Bradford District Health and Wellbeing Board

Better Care Fund Narrative Plan for 2022/23

SUBMISSION SUMMARY

Local Authority	City of Bradford MDC
Integrated Care Board (ICB)	NHS West Yorkshire Integrated Care Board
Boundary Differences	The West Yorkshire ICB covers the geography of the five upper tier Local Authorities in West Yorkshire, plus the Craven District of North Yorkshire. Bradford District is wholly within the geography of the ICB
Date of narrative submission:	26th September 2022
Minimum required value of pooled budget: 2022/23	£72,852,176
Total agreed value of pooled budget: 2022/23	£72,852,176
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– Implementing the BCF policy objectives: • enable people to stay well, safe and independent at home for longer • provide the right care in the right place at the right time

AUTHORISATION AND SIGN OFF OF THE

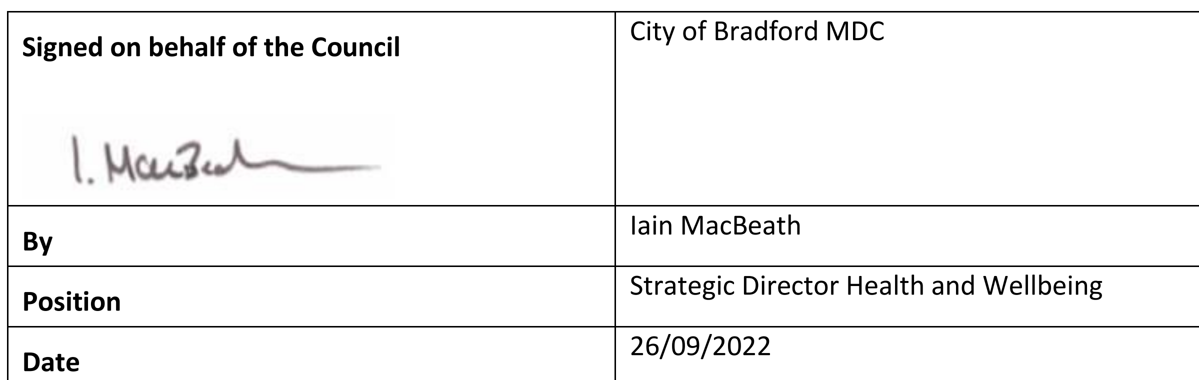
BRADFORD DISTRICT BETTER CARE FUND

The BCF Plan has been produced by officers of NHS West Yorkshire ICB and City of Bradford Metropolitan District Council with support from the Voluntary Care Sector, Housing and Disabled Facility Grant leads. All local partners work together as the Bradford District and Craven Health and Care Partnership

This plan has been jointly agreed by City of Bradford Metropolitan District Council, NHS West Yorkshire ICB and the Chair of Bradford Health and Wellbeing Board. The plan has been presented at a number of forums including Bradford District & Craven Health and Care Partnership Leadership Executive, which has the following core membership:

- Place Lead for Bradford District and Craven, West Yorkshire ICB
- 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 VCS Alliance, 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
- Strategic Director of Childrens Services, City of Bradford Metropolitan District Council
- Director of Public Health, City of Bradford Metropolitan District Council
- Medical Director of the Local Medical Committee (GPs)
- Chair of the Clinical Advisory Board (PCNs)
- Chair of the Clinical Forum

Signed on behalf of the ICB	NHS West Yorkshire Integrated Care Board
By	Mel Pickup
Position	Place Lead Bradford District and Craven
Date	26/09/2022



Signed on behalf of the Council	City of Bradford MDC
By	Iain MacBeath
Position	Strategic Director Health and Wellbeing
Date	26/09/2022

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	26/09/2022

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 2022-23. The Framework forms part of the NHS mandate for 2022-23.

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 ICB minimum contribution.**
- **Invest in NHS commissioned out-of-hospital services**
- **Implementing the BCF policy objectives:**
    - enable people to stay well, safe and independent at home for longer
    - provide the right care in the right place at the right time

Since the last Better Care Fund Plan (2021/22), The Health and Care Act 2022 required the establishment of integrated care boards (ICBs) and the creation of integrated care partnerships (ICPs). Integrated care partnerships bring together health, social care public health and wider voluntary, community, and social enterprise representatives.

The Bradford District and Craven Integrated Care Partnership (ICB) was established in July 2022 and will now exercise the commissioning functions, previously exercised by clinical commissioning groups (CCGs), including those within the Better Care Fund.

This narrative alongside the income and expenditure template 2022/23 responds to the BCF Policy Framework and BCF Planning Requirements 2022/23.

The Better Care Fund in Bradford remains a key vehicle supporting the priorities of our Placed Plans and the delivery of the Health and Wellbeing Strategy. The joint fund held by the Council and the ICB support schemes which sustain admission avoidance, enhanced personalisation, supporting prompt hospital discharge to return people back to their normal place of residence and improve equality and reduce health inequalities.

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 Partnership Board

The Partnership provides the formal leadership for the Bradford District and Craven Health and Care System.

As a system we are working to a new integrated approach to leading **performance development** and culture change, encompassing:

- operational performance,
- quality and outcomes,
- service transformation, and
- finance.

Our approach must be **value adding** in comparison to the old NHS model. Featuring:

- a **single framework**, covering individual places, and WY as a whole;
- An increasing focus on making judgements about a **whole place**, while understanding the positions of individual organisations;

- a strong element of **peer review** and mutual accountability.
- a clear approach to improvement-focused **intervention, support and capacity building.**

Shared Purpose

Our population to have more chances to lead healthier lives

To create a sustainable health and care economy that supports people to be healthy, well and independent, our approach now signals a move from one of a predominantly health care focus to one of population health; planned and delivered from a system, not organisational, focus. Our response to the pandemic exemplified this when we all pulled together with a single shared purpose achieving huge gains. Our strategy sets out the commitments that will allow us to make cohesive plans that will make a difference to the health and wellbeing of local people.

Our strategic priorities are ambitious but feasible. We will increasingly align ourselves to a common set of goals, supporting the shift towards a partnership that has strong engagement with communities, helping people lead healthier lives.

Our four primary purposes 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.

We have set tackling inequality in health, wellbeing, outcomes, and access as our shared purpose because less equal societies fare worse than more equal ones, across everything from education to life expectancy. Our health inequalities can only be mitigated through working in partnership, developing new integrated service offers between health and care at every interface that reflect the fundamentally changing nature of our population in coming years.

For our Partnership, we will all:

- Lead as One in partnership with our population, in their communities
- Share as One the power and responsibility to make the best use of our collective assets
- Grow as One to strengthen our relationships, trust and our ambition; improving together
- Deliver as One through our shared, skilled and trusted workforce
- This first strategic plan provides direction and guiding principles to inform our choices and purpose as Bradford District and Craven Health and Care Partnership.

Membership

The Partnership Board will include the following members:

- Independent Chair
- Place Lead
- Primary Care Leadership (Chairs of the LMC & Clinical Advisory Boards)
- Providers of acute, community and mental health services
- People who use services and their representatives, including Healthwatch
- Local authority Chief Executives & Strategic Directors

- Social care providers
- VCSE sector senior reps
- System committee Chairs

City of Bradford Metropolitan District Council is the Housing Authority, the Chief Executive and relevant Strategic Directors sit on Health and Care Executive Board. Leads within those areas for DFG etc are invited as appropriate.

Bradford District & Craven arrangements

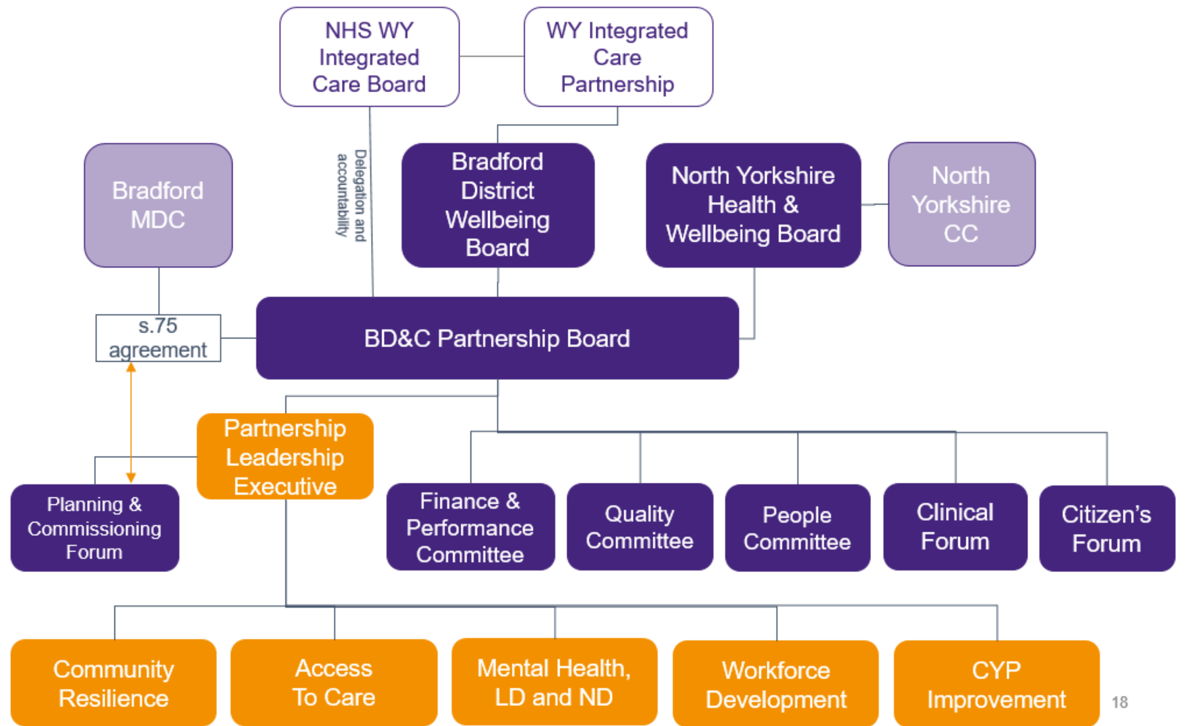


Figure 1. Bradford District & Craven arrangements

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.

Our partnership needs to prepare us for a sustainable future, from sharing good practice, collaborating on workforce developments, to enabling integration to support delivery. Collaboration has become

an essential part of a sustainable future; allowing us to design how we will work as we move to acting as one integrated care partnership.

We will Act as One in our approach to planning, recovery and priority setting in our pursuit of improved health outcomes. We will be held to account, and hold ourselves to account, for the reduction in health inequalities for our population.

We want our partnership, and our leadership, to unlock opportunities for better population health, working at the level of the neighbourhood and communities, as well as the district and with regional partners across West Yorkshire. We have chosen to widen our focus to all local people, not only patients requiring treatment.

Our 5 priority areas are:

- Community Resilience
- Access to care
- Mental health, Learning Disabilities and Neurodiversity
- Workforce development
- Children and Young people Improvement

2.4 Better care Fund 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, providing assurance to the Partnership Board.

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.

3. Overall Approach to Integration in Bradford

Greater value through the best use of our collective resources

Our partnership needs to prepare us for a sustainable future, from sharing good practice, collaborating on workforce developments, to enabling integration to support delivery. Collaboration has become

an essential part of a sustainable future; allowing us to design how we will work as we move to acting as one integrated care partnership.

We will Act as One in our approach to planning, recovery and priority setting in our pursuit of improved health outcomes. We will be held to account, and hold ourselves to account, for the reduction in health inequalities for our population.

Our experience of the pandemic underlines the importance of a focused population health approach; preventing disease, protecting people from threats to health, and supporting individuals and communities to improve their health and resilience.

Our health and care system continues to experience multiple challenges. It has also brought out the best in our people and our leadership. It focused our efforts, used our skills and experience in new ways, enabled shared decision-making and built lasting, trusted relationships. We did the things that mattered most, and organisational boundaries virtually disappeared. Our collective workforce is our most valued asset, being best placed to do the right things to support people. We will endeavour to empower our workforce to act in this way beyond traditional limits.

We want our partnership, and our leadership, to unlock opportunities for better population health, working at the level of the neighbourhood and communities, as well as the district and with regional partners across West Yorkshire. We have chosen to widen our focus to all local people, not only patients requiring treatment. Our communities with the highest deprivation were those hit hardest by the pandemic. It has exacerbated our health inequalities and makes our core purpose even more important. Alongside this, the health and care needs of the people of Bradford district and Craven are changing; our lifestyles are increasing our risk of preventable diseases, we are living longer, often with life-limiting conditions and the health inequality gap is increasing.

Too many people report significant assessment and treatment delays for serious medical conditions, fragmented management of care through the system with a lack of care coordination, and duplications of assessment and referral procedures.

Our population health approach, informed by insights from data; is aimed at preventing disease, protecting people from threats to health, and supporting individuals and communities to improve their health and resilience. Population health management and predictive analytics are integral to our creation of a fully integrated health and care system.

Bradford District and Craven Health and Care Partnership

ACTasONE

OUR VISION

By meeting people where they are, working with them to access the tools and opportunities to enable them to live longer in good health...

we Act as One to keep people Happy, Healthy at Home

OUR ADDED VALUE

OUR POPULATION
Supporting the delivery of our priorities and a better experience of health and care

OUR SHARED PURPOSE
All working to the same goal, for our population to have more chances to lead healthier lives

OUR PARTNERSHIP
Greater value through the best use of our collective resources, minimising duplication and waste

WHAT CONNECTS US

Narrowing the Gap
Positioning our collective resources to focus on the greatest need to improve health and wellbeing

Our Workforce
Empowered to lead On behalf of the Partnership and the people we serve

Equity and Justice
Choosing equity as our way to reduce inequality because more equal societies benefit everyone

Inverting the Power to Act
Sharing responsibility and power, for people to become active and engaged partners

Our Partnership Plan
Tackling the issues no one part of our partnership can address alone, through public stewardship

OUR COMMITMENTS

We will all:

- **Prioritise as One** those who have the worst outcomes for health and wellbeing
- **Understand as One** what matters to local people
- **Work as One** with people in our system and our community to achieve what matters
- **Integrate as One** to better enable people to achieve what matters to them

our People

We will all:

- **Commit as One** to our role in making our district a great place to live, work and thrive
- **Plan as One**, taking actions now that create a legacy for future generations
- **Focus as One** on preventing the causes of ill health
- **Measure as One** our impact on health and wellbeing through one data

our Place

We will all:

- **Lead as One** in partnership with our population, in their communities
- **Share as One** the power and responsibility to make the best use of our collective assets
- **Grow as One to** strengthen our relationships, trust and our ambition; improving together
- **Deliver as One** through our shared, skilled and trusted workforce

our Partnership

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 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 joint posts at system level - the Strategic Director Health and Wellbeing within the Council also of and also holds the post of Director of Integration within Bradford District Community NHS Trust. In addition, within the Commissioning Team there are 4 joint posts between the local authority and the ICB – Joint Commissioning Manager Early help and Prevention/ Voluntary Care Sector, Joint Commissioning Manager Older People, Physical Disabilities and Sensory Impairment, Joint Commissioning Manager All Age Mental Health and Joint Commissioning Manager Learning Disabilities, Autism and Neurodiversity.

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. The three tiers describe how Adult Social Care supports people and is set out in the diagram below:

Figure 2 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
- Trusted assessors, care staff and social workers in the discharge to assess /short term support services have been trained in community led support and strength based conversations/approaches.

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. Tech enabled care and access to equipment to enable people to be independent at home or after a stay in hospital has been incorporated into the short term social care offer using the BCF equipment budgets.

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

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. Further enhancement and training has strengthened the home support reviewing team with input and support provided by occupational therapists, social workers and community nursing /fast track team. The HSRT have an agreed pathway to screen and refer for CHC assessment. The team are working with independent providers of home support to enable them to continue supporting people when their needs change either after a stay in hospital or in their place of residence.

Trusted social care assessors have been trained and this continues as they further develop to focus on home first and now use a home first short term support assessment as part of discharge to assess. They are included in both hospital Multi Agency Integrated Discharge Team's (MAIDTs) and over the past year a continuous improvement process has taken place of operating models in both hospitals. Social workers offer input where needed but in the main focus on assessing people out of hospital in

line with guidance. Carer Navigators commissioned from the VCS and part of the jointly funded Carers Resource Service across the district have worked with trusted assessors and social workers to support unpaid carers of people receiving short term support or being transferred from hospital.

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. Additional funding for MAST was made using social care funding to increase the alcohol related support and social prescribing in order to reduce the demand for pathway 1. The MAST team is co-located now in both hospitals with the Core 24 teams and has joined up operations with the MAIDTs in both hospitals. Wellbeing hubs have been established provided by the VCS (VCS Alliance manage) in 6 areas across our place, a referral pathway via MAST is established which includes A&E and pathway 0. The Wellbeing hubs were funded from winter pressure funding last year and are linking in with existing family hubs and safer places (mental health alternative crisis services) in communities. This is part of our Community resilience and addressing inequalities plans. Welfare benefits, fuel and food anti-poverty initiatives will be included in the wellbeing hubs along with a range of other services commissioned from the VCS. We will communicate and work with PCNs and community health services so they are aware of the advice and support services available to people who are at risk of harm due to fuel and food poverty. We have also reviewed and strengthened our homeless and rough sleeping joint pathways and we are increasing our use of multiagency care coordination with increased involvement from the VCS and partners e.g. Police. We continue to fund home from hospital and supported discharge. Equipment provision from BACES has been reviewed and enhanced as well as local authority occupational therapy provision. Tech enabled care has been further enhanced over the past year and is being embedded in enablement over the next year.

The development of an integrated urgent community response service in line with the NHS plan continues to be progressed building on the partnership working between BEST, Rapid 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. The 2-hour social care response services (includes falls response service) has been brought under the management of BEST and is being optimised as part of the integrated community response service. Additional equipment for lifting people who have fallen has been provided to BEST teams and care homes along with training to reduce the need for conveyancing to hospital by ambulance. The safe and sound service (community alarms) work with the telemedicine hub and YAS to support hear and treat approaches. Work is ongoing on upskilling care staff both delegated tasks from nurses and therapists supported by the telemedicine hub.

3.3 BCF Metrics

Plans have been set for each of the BCF key metrics for 2022/23. The targets have been set in line with other plans and priorities across the Bradford health and social care system, in particular the operational plans of Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) and Bradford District Care NHS Foundation Trust (BDCFT). Targets are shown in the table below.

Metric	Plan	All England Av/CIPFA Comp
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions – 2022/23 plan (average per quarter) 1,222	Bradford ranks 120 out of 152 Local Authority areas, based on 19/20 data (latest data available on BCF Exchange).
Discharge to normal place of residence	2022/23 plan - 94%	Bradford 30 out of 152 Local Authority areas
Reablement	2022/23 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	2022/23 plan- 502.4	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)

Current Q1 position indicates a reduction of 8% based on same period last year. However, Covid may have had an impact in 2021/22 so plan based on 4% reduction bringing admissions below the BCF data pack value of 4,919 for 2021/22

3.3.2 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.

3.3.3 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.

3.3.4 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 21/22 numbers for admissions to permanent care against a background of anticipated winter pressures and ongoing recruitment challenges, is a stretched position for Bradford.

3.4 Services impacting on the key BCF metrics

A range of BCF schemes support the ambitions set in these key metrics. Options have been commissioned in order to avoid unnecessary admission to hospital. The MAIDT (see 4.2) has the ability to flex home based services within the community, provide rehab or admit to a flexi-bed with a care home or nursing setting to directly avoid admission to hospital.

BCF commissioned services also 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.

The Virtual Ward provides an alternative to an acute hospital bed to support early discharge and admission avoidance. The virtual ward has been established as an enabling multi-disciplinary team to support older people at home. To date it has largely been a step-down model with a 'discharge to assess' mentality linked to our older people assessment unit. Moving forward the service will offer a comprehensive geriatric assessment to all older patients, with a view to preventing admissions from primary care.

In the community, 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 2021/22 shows that 94% 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. Implementing the BCF Policy Objectives (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.

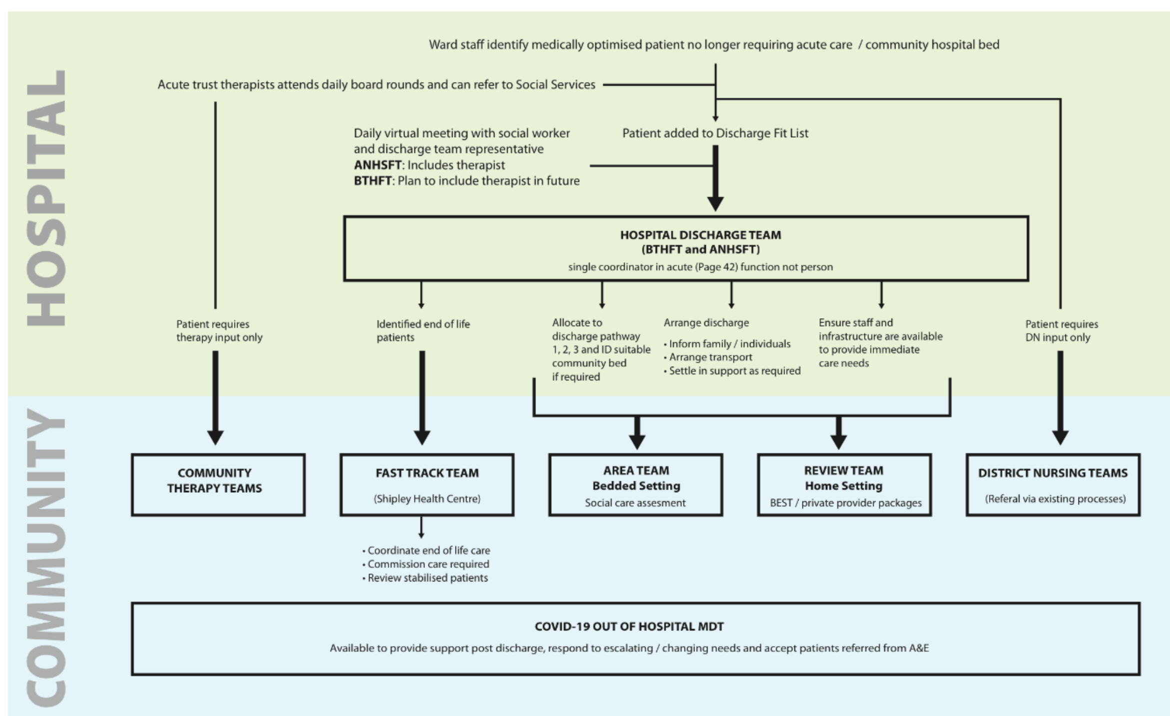


Figure 3. Hospital Discharge Flow Chart

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
- A self-assessment of implementation of the High Impact Change Model for managing transfers of care and has been undertaken and an action plan for improvement has been agreed and is in action.

High Impact Change Model

A self-assessment of implementation of the High Impact Change Model for managing transfers of care and has been undertaken and an action plan for improvement has been agreed and is in action. A summary of each change is highlighted in the table below.

Impact change	Where are we now?	Update on Implementation
Change 1: **Early discharge planning EDD** **Elective & Non elective**	Established.	**What have we done so far?** We are working together at both hospitals to improve joint operating models which includes EDD and planning for discharge if the person is going to require ad). As part of our strategy Happy, Healthy and at Home we have a home first joint document being used in the MAIDT (Multiagency Integrated Discharge Team) which is focusing on a strength based, community led support approach to reduce the over prescribing of care and support in discharge planning. Tech enabled care and support is also part of our plans to reduce the need for care and support. This is intended to reduce the need for care/ support on discharge. CTR, CTD and LOS are closely monitored via MAIDT MDT at both hospitals. Staff in adult social care are being trained and coached in these approaches which are already being used in our localities. **Next Steps** To review early discharge planning for elective care as a system in both BTHFT and ANHST now we are operating as business as usual after the Pandemic. We have plans to continuously improve our DTA processes, this is overseen by the DTA system operational group as part of the Aging Well Act as One programme.

Change 2: **Monitoring and responding to system demand and capacity (joint analysis of current capacity,** **Pathways 0-3, market shaping, optimum run rate to maintain flow)**	Mature/Exemplary	**What have we done so far?** BTHFT have a command Centre and a wall of analytics, with the MAIDT adjacent – the data drives the response from MAIDT and other services. The MAIDT work with one version of the truth and focus on solutions for transfer home. ANHST MAIDT are working together to also have one version of the truth and have made significant progress over the past year. There is a continuous improvement approach being taken in both hospitals. Sufficient supply of home support to move people out of enablement services into longer term support is a challenge, despite a home support reviewing team within BEST who work with the brokerage team and independent home support providers to keep the flow though enablement services. The timely review post discharge that they provide also promotes independence resulting in support appropriately reduced and improved outcomes for the individual, supporting capacity for the system. Performance and flow through adult social care services is measured and reported throughout the day, seven days a week. Recruitment of care staff is the issue. Market shaping, redesigning of models of care, engaging the care sector as a partner in our system is not an issue and relationships have strengthened since the CQC system review in 2018 as a result of the Covid joint working. **Next Steps** The home support contracts with the independent sector are being re procured next year a plan of market engagement has started and this is being led by Adult social care but health partners and the care sector are involved in the co design of the specification and models. This is influenced by what we have learned together over the past 3 years.
Change 3: **Multi-disciplinary working, Transfer of Care hubs, System Co-Ordinator /leadership**	Mature/Exemplary	**What have we done so far?** Both hospitals have MAIDTs (community nurses are included in the MAIDT) with joint operating models, and the VCS, housing pathway providers are commissioned to operate within the model. There is an Executive system leader, and joint leadership across health and social care in both hospitals. Adult social care has a single point of access via trusted assessors for all restarts of home support, enablement and short term beds (180) managed by the LA. **Next Steps** Work is taking place improve our staffing levels across the system.
Change 4: **Home first D2A reference to the Principles**	Mature/ Exemplary –CQC system review 2018 and performance over last 3 years.	**What have we done so far?** Happy Healthy and at Home Strategy and Act as One approach clear in our joint operations. Home First document being used as assess to transfer out of hospital. Trusted assessors for home support and short term beds work with discharge nurses/therapists. Relationship with care sector managed via single point of access in adult social care. Performance monitored in relation to outcomes of short term support and long term placements. CHC assessments are undertaken out of hospital other than on rehabilitation units in hospital. Joint improvement work re FAST track and CHC is ongoing as part of ACT as One.

		Next Steps Work is taking place improve our staffing levels across the system.
Change 5: **Flexible working patterns 7 Day Discharge**	Established	**What have we done so far?** The MAIDT in BTHFT and ANHSFT operates 7 days a week and transfers take place 7 days a week. ANHSFT also developing their criteria led discharge processes/practice to improve weekend discharge activity on pathway 0. **Next Steps** Work taking place at ANHSFT internally to focus on processes
Change 6: **Trusted assessment**	Established	**What have we done so far?** Trusted assessors have been included into the MAIDTS and social workers have been focused on care act assessments out of hospital in line with DTA guidance, this is in place but is not fully optimized yet. **Next Steps** We have plans to further optimize strength based approaches, tech enabled support and VCS services to increase pathway zero.
Change 7: **Engagement and choice, Community and Voluntary sector involvement**	Mature	**What have we done so far?** Voluntary sector have contracts in place funded by the BCF, LA and CCG Carer navigators, MAST, home from hospital, homeless pathway. Developing a 'Leaving Hospital Folder' to support conversations around 'moving on policy' but to also ensure patients/carers/relatives feel they have the right information and support when returning home **Next Steps** Leaving Hospital Folder will include information about the different voluntary and community services they might receive once back at home
Change 8: **Improved discharge to care homes** **Anticipatory Care for residence**	Established	**What have we done so far?** We have the Telemedicine service (TMS) delivered by Immedicare in place across Care Homes. Under the Ageing Well Programme a review of this service has taken place and the service was re-launched in May 2022 to increase usage and engagement. During the Pandemic we extended the TMS to include the Super-Rota. Care Homes also have access to UCR & Virtual Ward via TMS and our Integrated Care Hub. Care-Coordination pilots have taken place within our place to focus on Identifying cohorts and establishing MDTs – work is ongoing to spread and share the learning of this across other PCNs. The Ageing Well Programme will also be supporting PCNs with developing plans against the Anticipatory Care guidance **Next Steps** Projects and system wide working groups established within the Ageing Well Programme to progress these pieces of work
Change 9: **Housing and related services-equipment**	Mature	**What have we done so far?** Homeless pathway in place, with short term enablement/supported housing post transfer out of hospital funded by adult social care. Healthcare funded by health (Bevan healthcare) **Next Steps** Work with system commissioners to establish robust plans to address gaps in provision

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 2022/23. In 2020/21 we increased the fee rate for home support by 4.3% and 7.2% in 2021/22. To continue to support the market we have increased fees again by a further 6.5%. These increases are 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.

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. Supporting Unpaid carers

Unpaid carers play a vital part in ensuring that individuals in need of care continue to experience a good quality of life. The Public Health England report 'Caring as a social determinant of health' (2021) highlighted the need for funding robust evaluations of promising interventions for carers of older people, with clearly established pathways to impact on appropriate outcomes.

5.1 BCF schemes supporting carers

The Better Care Fund continues to be invested in areas that provide support to unpaid carers. Bradford Carers' Resource is a joint commissioned BCF funded service, providing 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. The BCF is used to contribute to a number of other services that support carers. 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.

The service provides help and support for unpaid carers to have a life of their own along with their caring role. This is done by helping carers to discover opportunities for social and leisure activities as well as training, work and education. The service offers support for isolated carers, a review of the carer's wellbeing will identify the support that can be provided, carer information tailored to individual needs and circumstances a carer small grant, which provides small one-off payments to carers to promote their own.

In addition, the Carers Emergency Planning Service aims to provide reassurance to carers about who will take on their caring role in the event of an emergency. The service will work with carers to make contingency plans, regarding how the person they care for would be supported if the carer were unable to do so.

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 between 45 and 50 new referrals for DFG each month over the last four years.

Delivery of the DFG programme during the Covid pandemic posed a number of practical challenges which introduced some delays to the programme. These included:

- DFGs are delivered to a vulnerable group, some of which were 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, concrete and timber.
- Ability to recruit and retain appropriately qualified housing surveyors.

Some elements of this have now subsided however there are still issues facing the programme as a result of the pandemic, these include the availability of materials and the increase in costs of materials; the demand for contractors and the reduction in the number of contractors operating after the pandemic and also the ability to recruit qualified housing surveyors.

High levels of demand for assistance with adaptations mean that the Council currently has 846 cases in the DFG process with an estimated total value of £10.2m. Whilst sufficient capital funds are available to complete works, processing times are dependent on a number of factors – contractor supply remains a national issue relating to the availability of contractors to complete work and the backlog held by contractors following the pandemic. The service is analysing current processing times and putting in place steps to address delays where possible.

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:

- There are 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.

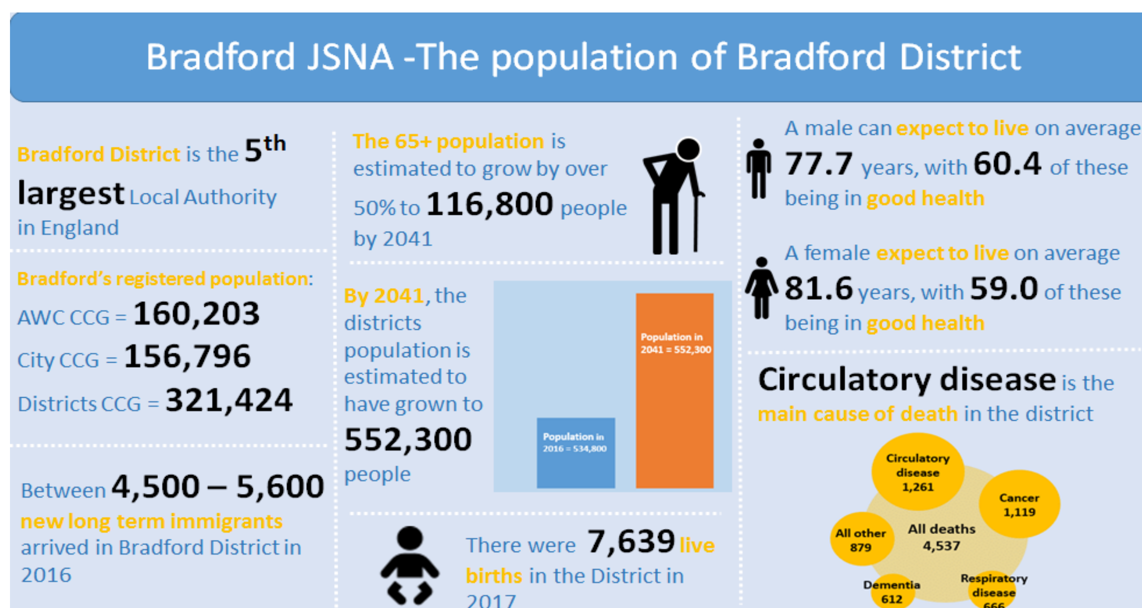


Figure 4 JSNA Summary

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.

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.

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 Population health management approach

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.

7.2 Reducing Inequalities Alliance

The Reducing Inequalities Alliance (RIA) is a new function which was established in Bradford District and Craven in July 2022. It has been established to support and coordinate action to reduce inequalities across our local place.

The role of RIA is to connect, co-ordinate, facilitate, and support the delivery of the workstreams and job cards prioritised by the alliance, including drawing together evaluations and learning from initiatives to reduce inequalities such as the Reducing Inequalities in Communities (RIC) programme. We will do this by:

- *Setting the vision*: for reducing inequalities in health (and the determinants of health)
- *Building capacity*: in our staff and leadership to reduce inequalities on many fronts
- *Supporting best practice*: in the ways we work, the skills we use and the evidence we draw on to reduce inequalities
- *Facilitating space and time*: For evaluation and learning from our approach

A particular focus of the RIA is bringing people together from the interfaces between large civic programmes, service interventions and transformation, and the community sector. In this way the alliance as a whole can become more than the sum of its parts.

To be successful we need to adopt a ‘Health in all policies’ approach. This requires a collaborative approach to link to tackle linked problems (e.g. an increase in people living with chronic illness linked

to our ageing society, movement of information and people around the district for jobs, care and support, less resources in some sectors and climate change). Addressing them requires innovative solutions, a new way of thinking about policy, and structures that break down the 'siloed' nature of local systems.

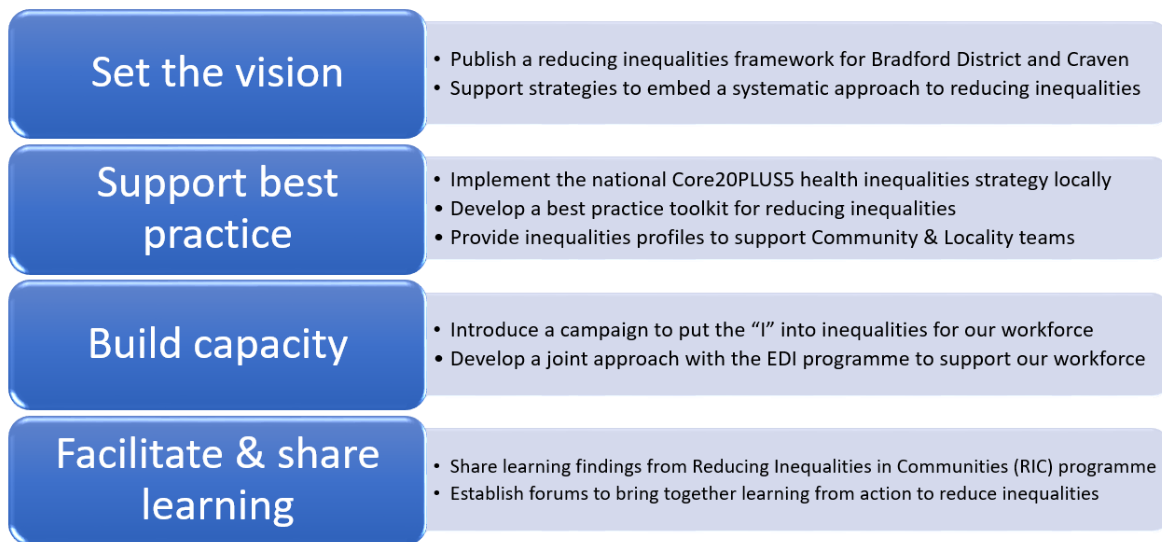


Figure 5. RIA 2 year ambitions

7.3 Reducing Inequalities in Communities (RIC) Programme

RIC is a movement of people and projects who are working together to reduce health inequalities and close the health gap in central Bradford.

It is a five-year programme, running from 2019/20 through to 2023/24, and is made up of a range of projects which aim to improve people's health and tackle inequalities at different stages of life. It is a collaboration of system partners who are committed to reducing health inequalities in our place. This partnership involves colleagues from primary and community care, secondary care and third sectors organisations, local authority, public health, and research. It has been, and continues to be, an ambitious programme of work that involves the implementation and delivery of 21 projects, and over 50 delivery partners.

RIC was designed to be a test bed of innovation in our local place. Working together we have identified a range of projects that we feel will help reduce health inequalities, or the impact of health inequalities, for their respective cohorts. Through implementing these projects, we hope to build a local evidence base of what works, so we can consider spreading these services more widely across our place, but we also hope to contribute to the growing research base around health inequalities.

The RIC projects are a group of interventions that range from: completely new services, such as Young People's Social Prescribing; to extensions of existing projects or services, such as BEEP exercise referral; to projects that project specific training or support to our workforce or communities, such as new approaches for raising awareness of increased genetic risk in close relative marriage.

Examples of impact

- *Central Locality Integrated Care Service (CLICS):* staff and patient feedback is showing that proactive, holistic care reduces reactive demand on practice teams. Community development element is creating self-sustaining support groups.

- *Proactive Care Team (PACT)*: staff and patient feedback is showing that a fully integrated, multidisciplinary team (involving physical and mental health support) is providing effective, co-ordinated care for people with complex health needs.

- *Young People's Social Prescribing:* early intervention and prevention from VCS teams provide much needed support to children and young people. It has been integrated into our mental health pathways, so it can be considered amongst the range to support offers.

- *Welfare Benefits Advice:* poverty effects health & wellbeing. This service provides valuable support to people in the area. Our VCS provider leads are working with the research team to evidence the wider impact of this service

- *Tier 3 weight management for CYP:* this new model delivers support via a family approach rather than a traditional clinical model. Early signs show this has a positive effect, on both the children being supported and their wider family members

7.4 Core20PLUS5 National Strategy and Funding

Key support for our inequalities programme has this year come from the Core20PLUS5 national strategy and funding

Our local place has agreed an approach and principles to allocate the funding:

- We will employ an equity based approach (using proportionate universalism across health and the wider determinants of health)
- We will focus on subsidiarity and decision making down to Community Partnership level where appropriate
- We will undertake intervention evaluation of funded services
- We will support, rather than replace or supersede, wider system efforts to local inequalities.

Core20PLUS5 operating model - *Three tier*

1. Bradford and Craven Health and Care Partnership (strategic oversight) - Support: Establishment of a small Core20PLUS5 support team for data, evidence, guidance, evaluation, prioritisation (housed within the Reducing Inequalities Alliance).
2. Locality model (x5 + Craven) - Key tier for delivery (within new integrated model between NHS/Council/VCS – Act as One in the Community
3. Community Partnerships/PCNs (x13) – the six most deprived partnership areas allocated core20 specialist posts and additional budget, working with existing Primary Care Inequalities Premium scheme

7.5 How BCF is contributing to reducing health inequalities in Bradford

In Bradford, COVID-19 has had a disproportionate impact on the poorest and most vulnerable, Black, Asian and Minority Ethnic (BAME) communities, people with disabilities, women and carers. It has

widened inequality so we must put working to secure equality and social justice at the heart of all we do. At the height of the pandemic, COVID-19 had a devastating impact on health and social care provision. It has meant that services and resources focused on self-care, prevention and early intervention to reduce demand on public services have had to be shifted to manage the pandemic. COVID-19 has disproportionately affected those facing financial hardship and vulnerable people in our communities, as well as people from BAME groups, widening health inequalities. The gap between the most deprived and least deprived remains large and will require sustained effort and targeted investment in the most deprived communities and neighbourhoods. As part of living with Covid-19, we will need to move resources and investment towards prevention and early intervention activities and make sure allocation is based on need. This will help citizens make long-term positive behaviour changes to improve their health and wellbeing.

The BCF Plan is a vehicle for articulating how we will use system and place level mechanisms to cement health inequality work described above 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. Efficient and effective hospital discharge remains a priority within the plan. BCF funding to support effective discharge, eg MAIDT, intermediate care service and post discharge support at home (BEST) all contribute to equity of care.

Services for older people and people with Dementia remain a priority - with the population of older people in the district estimated to rise by 50% by 2041 services are prioritised for this group. Additional bespoke Extra Care accommodation in the District has been developed. Fletcher Court 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 flexible, individualised care support.

Our Small Grants process now included a standard clause ensuring resources can be mobilised in response to emerging inequalities.

The Planning and Commissioning Forum will review BCF schemes during 2022/23 to. As part of our integrated commissioning agenda, we will ensure that overarching goals to address health inequalities are embedded; for example, preventing people from dying prematurely, enhancing quality of life for people with long-term conditions and helping people recover from episodes of acute ill health or following injury.