BCF narrative plan

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this template.

Cover

Health and Wellbeing Board(s)

The Calderdale Health and Wellbeing Board have developed the strategic context for the BCF as part of their recent refresh of the Calderdale Wellbeing Strategy, and through development of their 4 partner alliances to drive delivery (Starting Well, Developing Well, Living and Working Well and Aging Well Boards. In terms of strategic direction, the work of the Calderdale Inclusive Economy Board is important in relation to actions to support our population in relation to; poverty, fuel poverty and the current cost of living crisis The Chair of the HWB Board will be sighted on this submission, and the submission will be presented retrospectively to the Board. The BCF Plan will also be submitted retrospectively to the new Calderdale Cares Partnership of West Yorkshire ICB

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

Members of the Calderdale Health and Wellbeing Board are:

- Calderdale Metropolitan Borough Council
- Calderdale Care Cares Partnership of West Yorkshire ICB
- Calderdale & Huddersfield Foundation Trust
- Locala CIC
- South West Yorkshire Partnerships NHS Foundation Trust
- General Practice
- Yorkshire Ambulance Service
- Community and Voluntary Sector
- West Yorkshire Community Pharmacy
- Local Care Direct
- Local Medical committee and GP leaders

For DFG - input has been from the Principle OT, who is part of Adult Services and Wellbeing Directorate, and is linked into the Strategic Housing function of Calderdale council

How have you gone about involving these stakeholders?

The BCF Plan is a synthesis of the current programmes and priorities held by the Calderdale Cares Partnership. The Calderdale Cares Partnership is currently developing its Forward Plan in line with timescales agreed for the development of the West Yorkshire Forward Plan. The work done to date is reflected in the BCF priorities. The Calderdale Forward Plan will combine delivery of; NHSE Operational Priorities, our Winter Plan, our BCF Plan and will support delivery of the West Yorkshire strategy.

Executive summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

A key change since development of the 21/22 plan is the transition from CCGs into ICBs, and the development of the Calderdale Cares Partnership – which builds on work to implement Calderdale Cares referenced in past submissions. Since the last submission we have also refreshed our Wellbeing Strategy and continued to implement our Inclusive Economy Strategy. We have also been successful in securing Treasury support for our hospital reconfiguration programme.

Please see 'Overall BCF plan and approach to integration' section below for Priorities 2022/23.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

Governance for development of this BCF plan is through the Health and Wellbeing Board. As we move forward with new architecture – the BCF plan will also be shared for governance by the new Calderdale Cares Partnership Board.

Implementation will be undertaken via;

- The Calderdale and Huddersfield UECB
- The Calderdale Discharge Executive
- The Calderdale Cares Community Partnership Board (which focused on both physical and mental health)

Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

Calderdale

Health and social care continue to work together to ensure that care and support is delivered in an integrated way, ensuring the best experience for local residents. The Calderdale Cares Partnership (ICB) and Local Authority have the same chief officer and work to the same vision and values. The Integrated Commissioning Executive finance group meets monthly and has senior representation from both organisations to ensure that BCF schemes and funding focus on shared outcomes that benefit Calderdale as a place.

These include an ongoing commitment to deliver person centred services to ensure local people receive seamless service provision regardless of their funding eligibility. Partners share the same commitment to supporting people to remain as independent as possible in their own homes. This extends to housing colleagues who are integral to the development of sustainable community services. In August 2022 a new extra care scheme was opened in Brighouse offering 65 apartments. Calderdale and DFG is being used to ensure bespoke adjustments are made to apartments to fully meet individual needs.

The BCF focuses on a range of schemes that ensure people can remain in their own homes as long as possible including the Handy Person Service and Carers Service. These services work with individuals to deliver person centred services that support people to remain in the community and increase their resilience.

The person-centred approach takes into account the individual needs of people accessing services, including their health, social situation and family circumstances. The Carers Service offers a range of access routes ranging from group sessions to individual 1:1 meetings for those individuals who require bespoke support. Case workers can visit people in their own homes where this is required. The Carers Service looks at the range of support available in Calderdale, this includes community groups, peer support, access to personal budgets to meet carers individual well-being needs as well as sign posting to statutory services. The service also helps carers to address the issues impacting on their well-being by sign posting people to benefits advice and supporting working carers to remain in employment

through support with their caring duties and advice around requesting flexible working arrangements.

The Integrated Single Point of Access (Gateway to Care) is a service designed to offer support advice and signposting at an early stage and delay or reduce the need for long term support. This service focuses on linking people to resources across Calderdale such as Staying Well Community services and acts as a SPA to ensure people requiring advice can receive person-centred personalised support, they require without the need to approach multiple agencies.

Calderdale has a varied offer in terms of Intermediate Care this includes Intermediate Care beds with therapy services aimed at supporting people to return home with by offering intensive rehabilitation based on induvial care plans. This service brings together health and social care staff to support short stay residents with their immediate needs but to ensure that onward support is arranged where required to enable a smooth journey home. Intermediate Supported Care (Heatherstones Reablement Unit) compliments this offer and brings together health, social care and housing related support to address people's holistic needs. The service was developed to respond to people who had wider housing issues that were contributing to delays in hospital discharges. It supports residents to reach their maximum potential in self-contained apartments with a focus on re-gaining independent living skills. Staff also work with residents on their individual housing needs and have a range of expertise from supporting tenancy applications, arranging adaptations or agreeing a programme of de-cluttering to allow a resident to move back into their home.

Home Hospice for End of Life is a further example of delivering a service to allow people to die in their place of choice and provide the health and social care support required to support the patient and family and their own individual choices and circumstances.

Joint priorities for 2022-23 are:

1 Keeping Well

- Development of a Starting Well strategy, based on findings from the
- Strength & Needs Assessment
- Implementation of work on Maternity, Infant and Early Years Speech Language and Communication Pathway
- Delivery of Ockenden Recommendations, and improvements in Maternity Care (including still births, neonatal and brain injury)
- Implementation of family hubs as a placed based approach to the delivery of family services for children of all ages 0-19
- Development and delivery of and winter care packs and the winter directory
- Build a picture of winter poverty challenges and data

- Agree our approach to locality and neighbourhood working to support delivery

2 Preventing illness in those at risk (social/behavioural factors/ long term conditions)

- Implementation of Community Diagnostic Hubs (Relates to indicator; 8.1 *see the BCF 2022/23 template (tab 6)*)
- Design 7 Day services across the system to improve access to support (Relates to indicator; 8.1, 8.3, 8.4, 8.5 *see the BCF 2022/23 template (tab 6)*)
- Reduce unnecessary ED attends through support for self-management (Relates to indicator; 8.1 *see the BCF 2022/23 template (tab 6)*)
- Enhance the role of C&V sector to support people to remain well (Relates to indicator; 8.1 *see the BCF 2022/23 template (tab 6)*)
- Timely access to general practice appointments, and increase in the number of general practice appointments
- Implement V&CS emotional wellbeing offer to 'at need' families (Relates to indicators; 8.1, 8.3, 8.5 *see the BCF 2022/23 template (tab 6)*)
- Further investment in 24/7 MH helpline (Relates to indicator; 8.1 *see the BCF 2022/23 template (tab 6)*)

3 Preventing hospitalisation and loss of independence in people that are ill

- Implement community mental health transformation programme for people with severe mental illness (Relates to indicators; 8.1, 8.3, 8.5 *see the BCF 2022/23 template (tab 6)*)
- Ensure adequate menu of community beds via joint commissioning of IC and other beds, reduce LOS in rehab units and shift to rehab at home (Relates to indicator; 8.3, 8.5 *see the BCF 2022/23 template (tab 6)*)
- Implement out of hospital pathways at scale- including virtual wards (Relates to indicator; 8.3, 8.5 *see the BCF 2022/23 template (tab 6)*)
- Increase mental health crisis offers (Relates to indicator; 8.1 *see the BCF 2022/23 template (tab 6)*)
- Continue to strengthen support and care offers for people with covid, and long covid

4 Optimising access to hospital (acute and mental health) care and reducing harm associated with delays in transfer of care

- Delivery of hospital reconfiguration programme and HRI and CRH (Relates to indicator; 8.1 *see the BCF 2022/23 template (tab 6)*)

Integrated Commissioning

The integrated Commissioning and Quality Team (LA) works in partnership with ICB commissioning contracts and quality colleagues. All proposed commissioning/recommissioning of services are presented at the Integrated Commissioning Board, which includes key stakeholders from health and social care. Opportunities for collaborative commissioning are explored wherever appropriate. Recent examples of jointly commissioned services include Care Homes contract Outreach and Sitting Services. These major pieces of commissioning have resulted in shared contracts and colleagues from both local authority and ICB have been involved in the commissioning and procurement of services. A care homes programme board has been established in partnership with the LA and ICB to oversee a new joint contract and service specification for residential and nursing care in Calderdale and review provision to ensure we have sufficient discharge to assess provision and therapy services to enable people to return home wherever possible.

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

Discharge Planning in Calderdale

1. Overview

Calderdale is a mix of urban and rural populations in the heart of West Yorkshire, and has a population of just over 211,000, with 18% currently aged 65+, rising to 25% by 2037. Calderdale MBC (including Public Health, Housing, Economy and Environment) and the current Calderdale CCG are coterminous, providing an ideal opportunity for testing integration. The population receive the majority of their

hospital and community services from our key partners in; Calderdale and Huddersfield NHS Trust, Locala CIC, and South West Yorkshire Partnership Foundation Trust. Care is built around 5 well established localities/PCN GP hubs – working alongside our vibrant community and Voluntary Sector providers. All are partners in this proposal.

We are in a relatively unique position in terms of our ICS Place Leader (Robin Tuddenham). There are very few joint Place Leads/Local Authority Chief Executives. Given the challenges in our system, this is a strength and USP in our application. There is a clear fit between Robin's objectives and the aims of Forerunner initiative.

We have a clear and owned strategic vision set out in our recently refreshed Wellbeing and Inclusive Economy Strategies. Calderdale has a long-standing and clear collaborative approach; 'Calderdale Cares' – which is integrating health and care across Calderdale and in localities. We have a set of defined and owned priorities and values, including a strong commitment to tackling health inequalities which affect discharge, and collaboration between different parts of the system. These principles enable; wider place-based collaboration (including the economic, public health, and social factors supporting effective discharge), linking to the West Yorkshire Combined Authority on workforce, skills in social care, and the economic factors which impact on discharge.

This common purpose is enhanced through reach into national thought leadership and think tank forums such as the Kings Fund and influence over the wider LA Chief Executive sector through Solace (Society of Local Authority Chief Executives)

Partners across Calderdale come together in a new Calderdale Cares Partnership Board, which is the basis for our integration and governance with our ICS and at place. This Board will have oversight of this work.

2. What we are trying to achieve

The key challenges faced locally in terms of post-acute care/discharge are:

- Delays in post-acute discharge which cause harm to patients – particularly physical and mental de-conditioning
- Potential life-changing decisions made at the wrong place in the patient journey
- The impact of these delays on elective recovery
- The fragility of the social care market and its workforce– which has been exacerbated by the pandemic
- The complex range of community offers which hide multiple gaps and duplications

- The arbitrary nature of service acceptance criteria – not based on a person's ability to benefit
- The lack of flexibility within community bed provision to meet both intermediate care and discharge to assess requirements for step-up and step-down referrals
- The increase in dependency and disability which place increasing pressure on health and care services, and understanding the health inequality aspects of harm
- Financial constraints

We have a clear view of our aspirations below, and believe the work we do as a frontrunner will leave us with a blueprint to deliver aspirations to;

1. Change our current community model; enabling delivery of radically different, but affordable, 'home first' model (*HICM, Change 4*) – aligned to delivery of our Wellbeing Strategy
2. Bring together physical and mental health offers – both current and new, including; Virtual Wards, Urgent Community Response and end of life services and at-scale PCN offers to; support people, avoid admission, enable effective discharge (*HICM, Change 1 & 2*)
3. Ensure the voice and influence of our communities is a key to our design.
4. Maximise opportunities from our Community Provider Collaborative, and their commitment to integration and collaboration (wide partnership including strong voluntary and community sector involvement (*HICM, Change 1, 2, 4, 7, 8 and 9*).
5. Develop a flexible menu of at-home and community-bedded offers which enable people to be discharged effectively, timely and safely - including a change to the way therapy and other rehabilitation teams work (*HICM, Change 1, 2, 4, 7, 8 and 9*)
6. Recover the resilience of our social care markets and their workforce - supporting new ways of working and collaboration (*HICM, Change 1, 3, 4, 5, 6, 7, 8, and 9*)
7. Challenge thinking about alternatives roles, models, and maximise 'one workforce', drawing in funding to test innovate new ways of working (*HICM, Change 1, 3, 4, 5, 6, 7, 8, and 9*)
8. Maximise opportunities for technology and community-based diagnostics – linking with our WY and place digital strategies (*HICM, Change 1, 2, 3, 4, 7 and 9*)

We have started on the journey on all 8 of these actions, however we are keen to receive support to ensure our models are; future-proofed, innovative, affordable, and

provide the best care for our population. We believe the aspirations above and our strategic direction are totally aligned to the outcomes in the Integration White Paper.

We would be looking to demonstrate improvements in the following types of metrics:

- Patient, family and carer related experience and outcomes
- Reducing the numbers of people admitted prematurely to long-term care, and increasing patients who remain at home with support
- Reducing the number on the reason to reside lists at CHFT
- Increasing community MDT working (rehabilitation, general practice and voluntary and community sector) - creating a sustainable workforce model that; avoids unnecessary admissions, increases responsiveness, improves access to rapid response reablement, acceptance of trusted assessment, and acceptance of share care planning approaches across physical and mental
- Maximising productivity, reducing delays, reducing review delays and reducing re-admission
- Ensuring bed capacity optimised to maximise elective recovery
- Increasing no of people remaining at home after reablement
- Delivery of the NICE recommendations; trusted assessment, personalised care planning and rehabilitation – particularly through the 0-6 week lens.

3. Next Steps

Through our UECB we have developed a workstream and based the results of our HICM and our plans for the 100 days challenge, we are in the process of developing an action plan which will be governed through the UECB.

HICM

Discharge is a key feature of our local, regional and national priorities. Working through the West Yorkshire Discharge Group, each place undertook a self-assessment against the 9 discharge high impact changes. The tables below represent the rating submitted for Calderdale, as well as those from other places across West Yorkshire. The aim of the assessment was to identify areas for individual and system improvement, as well as identifying opportunities for learning. The assessment was undertaken with a critical eye with a view to identifying key areas of improvement.

June 2022	Calderdale	Wakefield	Bradford District & Craven	Kirklees	Leeds	ICS Average
Change 1: Early Discharge Planning	2	3	4	2	3	3
Change 2: System demand & capacity	2	3	4	3	2	3
Change 3: MDTs	2	3	4	3	3	3
Change 4: Home First	3	3	3	3	2	3
Change 5: 7 day discharge	2	3	3	3	3	3
Change 6: Trusted assessment	3	3	4	4	2	3
Change 7: Engagement & Choice	3	3	4	2	2	3
Change 8: Discharge to care homes	3	3	4	2	2	3
Change 9: Housing & related services	3	4	3	3	3	3
Strategic leadership, Shared purpose, Joint vision	3	4	3	3	3	3
Established governance structures	2	3	3	3	4	3
Mechanisms to support joint funding, commissioning	3	3	4	3	3	3
Development of a flexible joint workforce plan	2	3	3	3	3	3
Data shared across the system & used to inform decisions	3	3	3	3	2	3

4	In place
3	Some elements in place but further required
2	Not in place but work started
1	Not in place and work not started

The Calderdale Executive Discharge Group, made up of leaders from; ICB, CHFT and more recently SWYPFT has oversight of delivery and improvement activities related to discharge, including actions from the self-assessment. Actions as a result of the self-assessment are to address key areas for improvement:

- the increase in admission and acuity (through schemes such as UCR and Virtual Ward). This will impact Change 1 and 2 of the HICM.
- market resilience issues in the social care market to reduce the level of hospital discharge delays which has the potential to harm patients and to challenge our ability to fully deliver our elective recovery (through schemes such as Intermediate Care Community Beds, Reablement & Co-ordinated Support at Home and Complex Discharge Co-ordinator). This will impact Change 4, 7 and 8 of the HICM.

We have built the key areas of improvement into our deliverable for the next 6 months. Delivery of remedial actions is being overseen by the Calderdale Executive Discharge Group, reporting to the Calderdale and Huddersfield UECB. They have also been captured in Calderdale Cares Forward Plan for the next 6 months, see excerpt from the Forward Plan below:

Objective 1:	Reduce the current level of systems delayed transfers of care and resulting harm to patients (HICM Change 1, 2, 4, 6, 8, 9)
	Increase access to 7 days (HICM Chang 5)
Actions:	Focus on Pathways 0 and 1. Enhance the role of C&V sector.
	Establish a Personal Assistant register partnering with Age UK.
	Commission additional capacity, social care, OT, Care Co-ordinators, brokerage team.
	Increase the level of early discharge planning
Source:	NHSE -Winter
	NHS -Planning/Discharge self-assessment
Leadership:	Discharge Executives (Lyndsey Rudge, Anne Flannagan, Debbie Graham)
Date:	October 2023

Objective 2:	Zero ED 12 hours delays (HICM Change 3)
Actions:	Monitored and reported daily – any themes considered and actioned
Source:	NHS - Planning
Leadership:	Jo Fawkes
Date:	In place

In addition, we have a set of initiatives to; Enable people to stay well, safe and independent at home for longer as well as providing the right care in the right place;

a) PCN development and new roles, including Healthy Aging workers in the Upper Valley, are having a significant impact on patients, and a potential reduction in patients accessing other services.

b) Continue expansion of Urgent Community response to provide rapid support to reduce avoidable admission, support people to remain at home and ensure access to rehabilitation offers.

c) Planning for implementation of Virtual Ward scheme to support patients who would otherwise be treated in hospital - soft launch October 22.

d) Implementation of initiatives that delivery the HWB outcomes to ensure older people are connected to their communities - and continued work of the Aging Well Alliance to implement a range of offers that address the wider determinates of health and focus on prevention of ill health.

e) Continue to expand services for those with dementia and their families and carers

f) Implement the newly agreed Carer's Strategy for Calderdale -agreed by HWB

g) Continue the work of the Anti-Poverty Board and establish practical support offers for those affected by the cost of living crisis and facing fuel poverty

In summary, the BCF Plan enables people to stay well, safe and independent at home for longer by focusing on a home first model in the community and support for people to return home wherever possible following hospital discharge. Schemes that underpin this approach include those focused on delivering greater capacity in the community e.g., Rapid Homecare, CQC Registered Homecare, Gateway to Care and Dementia Support. All of these services have one key aim to enable people to stay safe, well and independent for as long as possible, tailoring support to their individual needs and circumstances.

This support is enhanced by flexibility offered through the DFG and Community Loan Store equipment that enhance the services above by making physical changes to ensure people's homes are safe, adapted to meet their needs and contain the aids they require to remain safe and independent. The availability and flexibility of these services is crucial to providing the right care in the right place at the right time. For example, Rapid Homecare Services that can be delivered at short notice and same day equipment deliveries

Supporting unpaid carers.

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

A new carers strategy has been developed in Calderdale. The strategy was co-produced through the engagement and involvement of representatives from partner organisations including Calderdale Metropolitan Borough Council, Calderdale CCG, Voluntary and Community Sector, providers of carer services, Carers Strategy Group, West Yorkshire Integrated Care System Carers Programme, South West Yorkshire Partnership Foundation Trust.

The Strategy is based on the views and concerns of carers themselves, outputs from engagement with the regional carers group, the 'listening to unpaid carers' local event and feedback from service providers on what has been heard from the carers they support. Carers as well as health and care staff attended a workshop in June 2022 and contributed to agreeing the vision and priorities for this Calderdale Cares Carers Strategy 2022 – 2027.

A number of schemes within the BCF plan underpin our strategic approach to carers including the Carers Offer scheme. The scheme is to provide carers with information and advice, including specialist support. Schemes covering adaptations including the Handyperson and DFG schemes support carers by making homes accessible and safe and ensuring informal carers have the equipment required to ease their caring duties. BCF funding contributes to the delivery of home care to ensure carers receive timely and appropriate support to care for relatives. Reablement services funded by BCF enable people to reach their maximum level of independence and reduce the potential level of informal care required.

The Carers Offer was recommissioned in 2021 with an increased focus on carers outcomes. Carers were engaged in the development of a new service specification that reflected their support needs. The new service has adapted to deliver greater levels of one to one support and offers increased advice around financial resilience and support areas carers increasingly need to continue to fulfil their essential unpaid caring role. The Carers Offer and Dementia Service have both developed training offers to build carers personal resilience. The Carers Service has a key role in supporting carers to apply for personal budgets in order to deliver support to carers that is flexible and meets their individual needs for example Short Breaks, Gym membership or Art Therapy.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

A new housing strategy has been developed in 2021. Housing partners have worked with colleagues from commissioning to ensure the strategy reflects the needs of older people and people with disabilities in Calderdale. Having good quality housing can help keep someone remain independent and connected and reduce the need for paid support. The strategy outlines plans to develop additional accommodation for older and disabled people. These include a long term plan additional extra care in all localities of Calderdale and the approach to providing good quality supported accommodation for people with disabilities. The strategy also outlines Calderdale's approach to create sustainable homes which are adaptable and meet the needs of an aging population.

Calderdale's Health, Social Care and Housing teams work together to ensure that people are supported to remain in their own homes. This ranges from the Handyperson service completing minor adaptations, to ensure people's homes remain safe to major adaptations in new properties. In 2022/23 we continue to use DFG funding to ensure supported living properties are adapted to a high specification for people with additional physical needs, the tenants and their families are integrally involved in the proposed adaptations to ensure that their new homes meet their long term needs and personal preferences. This collaborative approach underpins our aim to support people to remain in their own homes and reduce the need to place people in residential care settings. In August 2022 a new extra care scheme was opened in Calderdale and DFG is being used to ensure bespoke adjustments are made to apartments to fully meet individual needs.

Housing colleagues continue to work closely with Commissioners and the Occupational Therapy Team to ensure that any new developments or refurbishments meet the long term needs of older people and people with a disability, this includes the installation of assistive technology into new developments to maximise independence.

The Handy Person Team (part of Calderdale's wider Adaptations Service) is now directly managed by the Principal Occupational Therapist. This enables the Handy Person Team to support timely discharge from hospital of people requiring minor adaptations such as key safes and hand/grab rails. The team has also developed 7-day working to support timely discharge from hospital.

Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

Calderdale

Health Inequalities

Within Calderdale, we have a range of partners who are engaged in activities that support different delivery models, and this incudes work done by CHFT to code the entirety of the elective backlog by 10 levels of deprivation, minority ethnic groups and people with a learning disability.

In addition, we are planning a placed based approach to investment of core 20 funding;

- Delivery of Wellbeing Strategy Priority Outcomes – looking at health inequalities through the NHS lens. Starting Well - Narrow the gap in readiness for school. Calderdale's recent Early Years Strengths and Needs Assessment identified that inequalities in Speech, language and communication are preventing all children be ready for school. A recent review of pathways to improve speech, language and communication outcomes found limited early identification and universal and targeted services leading to long waiting lists for specialist services. Work will be targeted based on level of inequalities. Funding will be on staff and upskilling. Model will be targeted outreach and family hub-based support

- Delivery of Wellbeing Strategy Priority Outcomes – looking at health inequalities through the NHS lens. Living and Working Well - Reduce Suicide - Calderdale has a high suicide rate with people regularly attending public places with suicidal ideation. A stakeholder review of follow up of these people is underway. This will be used to inform a robust follow-up programme, providing support in a place of safety, robust follow-up, and support access, utilisation and reduced attrition for support from existing services. There also appears to be a link between the increase in the number of people in these circumstances and the cost-of-living crisis/poverty.

- Screening and Immunisation (all ages) - Focus will be on an equitable recovery of screening and immunisation following the pandemic, learning from models developed during the pandemic to address inequalities in Covid vaccination

- A community led health and wellbeing recovery from the Covid-19 pandemic, in those communities impacted most - Focus is on Park Ward and Central Halifax and North Halifax. A programme of community led health and wellbeing recovery is planned for the 2 areas, working with community anchors and linked to regeneration funded by public health. The approach will use participatory approaches with the aim of empowering communities and increasing community resilience. Primary care and community health services have an important contribution to make to the recovery of health and wellbeing following the pandemic. Investment from health inequalities resources would be used to support PCNs to develop, invest and evaluate community-led programmes that support improvement in health and wellbeing in these areas.

- Gypsy Roma Traveller – additional capacity to support development of a traveller site and improve health and wellbeing of travellers.

Equality is a key consideration when developing each of the BCF schemes. This requirement has been heightened by the Covid pandemic. All integrated commissioning includes a joint Equality Impact Assessment jointly completed by the ICB and the Council .The EIAs address all strands of equality and focus upon ensuring schemes can meet the needs of the Calderdale population. A number of schemes have had to adapt or widen their approach to continue to meet the needs of an increasingly diverse population. Examples of this include the development of the Urgent Community Response Service (UCR), with the ability to deliver direct support in a person's home in urgent situations. This reduces the need for people with multiple needs to access and navigate several services and supports people to remain in their own home. Heatherstones continues to provide support to people who have housing needs as well as health and social care needs. Many of these people have associated issues with addiction and social interaction, providing an accessible solution that allows further support to be offered to this group, facilitates timely hospital discharges and an integrated approach to their longer-term housing, health and social support needs.

Long Covid Support has been developed in response to the pandemic following the need to support people with the ongoing impacts of Covid. Other BCF schemes have adapted in response to Covid e.g., transitional beds have been used to support people to leave hospital and avoid the onward spread of Covid where there have been hospital outbreaks putting people who are ready for discharge at greater risk.

Covid has increased health inequalities as hard to reach groups have become socially isolated during the pandemic and have found accessing the support they require more difficult in recent years. A number of services within the BCF plan moved to virtual delivery during the pandemic and have worked to ensure hard to reach groups are able to return to face to face support so that bespoke support is put in place to access any online provision.

An example of this is the Targeted Prevention for Dementia scheme that has recently been re- commissioned. The new provider has made community links and is working to widen their offer too hard to reach groups such as the BAME community. Following the pandemic, a number of carers expressed concerns regarding attending group sessions and the provider has adapted their offer to provide more one to one support in family homes. This addresses fears around community transmission of covid and ensures carers receive support advice and sign posting in a comfortable environment. Staff have supported carers to attend community cafes and events where they have lacked confidence to do this and helped to re-build community links.

The Quality in Care Homes scheme focuses on addressing health and social inequalities within this sector. The covid pandemic created isolation for some residents who could not receive visits in person and had reduced access to social opportunities. The Quality team worked with services to promote access to technology enabling virtual family contact. Virtual sessions were also arranged to support social support and entertainment for residents. Intensive support was also given to this sector to return family visits as safely as possible at the earliest opportunity and to ensure preventative health care service s reached resident. This was aided by the promotion of Enhanced Health in Care Homes building links with PCNs and ensuring pro-active health management takes place.

The Urgent Community Response Service was introduced to address the need of people who require urgent support to prevent hospital admission. These are often older people or those who have not sought early health support and may be marginalised and not feel able to address health needs until they reach a point of crisis. This service brings together a range of multi-disciplinary support to avoid hospital admissions, address urgent needs and also tackle longer term health needs by encouraging access to the services individuals need to address their longer term health and social care needs.

Community Equipment (including the Loan Store) have adapted their approach to delivering equipment safely and ensuring that people felt safe in receiving equipment during the covid pandemic. The service also introducing a new automated telephone system to allow easy access to bookings and returns without joining telephone queues or allowing access out of hours. The service will also be available in range of languages to widen access to those whose first language is not English.