the care sector. Further recommendations for the Workforce Capacity Fund include Commissioning specialist support to develop a longer term workforce strategy and pass porting funds direct to care providers to allow them to offer incentives such as joining and retention bonuses.

Bradford is an Ethical Care Council and committed to commissioning homecare services in

line with the Ethical Care Charter. A number of commissioning test-bed models are currently being piloted over winter 2021/22 ahead of a larger review of Home Support ahead of recommissioning in 2022/23. These models will allow us to test out the effectiveness and proof of concept over the difficult winter period to support providers with recruitment and retention. Initiatives include Extra Rural rates for LS29 area, an area where staff recruitment is particularly challenging and block purchasing a number of hours to give financial stability to providers in order to respond flexibly to the rapid changing demand in hours as a result of discharge to assess.

6. Disabled Facilities Grant (DFG) and wider services

The Disabled Facilities Grant (DFG) continues to be pooled within the Better Care Fund and aligned to the strategic intentions of the fund. The objective of this scheme is to ensure that funding is used and targeted at specific people to either enable timely hospital discharge or provide a proactive service that prevents hospital admission.

The delivery of DFGs is a statutory duty of the Council and is a long standing method of providing adaptations to resident's homes to enable them to live safely and independently. This work is under pinned by the provision of equipment and low level adaptations provided by the BACES service, also funded through BCF. Health and Occupational Therapy services work alongside Social Care to assess need and through the delivery of DFG ultimately ensure that people are safer and can remain as long as possible in their own home which supports the Home First model.

Use of the Grant aligns to the Bradford Housing Strategy (2020-2030). This strategy sets out the vision, priorities and approach for meeting the housing needs of the residents of Bradford District in ways which can contribute to a more productive and inclusive economy, address health and social inequalities, tackle the challenge of climate change and help build stronger communities. The District has a growing population of older people aged 65 and over that is expected to increase by 39.5% to around 113,000 by 2037 adding pressure to provide housing which is suitable for our ageing population. This is reflected in the ongoing demand for major adaptations funded through DFG, with the Housing team receiving an average of 50 new referrals for DFG each month over the last four years.

High levels of demand for assistance with adaptations mean that the Council currently has 730 cases in the DFG process with an estimated total value of £8.8m.

Delivery of the DFG programme during and after the Covid pandemic is posing a number of practical challenges which have introduced some delays to the programme. These include:

- DFGs are delivered to a vulnerable group, some of which are understandably reluctant to have officers/contractors in their homes due to their vulnerability to Covid.
- Availability and capacity of contractors to deliver the programme, particularly the larger and more complex cases that require extensions
- Availability of materials such as plaster, doors and timber
- Ability to recruit and retain appropriately qualified housing surveyors

A key objective of the Bradford Housing Strategy (2020-2030) is 'Homes for All' and to ensure provision of sufficient housing to meet the needs of people with disabilities through adaptations, and the provision of more homes with level access and homes that are able to be adapted

- The number of people aged 65 and over is projected to increase from 81,000 in 2019 to 113,000 by 2037, a 39.5% increase. The 75 plus will increase by 56.7% and 85 years plus by 68.5%.

- The level of people diagnosed in the District with dementia is increasing, partly due to improved and earlier diagnosis, with an estimated 5000 people living with the condition currently.
- Estimates of people with a Learning Disability vary between 8000-9400 but represent significant challenges for housing, care and support providers.
- 1,400 people with complex need are placed in supported housing each year.
- Around 12,000 households live in properties which have either been adapted or purpose built for someone with an illness or disability. Analysis estimates that about 9,100 wheelchair adapted homes are needed now or in the next 5 years
- Bradford District is ethnically diverse with 64% classed as White British, total Black and Minority Ethnic 36%, with the South Asian population 26.8%, and the largest grouping amongst the BAME being the Pakistani population representing 20.4% of the population (Census 2011). The 2011 census identified there were 424 gypsy and traveller households of whom 76.4% lived in general housing and 23.6% in caravans.

Challenges include:

- A recent housing strategy engagement event identified that there were over 30 groups in need of support and assistance representing the breadth of challenges facing support services.
- An ageing society poses specific challenges when developing and delivering services with a range of needs associated with old age.
- Poverty associated with worklessness and low skills levels represent a major challenge when attempting to address access to suitable accommodation for many of our households

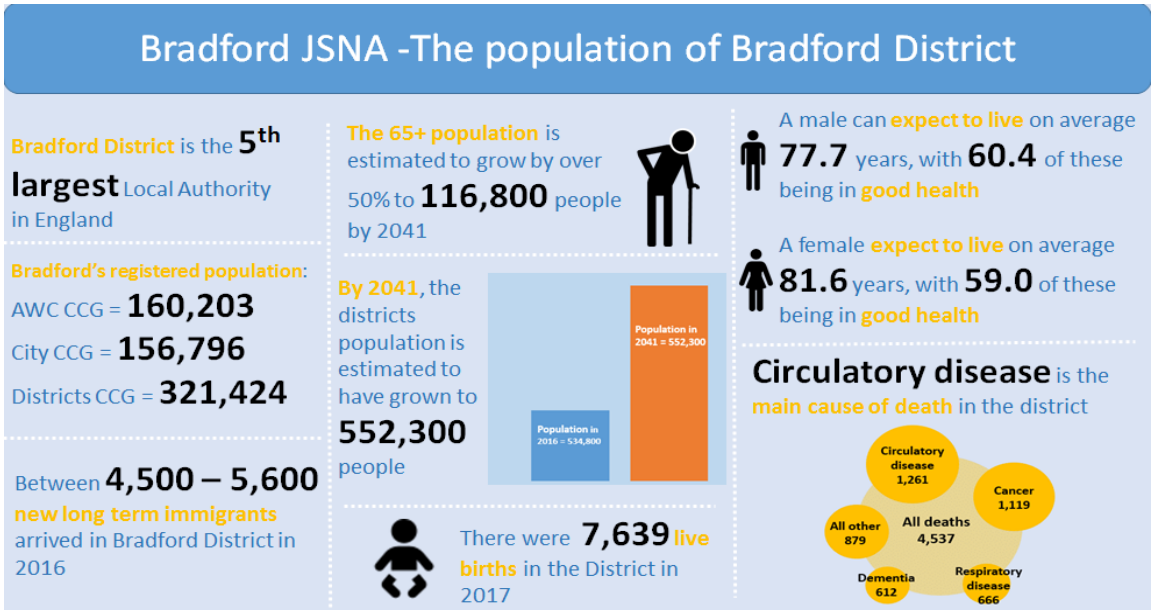
Our approach to delivery:

- Policy makers and planners will have regard to size, location, and quality of homes needed for future needs of older people and other needs groups, in order to allow them to live independently and safely in their own home, and, if and when the need develops, to enable them to move into more suitable accommodation.
- A wide choice of housing options will be made available by the sector including Extra Care, adapted housing, shared housing and self-contained units with the necessary care and support to maintain a good quality of life.
- We will ensure provision of sufficient housing to meet the needs of people with disabilities through adaptations, and the provision of more homes with level access and homes that are able to be adapted.
- We will encourage developers to provide dementia friendly and “Lifetime Homes”.
- The Council and the Housing Partnership will work with the health sector to minimise the impact of poor housing on health including impacts of fuel poverty.

Aligned to the strategy, a number of housing options are available for individuals whose care and support needs have increased. Extra Care Housing is designed to meet the care and support needs of people over 55 and younger people with disabilities who are becoming more frail and less able to do everything for themselves. There are seven different schemes in the Bradford district, managed by five housing providers. The schemes provide a community based alternative to residential care for older people who value their independence, by providing a range of self-contained housing with support and care onsite. The Council has taken proactive and strategic action with regard to the provision of high quality Extra Care accommodation in the District and in doing so has developed Fletcher

Court which is the newest Extra Care Housing development in the district. Designed to dementia friendly standards this facility is intended to support people to live happy healthy lives behind their own front door, with care support.
In addition, there are 4 other extra care housing schemes. Within each scheme are dedicated units providing support for people whose needs have increased following an acute hospital stay, or where their own home may not meet their needs upon discharge. This allows people a period of reablement, rehabilitation and confidence building before they return back to their own home.

7. Equality and health inequalities.



Across Bradford District and Craven, there are significant health inequalities in communities and the gap in how long people will live is stark. People in the most deprived areas of our district are living with more ill health and dying earlier.

Tackling health inequalities in Bradford is a key strand in all programmes. Our Reducing Inequalities in Communities (RIC) programme is a movement of people and projects who are working together to reduce health inequalities and close the health gap in Central Bradford; so everyone can live healthier, happier and longer lives.

7.1 The Health Gap

Health Inequalities are prevalent across the district. Starting in the least deprived area, Wharfedale, life expectancy is 87 years for women and 84 years for men. Moving into central Bradford, this dramatically reduces. In the most deprived area, Manningham, people's life expectancy here is around 10 years less than Wharfedale.

It is not just about how long people live, it is how well they live too. If we take away the time people are living with poor mental wellbeing and ill health we see healthy life expectancy. On this measure the gap gets bigger with people living in Manningham experiencing 20 years less healthy life than those in Wharfedale.

7.2 Population health management approach

The RIC programme follows a population health management framework, using data and knowledge about our local communities to see where there are the greatest inequalities. It involves identifying groups of people at risk of ill health and then focusing on what can be done to prevent it or help them to manage it.

Within Bradford District and Craven (BDC) we are creating a Reducing Inequalities Alliance (RIA) which will support the ICS aim to 'tackle inequalities in outcomes, experience and access'. The RIA will raise awareness and understanding of health and wider inequalities and provide a place through which Bradford District and Craven will take collective action to

reduce inequalities.
As a system we are currently defining how the RIA will operate and achieve its aim.
The development of the RIA builds on the work that has been established within the Population Health Management (PHM) Programme, itself an enabling programme of Act as One. The Act as One PHM enabling programme board is responsible for overseeing and coordinating the implementation of PHM as an enabler across the Bradford District and Craven place to improve population health and wellbeing and reduce health inequalities.
Our Population Health Management (PHM) enabling programme has been created to support the system to improve our PHM approach across Bradford District and Craven. This involves all of the key partners across the system collaborating and bringing our data processing and analytical capabilities together in order to generate better questions, intelligence and hypotheses for action, interventions and ultimately to have a more potent impact upon the health and wellbeing of our population.
The aim of PHM programme is to facilitate the PHM approach at place and neighbourhood levels, building on existing networks and a shared commitment to reduce health inequalities.
Our approach to PHM recognises that PHM is 10% data and 90% engagement, leadership and culture and a core function of this enabling programme is to facilitate the interpretation of that data by presenting it in ways which are appropriate for multiple users in the system, each of which will have their own requirements in terms of presentation. What they will have in common is a need for the system to generate intelligence.
Our PHM approach is to build from intelligence, identify effective, evidence-based interventions and implement them. It is not necessarily about making wholesale changes to the local health and care environment, but rather seeing where existing services, system and community assets could be adapted or tweaked so they are more relevant and useful for the population and to re-balance services in favour of prevention and long-term wellbeing.
Locally led Community Partnerships (CPs), operate on a 30,000-60,000-population footprint. Working alongside our primary care networks (PCNs) these CPs engage proactively with communities, take a strengths-based approach, and focus on prevention. Membership of the CPs has been driven by need to reflect local communities, and groups involved include VCS, community services, local authority ward officers, general practice and acute staff. Mental health is also included.
The Bradford VCS Alliance (BVCSA) works closely with local VCS Organisations, the importance of local and grassroots organisations and their role in understanding and being known to (trusted by) local communities. This ensures that projects are delivered in an appropriate manner for the communities they serve, be they BAME, LGBT, people with dementia etc.

7.3 How BCF is contributing to reducing health inequalities in Bradford

The BCF Plan is a vehicle for articulating how we will use system and place level mechanisms to cement health inequality work in strategic and operational planning. The Director of Public Health is a key member of the Planning and Commissioning forum which operationally oversees the Better Care Fund Plan. One of our key commissioning principles as a system is Reducing Inequalities through ensuring services and interventions are designed to align uptake with the distribution of need, including removing barriers to access; distributing resources and intervention proportionately to address need so as to achieve more equal outcomes; and recognising the earlier onset of conditions in deprived areas compared to the least deprived areas.
This means that there is a robust connection between decision making at programme level and subsequent allocation of BCF funds to address inequalities and frontline services. We are continuing to make the connections across the system, as well as seeing the benefits in the process of flexible commissioning activity to reduce inequalities.

During the last 12 months, contracts have been issued to VCS providers in response to the changing needs of the pandemic. The Covid 19 Small Grants process included a standard clause ensuring resources were mobilised in response to emerging inequalities.

Appendix B – BCF Expenditure plan

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