Bradford

Local system review report
Health and Wellbeing Board

Date of review:
12 – 16 February 2018

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and Social Care and for Housing, Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:
Senior Responsible Officer: Alison Holbourn, CQC
Lead reviewer: Deanna Westwood, CQC

The team included:
- Two CQC chief inspectors
- One reviewer
- Three inspectors

- Two CQC Experts by Experience; and
- Three specialist advisors (a LGA representative, a Director of Adult Social Services and a Consultant Physician)

How we carried out the review

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on **older people aged over 65**.

We also focussed on the interfaces between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across three key areas:
1. Maintaining the wellbeing of a person in their usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we asked the questions:
- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We then looked across the system to ask:
- Is it well led?

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We asked the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

We also developed two online feedback tools; a relational audit to gather views on how relationships across the system were working, and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use services, their families and carers. The people we spoke with included:

- System leaders from Bradford City Council (the local authority); NHS Airedale, Wharfedale and Craven Clinical Commissioning Group , Bradford District Clinical Commissioning Group, and Bradford City Clinical Commissioning Group (referred to collectively as the CCGs); Bradford Teaching Hospitals NHS Foundation Trust (BTHFT); Airedale NHS Foundation Trust (ANHSFT); Bradford District Care NHS Foundation Trust (BDCFT); and the Health and Wellbeing Board.
- Heath and social care professionals including hospital staff, commissioning leads, workforce leads, Mental Capacity Act leads, social workers, occupational therapists, GPs, independent care providers and their employees.
- Healthwatch Bradford and District, and voluntary, community and social enterprise (VCSE) sector organisations
- People using services, their families and carers at the Carers' Resource, Age UK, a Black and Minority Ethnic forum and a care home.

We reviewed six care and treatment records and visited nine services in the local area including acute hospitals, intermediate care facilities, care homes and a hospice.

The Bradford context

Demographics

- 13% of the population is aged 65 and over.
- 67% of the population identifies as White.
- Bradford is in the top 20% bracket of most deprived local authorities in England.

Adult Social Care

- 88 active residential care homes:
- One rated outstanding
- 42 rated good
- 29 rated requires improvement
- Four rated inadequate
- 2 currently unrated
- 43 active nursing care homes:
- 18 rated good
- 14 rated requires improvement
- Three rated inadequate
- Eight currently unrated
- 70 active domiciliary care agencies:
- 38 rated good
- 18 rated requires improvement
- 14 currently unrated

GP practices

- 82 active locations
- Three rated outstanding
- 75 rated good
- Two rated requires Improvement
- One rated inadequate
- One currently unrated

All location ratings as at 08/12/2017. Admissions percentages from 2016/17 Hospital Episode Statistics.
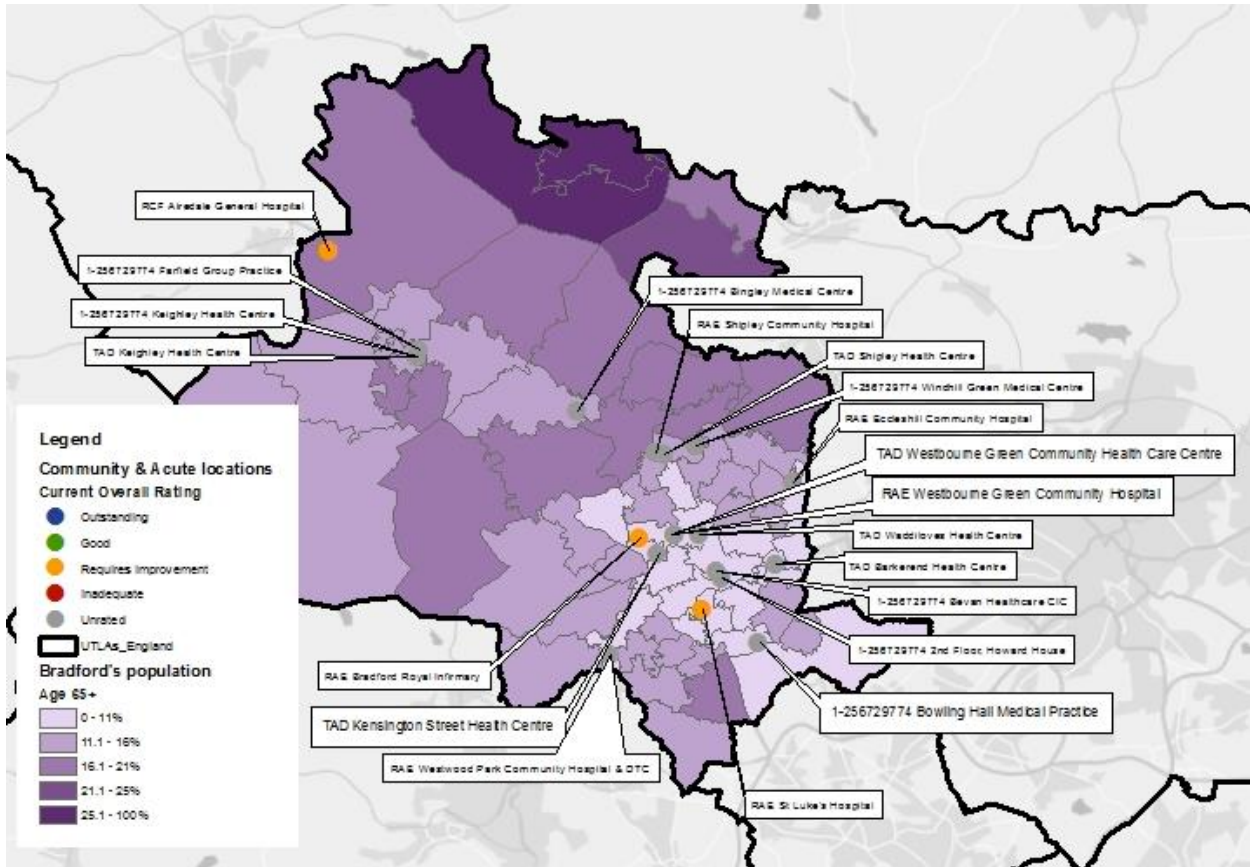
Acute and community healthcare

Hospital admissions (elective and non-elective) of people living in Bradford are found at the following trusts:

- Bradford Teaching Hospitals NHS Foundation Trust
  - Received 66% of admissions of people living in Bradford
  - Admissions from Bradford made up 88% of the trust's total admission activity
  - Rated requires improvement overall

- Airedale NHS Foundation Trust
  - Received 22% of admissions of people living in Bradford
  - Admissions from Bradford made up 63% of the trust's total admission activity
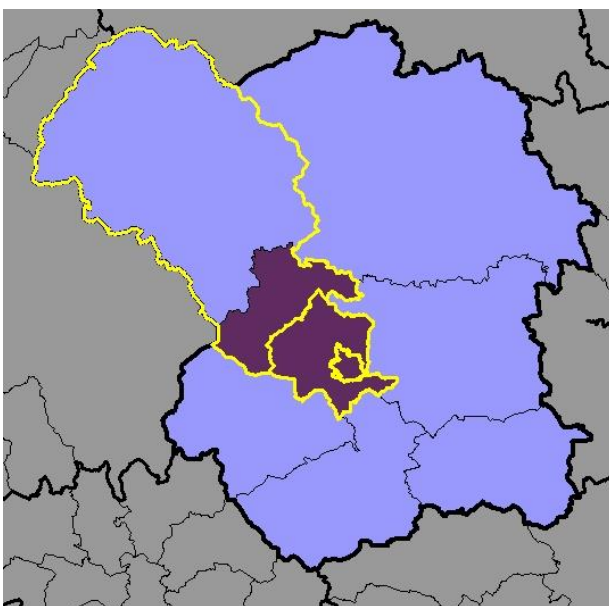 - Rated requires improvement overall

Community services are provided by:

- Bradford District Care Trust
  - Rated requires improvement overall

- Airedale NHS Foundation Trust, via the Airedale Collaborative Care Team and Community Therapy Services

Map one (above): Population of Bradford shaded by proportion aged 65+ and location and current rating of acute and community NHS healthcare organisations serving Bradford.

Map two (left): Location of Bradford within the West Yorkshire STP. The Airedale, Bradford Districts and Bradford City CCGs are also highlighted.

Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- There was a clear shared and agreed purpose, vision and strategy described in the Happy, Healthy at Home plan which had been developed by the system. This was articulated throughout and at all levels of the system. We found that the majority of staff across the system, including adult social care, primary and secondary care sectors, and the voluntary sector were committed to the vision, although some areas acknowledged that there was still work to do to embed the supporting culture. Some of this was related to the interface of health and social care and there was a will to work towards pulling this together. There had been positive development around the Health and Wellbeing Board extending its membership to wider parts of the system, including housing, the VCSE sector, police and fire services.

- We saw that system leaders across health and social care were compassionate and caring. They were clear that the needs of the person sat at the heart of their strategy and vision. They recognised that individuals living in Bradford had different needs, goals and aspirations, and also recognised the differences in geographical communities; system leaders encouraged the development of communities to build support around the person.

- The next steps for the system will be to translate the vision into detailed modelling and then operational practice. The challenge will be to ensure the translation of the vision is in a common language that is understood by all partners.

Is there a clear framework for interagency collaboration?

- There was a defined system-wide governance arrangement that pulled the system together and a clear architecture for development and roll out of the transformation of services in line with the plan. There was a clear locality structure emerging which included the VCSE sector as equal partners but there was still more work to do regarding the alignment and integration of frontline delivery of services. We saw evidence of joined up reporting through the reporting framework including the Health and Wellbeing Board from a health and finance perspective, but there was a challenge in doing this when each organisation has separate reporting frameworks. There was more work to be done to finesse this, but it was clear that the system was on a journey to achieving this.

- At an operational level, there was more work to be done to embed integrated working through integrated commissioning and funding. Much of the success of this depends on high trust relationships and the clear and strong commitment of leaders to the strategic vision.

System leaders need to consider how this is secured so that in the event that changes in leadership occur, the systems are in place to continue with the good work that has been built around strong relationships. There is a risk that in the event of significant unforeseen challenges that different parts of the system retreat back into their own organisations.

- The system needs to continue to build on relationships throughout all levels and consider how the independent provider market is engaged as equal partners.

- There were structures in place to discuss and negotiate commissioning intentions however we were aware that the partnership could be tested by a number of challenges including budgetary pressures within the local authority. Our observations were that Bradford had a good infrastructure through the Integration and Change Board (ICB) and Executive Commissioning Board (ECB) to enable early discussions in this regard.

- Although frontline staff found that sharing of information was still an occasional barrier, we also found that some of the information sharing processes were well developed. There were clear advantages where GPs, the mental health and community trust, and one of the acute trusts had a shared IT system. Although one of the trusts did not share the same system we saw that there were workarounds in place to manage this.

- Integration was ongoing and planned with some effective practice where multidisciplinary teams could access SystmOne. However, we did find some outdated practice such as using a fax machine for communication across the system. It was time consuming for staff to complete paper forms and where people needed re-referral, these forms would need to be completed on each occasion.

How are interagency processes delivered?
- We found some good joined up interagency processes, particularly the Bradford Enablement Support Team (BEST) for reablement and the MAIDT (multi-agency integrated discharge team). The MESH team (the medicines service at home) was a further example of innovative practice. The intermediate care hub was the first point of contact to enable people to receive step up care or support when their needs changed and they were living at home. There was also good use of the VCSE sector to deliver services in equal partnership with health and social care staff.

- There were different ways for people to access services and they might be confused by different pathways into services. There were a number of 'single points of access' for example mental health first response, the EDT access team, the intermediate care hub, and the community nurse team. These areas would benefit from being brought together as a single network and system leaders have recognised this.

What are the experiences of frontline staff?

- Despite pressures on the workforce owing to difficulties around recruitment across health and social care, the workforce managed the flow through the system well and we saw that referrals, assessments and delivery of services were timely.

- Staff we spoke with were committed to improving outcomes for people and developing their strength-based approach. We saw good evidence of prompt responses in our case files. We found that staff were involved in developing the workforce strategy which would enable them to contribute to and to buy in to the system vision.

What are the experiences of people receiving services?

- People who lived in Bradford were supported to live in their own homes and their communities for as long as possible. They received holistic assessments of their care that took into account all of their social and health needs based around their strengths. Where possible, the provision of virtual wards meant that people could receive consultant-led medical care at home rather than in hospital.

- People were supported to live independently in a community-based support system. For example, we heard about a person who lived on their own and would visit particular shops and premises in their local area. Through the use of community connectors, there was a whole community support system put in place whereby local shops and services knew the person, and knew who to contact and report to if they had concerns about the person's wellbeing. This meant that they could continue to do the things they enjoyed in life and reduced the risk of social isolation. However, people who were not eligible to receive funding for services had difficulties finding support and navigating through services.

- People were able to access help and support to stay safe in their homes through the use of technology and telecare systems. People in some care homes had access to clinical assessment via video link with the Digital Care Hub. Where additional support was needed referrals were made to the appropriate service to visit them in the care home, for example GPs, community teams and out-of-hours services. This meant that there was less disruption to their lives particularly if they had needs associated with dementia and could find changing environments stressful.

- Although 87% of GPs provided partial access to extended provision which meant that people could access pre-bookable appointments, some people we spoke with told us that they could not get GP appointments when they needed them. This meant that they were more likely to attend A&E if they were anxious or unwell.

- People did not have to stay in hospital longer than they needed to. There was good support to enable them to return home safely. The provision of a retainer to domiciliary care agencies to hold packages of care meant people had continuity of care and did not have to wait for a new package to be commissioned upon their discharge from hospital. System leaders told us about successes in terms of reducing length of hospital stays and we saw that there was focus on getting people home as soon as possible.

- However, the experience of some people on their pathway through hospital was difficult. We heard that some people did not feel listened to when their needs were assessed or that the views of people who knew them best were considered. Despite a good ethos of not moving frail or elderly people through the hospital, we heard examples of this continuing to happen and some people we spoke with told us that this could be distressing.

- People felt supported by the Home from Hospital service managed by Carers' Resource which was a positive initiative supporting people out of hospital. We heard that it was responsive and was an important factor in enabling people to feel confident and secure on their return home.

Are services in Bradford well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, interagency and multidisciplinary working and the involvement of people who use services, their families and carers.

We found that that there were strong relationships across the health and social care system, which meant that all parts of the system were committed to the delivery of the Happy, Health at Home vision. There were high levels of trust and commitment between system leaders and elected members. We saw that there was a strong and compassionate approach to delivering better outcomes for people who lived in Bradford and a culture of seeking best practice and continuous improvement. The involvement of wider stakeholder groups such as the Voluntary, Community and Social Enterprise (VCSE) sector services, GPs and housing teams in the design of services ensured that there was a joint focus on prevention and keeping older people in their own homes for longer; however independent care providers were not yet partners in shaping the future of services.

There was still some work to be done around embedding joint arrangements. There was potential for pressures such as budget constraints or changes in leadership to impact on the delivery of transformation.

Strategy, vision and partnership working

- There was a clearly articulated vision for people living in Bradford which was subscribed to by staff across health and social care and at all levels of the system from leaders through to frontline staff. There were clear strategic and organisational threads running through from the West Yorkshire and Harrogate Sustainability and Transformation Partnership (STP) to the Happy, Healthy at Home plan which is the Bradford District and Craven plan borne out of the STP, down to the Bradford District Plan. The plan had been adopted by the Health and Wellbeing Board and replaced the strategy that was in place from 2013 to 2017. The vision of Happy, Healthy at Home was reflected throughout and was recognised by all parts of the system including the VCSE sector. The positive approach to developing a sustainable health and care system was not just narrowly linked to health and care service and budgets, but linked to wider economic growth. This recognised that regeneration, and tacking wider determinants of health were critical to long term sustainability.

- The Happy, Healthy at Home vision was underpinned by a number of joint strategies, such as Home First and Healthy Bradford with the focus on ensuring that people could stay healthy at home for as long as possible. System leaders told us that plans had been underpinned by the Joint Strategic Needs Assessment and the new joint health and wellbeing strategy which would deliver on the vision. The health and wellbeing strategy that was available to the public on the local authority website was out of date (covering 2013 to 2017); however the Health and Wellbeing Board had agreed an updated strategy which articulated the joint vision for Bradford. We saw that the iBCF plan and the social care precept planned expenditure had been used to align funding to the strategy with person-centred outcomes. System leaders were able to demonstrate in their Q3 iBCF return where improvements had already been made through the alignment of the funding streams to the strategy and vision.

- Other external agencies also commended the work that had been undertaken in the joined-up development of system plans. For example, NHS England described the senior leadership in Bradford as flexible and proactive in terms of meeting people's needs. We saw that the Chief Executive of Public Health England had visited the local authority shortly before our review and referred to "a sea of good practice", particularly around the work that health and social care partners had undertaken to identify the priority outcomes for people living in Bradford.

- We saw that system leaders, including elected members, were compassionate and focused

on improved outcomes for people while managing the realities of pressures on funding. When we spoke with system leaders they were often able to describe anecdotal examples and case studies while they were talking about their vision and plans which showed that they kept the person at the heart of their planning. Our relational audit (responded to by 168 people working across the health and social care system in Bradford) found that people had mixed views of relationships in the system, with more positive scores against statements around acknowledging and appreciating each organisation's contribution and investment in a shared purpose. However; when we spoke with frontline staff we sometimes heard that they did not feel that they were equally valued with colleagues working in other sectors.

- There was a clear organisational structure being developed to further the strategy. Two accountable care programme boards had been developed. In the Bradford district, north, south and central locality hubs would sit beneath the Bradford Accountable Care Partnership with 10 communities sitting below those. The Airedale, Wharfedale and Craven Accountable Care Partnership had three localities sitting directly below it. The VCSE sector was seen as an equal partner in the development of these plans as system leaders understood and valued the role that it could play in supporting communities around the preventative agenda.

Involvement of service users, families and carers in the development of strategy and services
- We found that Bradford was a system that focused on the person at the heart of the journey. Healthwatch Bradford and District led on much of the engagement with people in Bradford around the development of services. In November 2017, they published The Big Conversation report following a series of events such as focus groups, public events, and face-to-face and online surveys. This was an opportunity for local people to have a say about what mattered to them in terms of the health and social care priorities, which services they felt worked, and which needed development. It was not clear how many of the respondents were people over the age of 65. Healthwatch Bradford and District were positive about their engagement with system leaders. They were able to sit on the Health and Wellbeing Board, the A&E delivery board and felt that they had good access to system leaders. They felt listened to and that system leaders were open, transparent, listened to feedback and acted upon it.

- There were other forums for older people to feed into the development of services. For example, system leaders told us that 8,500 people had been invited to participate in the development of person-centred care in the Home First strategy. However, some system leaders acknowledged that they needed to ensure that they were not developing services around assumptions of different community needs.

- Representatives of the VCSE sector sat on the People's Board, and members of the

People's Board sat on the boards of governing bodies so that there was an upward flow of feedback and information. The Bradford Assembly enabled VCSE providers to meet and discuss the planning of services and support, however we found that smaller organisations in the VCSE sector and the people they represented did not always feel engaged. Some of these we spoke with were not aware of the assembly and this meant that there were potentially missed opportunities for these smaller groups to enable the voices of the people they supported to be heard.

Promoting a culture of interagency and multidisciplinary working

- The Health and Wellbeing Board promoted interagency working and collaboration. It had recently refined its terms of reference to include "mutual accountability between strategic partnerships for the delivery of [their] goals in the District Plan and Health and Wellbeing Strategy". Common goals and measures between strategic partnerships, and a plan to develop a common data set would further embed this culture.

- We saw that interagency working was embedded in Bradford and there were many examples of how this supported people to stay well in the community and to leave hospital promptly. Planning for winter pressures had included multiple agencies and staff across the health and social care sector. For the winter of 2017/18 a single joint plan had been produced rather than a joint submission of individual system plans. We heard from staff that they felt that they worked well together, particularly when there was a crisis. There were high levels of trust and leaders were willing to flex resources promptly to support each other in times of pressure.

- Frontline staff told us during our review that an increase in networking had shifted the culture and helped staff to move away from a blame culture. However, one of the lowest scoring statements in our relational audit was "People take organisational risks where this has the potential to serve wider system goals, without fear of criticism or failure".

- Staff told us shared working meant that they could have strong and open discussions, which enabled problem solving and they knew which experts could support them with advice. This had reduced the need to escalate issues. Sharing of some budgets had supported these processes. For example, the CCGs funded a purpose-built area in A&E to help speed up processes, where a consultant and health care worker began investigations and tests prior to the person being moved further into the department. Therefore, when people were moved, for example into minor injuries, test results should be back for the clinicians to see and to support diagnosis. Although it had taken time, system leaders had worked hard to develop relationships between the VCSE sector and the GP federation to develop joint working around self-care and prevention.

- The STP had created further opportunities for interagency working. The West Yorkshire hospitals created an association of acute trusts which meant that there were opportunities to learn from each other and share best practice. Although we heard that it had taken time and trust to build relationships between organisations that had previously worked in competition with each other, relationships had developed to a point where they could jointly start to look at issues such as their estates strategies.

- Providers and frontline staff in the residential and domiciliary care sectors told us that they did not feel valued as partners in planning and discussion regarding people's pathways of care. Very often these were people who could be strong advocates for people who could not representative their own views and needs. Enabling independent provider staff to have a voice in interagency and cross sector working could benefit other aspects of commissioning including stabilising and improving the quality of the market.

Learning and improvement across the system

- There was a positive culture of continuous learning, self-reflection and seeking best practice. Learning was shared across the system. We saw that in areas where system leaders were already successful, such as the good performance with regard to delayed transfers of care, they still continued to actively seek ways to improve. Leaders engaged with experts from outside the region to develop their own learning at leadership and operational levels.

- Winter planning had been developed based upon learning from the previous winter. A comprehensive review of winter 2016/17 was submitted to the urgent care programme board in August 2017. It identified pressure points in the system and included a detailed analysis of impacts such as delayed transfers of care. The report made a series of recommendations for implementation in the 2017/18 winter plan. We saw that many of these formed part of the Bradford Home First strategy and the BCF plan, such as the increased support for the homecare market and the use of the VCSE sector to support work on ill-health prevention.

- System leaders continued to evaluate hospitals stays and look at options for improving people's experiences of discharge from hospital. The Public Health Team undertook a survey of people in acute hospital or intermediate care beds looking at the person's capacity and cognitive impairment and testing whether the hospital admission could have been avoided. They found about 13% of admissions could have been avoided and 27% of people surveyed could have benefited from an intermediate care option. They also found that although people from Black and Minority Ethnic (BME) communities were proportionately represented in terms of admissions, they were under-represented in terms of take up of intermediate care so there were opportunities for system leaders to build on this information for further improvement.

- Although work was regularly evaluated, much of the practice we saw around the improved funding for homecare agencies and the work around the Home First strategy was relatively new and was yet to be evaluated. In the iBCF Q3 report the system was able to report improvements regarding residential care placements and reablement. It was too early to measure the impact of support from initiatives such as BEST, which provided short-term support to avoid admissions and facilitate discharges from hospital although leaders told us that early indications were positive.

- There were opportunities to learn when things went wrong. For example, the medicine safety group included representation from hospital trusts, the CCGs and a Local Pharmaceutical Committee representative. This group ensured that lessons could be learned and shared this with relevant stakeholders through newsletters.

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.

We found governance arrangements were uncomplicated with clear lines of accountability. The structures in place enabled integrated working across health and social care with support from political members and external stakeholders. There were robust risk-sharing processes and a shared view and responsibility of risk. Information governance was well-developed. Telecare, telehealth and other digital solutions were being developed with a long-term aim of people being able to manage their own information. However, while many developments were proceeding at pace and appeared to be having a positive impact which was being evaluated, system leaders needed to be able to challenge themselves to ensure that developments continued in line with the joint vision.

Overarching governance arrangements
- The Health and Wellbeing Board had the overarching strategic leadership of the health and social care system in Bradford. System leaders described their governance arrangements as "strong" with "high-level political ownership and scrutiny". The Board was chaired by the leader of the council and comprised stakeholders from across the system including the VCSE sector, the police and fire services, housing teams and Incommunities (the social care housing provider).

- Although there were three CCGs covering the Bradford District area, there was one overarching chief officer which ensured that the CCGs were strategically aligned. This also meant that people living in Bradford did not need to navigate different systems. However, the

areas they covered had different demographics and by keeping them as separate entities they were better able to report on and respond to the needs of people in their area.

- There were clear lines of accountability through the Executive Commissioning Board (ECB) and the Integration and Change Board (ICB). The ECB was chaired by the local authority Strategic Director of Health and Wellbeing and had responsibility for the operational delivery around the implementation of integrated commissioning and the BCF. The ICB was chaired by the local authority Chief Executive and managed the strategy around transformation. There were joint posts that linked across health and social care. For example, the Strategic Director of Partnerships was employed through the CCG and was the senior responsible officer for the prevention and self-care agenda. The Programme Director for the ICB was a jointly funded post.

- However, one of the challenges to system partners was around holding each other to account. Relationships and trust among leaders were strong but there was no form of self-auditing in place at the time of our review to ensure that outcomes for people were embedded. This needed to be in place to ensure that that a change in leadership would not impact on the processes or on delivery of the strategy.

Risk sharing across partners

- The A&E delivery board had oversight of performance and risk across the system. This board was chaired by the Chief Executive of Bradford Teaching Hospitals NHS Foundation Trust and undertook the assurance of service delivery and performance. Providers and commissioners worked through the A&E delivery board to ensure that escalation plans were aligned. The board also monitored progress in relation to winter resilience and the delivery of the high impact changes, from the national model for the management of transfers of care.

- We saw that risks, particularly around winter pressures, were shared across the system. We saw ANHSFT's January 2018 winter update which it presented to the board. It showed that despite "unprecedented" pressures in the preceding weeks, performance had improved on the previous year and commended the work of staff teams.

- There was a BCF risk log in place and this linked to the CCGs' and the local authority's corporate risk registers. This included an honest assessment of progress in some areas needing further development for example trusted assessors and the consistent application of policies around patient choice.

- A system progress report against the Health and Wellbeing plan was submitted in February 2018 that measured outcomes against targets and reported on risks against a range of health and social care metrics and described what systems were doing to improve

performance and mitigate against risks. The Health and Wellbeing Board scrutinised dashboard performance against the locality plan. It was effective in having standing items such as workforce development and budget review which meant that wider risks were continuously monitored.

- More work was needed to identify emerging risks in the independent care sector. We saw that systems had been put in place that identified which services needed support however this was predominantly based on findings from CQC inspections and system leaders needed to ensure that health and social services partners were working together to share information and manage emerging risks.

Information governance arrangements across the system
- Information governance arrangements and digital interoperability were well developed across health systems in Bradford. System leaders described themselves in the response to the SOIR as "one of the first digital health economies" through the use of integrated records, telehealth and telecare. In 2016 a Digital2020 Board was formed "where leaders from across the health and care system committed to promote and implement the innovative use of technology and data".

- GPs, social workers, and the community and acute trusts could access information through access to SystmOne. Information governance and data protection issues were resolved through the application of honorary contracts so that staff across the health and social care system could access the necessary records. However, the systems were not yet embedded and there had been some difficulties around information governance with regard to the supplier and NHS England. System leaders anticipated that these would be resolved before the end of 2018 and "two-way information sharing" would be in place. Frontline staff we spoke with also told us that co-location of teams meant that information could be shared more easily.

- Some work was being trialled at the time of our review that enabled domiciliary care workers to share information with people, their families, GPs and social workers through a hand-held tablet kept in the person's home. We saw how this could be effective in providing reassurance for people who used services and their families, for providing information to health professionals in an emergency and for enabling care agencies to be person-centred and responsive to people's needs.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.

We found that there was an integrated workforce programme in place to deliver the strategy and that system leaders were committed to developing a workforce that was aligned to the vision of integration in localities. There were difficulties recruiting staff however there were innovative solutions being developed to attract young people to the sector such as the Centre of Excellence. There was more work to be done to support the independent social care sector and the VCSE sector to reduce staff turnover and vacancies.

System level workforce planning
- System leaders had a focus on developing a workforce that could deliver on the integrated strategic vision. The local authority senior leadership team had a clear vision of enablement for people using services and the role of social workers as advocates for clients within a clear legislative context. The community health trust told us that their workforce was aligned to the strategic system wide vision. For example, the clinical team was involved in the out of hospital programme, and the trust board was also signed up to the vision. When the planned localities are in place, district nurses will be embedded into specific populations and be better able to understand the asset based approach.

- The Integrated Workforce Programme Board was chaired by the Medical Director of ANHSFT and led on the delivery of the workforce strategy across the system which was supported by an integrated workforce programme. There was a shortfall of available staff and to manage this, in line with the strategy, they were looking at "blended" roles combining health and social care. Although there were some jointly commissioned staff in post, workforce leads told us that there was still work to do around "future proofing" and changing the workforce to fit around an asset based approach. There was some frustration that national education systems still supported training that encouraged future jobseekers to choose between health and social care career pathways rather than encouraging integrated development at the early stages of people's careers.

Developing a skilled and sustainable workforce
- Recruitment and retention across the system was a challenge. For example, pharmacy leads told us that despite there being a school of pharmacy in Bradford, they experienced difficulties recruiting band 6 professionals. Analysis of electronic staff record data between July 2016 and June 2017 showed that that the turnover rate of nursing and medical staff was higher in both acute trusts than the England average.

- There was a proactive approach to developing the local workforce to attract young people into the health and social care industry, through apprenticeships, an industrial centre of excellence and the West Yorkshire excellence centre. Workforce leads were working with providers to develop the prospectus for development and training to grow a workforce that was aligned to their vision. International recruitment for GPs had been approved for Bradford and Kirklees. Leaders were also considering associate nurse roles and consideration was being given to attracting people who were new to the employment market but who had experience of providing care in their own communities.

- Analysis of workforce estimates from Skills for Care showed that recruitment and retention was a particular issue for providers of adult social care services. Turnover of social care staff had increased in line with the England average and in 2016/17 was at 27.8%, however this was higher than the average of comparator local authorities. Vacancy rates had increased steeply between 2015/16 and 2016/17 from 5.6% to 9.1% and were above national and comparator averages.

- System leaders recognised this as a risk to the stability and quality of services. They felt that there were opportunities through the workforce programme and working with agencies such as Skills for Care to support more people in domiciliary care and care home settings to complete the right qualifications. Workforce leads had identified providers' reluctance to release staff for training and system leaders needed to find ways to address this.

- VCSE providers also had difficulties retaining staff. They felt that some of this was a consequence of uncertainty around contract arrangements which meant staff would be attracted away to positions that appeared more secure.

- Overall Bradford is within the 20% most deprived local authorities in England; however within the local authority area levels of deprivation vary, with the most deprived wards centred around the urban areas of Bradford city centre and Keighley town. In less affluent areas CQC inspectors felt that workforce was more of an issue in terms of quality and recruitment of staff. In addition, staff in these areas felt less valued by health professionals. There was a risk to people living in care services as the difficulty in recruiting qualified staff led to a lack of clinical oversight. This was reflected in the CQC ratings of nursing homes where 7% of services were rated as inadequate and only 42% were rated as good, compared similar areas where 3% were rated inadequate and 59% rated good.

> **Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?**

We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.

We found that system leaders had taken an innovative approach to supporting the VCSE sector in the formation of a formal alliance which would bring more stability to the sector and enable them to work closely together to develop their preventative agenda. They had also used funding to stabilise the homecare market and the success of this was reflected in very few delayed transfers of care. The GP alliance was supportive of the commissioning shift towards preventative services and engaged with the VCSE alliance.

However, system leaders needed to take a more robust approach to contract management and oversight, particularly with regard to the independent provider market as overall the provision of care was not good and people were required to pay a top up if they wanted better quality care. The commissioning of fifteen-minute care visits meant people sometimes had a poor experience and there had been an increase in medicines errors.

Strategic approach to commissioning
- Commissioning plans were developed in line with the Happy, Healthy at Home vision, underpinned by the transformation towards localities. System leaders told us in the response to the SOIR that the Joint Strategy Needs Assessment (JSNA) informed their planning alongside more detailed and focused pieces of work such as their dementia needs assessment and winter resilience work. They told us that the JSNA enabled them to identify priorities for commissioning based on evidence and need. We saw that there was a JSNA for older people with a number of analyses sitting below this such as dementia and hospital admissions.

- We saw that work was ongoing to implement commissioning plans in line with the strategy. Health and social care partners were working together to align their commissioning intentions. System leaders told us that Bradford had a long history of involving the voluntary sector in strategic planning and that the VCSE sector played a vital role in the provision of services for older people. Frontline staff told us that advocacy services have been recommissioned to build an asset based approach.

Market shaping
- Partners we spoke with recognised that there were significant challenges in the domiciliary

care and care home sectors and system leaders recognised that the market was fragile. There was a previous history of poor partnership working with the sector. Steps had been taken to address this in the homecare sector through the iBCF uplift in order to retain supply and capacity.

- Although the strategic vision was directed at keeping people at home for as long as possible, so that people would only need to move to a care home if they had multiple needs that could not be managed at home, there was a shift in provision in the independent sector from nursing home to residential provision. Our analysis showed an 18% reduction in nursing home beds between April 2015 and April 2017 in Bradford; a greater reduction than in 14 of its 15 comparator areas, while the England average was a reduction of 2%. Over the same time period there was an increase of 13% in residential care beds. Commissioners were unable to identify the reasons for this although there was some speculation that it might be related to the difficulty in recruiting qualified staff. The market in Bradford had been difficult with a larger number of smaller providers however system leaders need to find a way of taking a strategic position so that they can anticipate and manage market changes. The local authority told us that in terms of their commissioning they had reduced the use of residential beds by 10% in a period of 10 months; this was supported by ASCOF data which showed a downward trend in the rate of long-term admissions to care homes for older people between 2013/14 and 2016/17. While this tied in with their strategic intentions, there was a greater risk of failure in the market as providers moved away from the nursing home market. This also placed a greater burden on system resources such as community nursing.

- System leaders recognised this and told us they had begun a major programme to tackle market issues, however they were in the first year of a three-year plan. The first step had been fee increases and retainers to help maintain capacity and build trust. There was work underway to clarify the type and volume of services needed which included a focus on in-house beds for short term care. There was a need to establish a fair price across the sector. We found that if people living in Bradford who received local authority funding wanted to be placed in a service rated as good by CQC, they would be required to pay a top up fee. This was confirmed by system leaders and also by our data which showed that 30% of care home beds in Bradford were partly self-funded compared to 13% in similar areas and an England average of 9%. This meant that there was a barrier for some people to receiving care from good services and a disincentive to services to improve if they did not attract funding from the local authority. Although Bradford had a significantly lower rate of delayed transfers than comparator areas or nationally, it had a slightly higher rate of delayed transfers resulting from the person or their family's choice. The quality of available social care services may have contributed to this.

Commissioning the right support services to improve the interface between health and social care

- Support and funding was given to the VCSE sector to enable the formation of a VCSE alliance as a legal entity. This was developed to support the VCSE sector to play a part in market development. System leaders told us that there had been some good work around self-care as a result of this and that there had been reductions in A&E attendance and in GP attendances. A number of VSCE organisations were getting reduced funding and system leaders recognised the need to stabilise the sector in order to support their agenda of self-care and prevention.

- The VCS Alliance, following receipt of funding from the CCGs was established as a legal entity; the CCG recognised that in order for the system's integrated vision to be realised they would need to invest in the voluntary sector to mobilise. As a legal entity, the VCS Alliance became an equal partner and has been able to take on contracts for the delivery of services and support members through the process. However, there was a need to ensure that the wider VCSE sector was engaged with opportunities. We found that there was continued uncertainty for VCSE providers. For example, a large VCSE provider managing an important contract to support people living with dementia did not know in February 2018 whether the contract would be renewed in April.

- System leaders had been bold in making the decision to use funding to pay a 30-day retainer to homecare providers when people were admitted to hospital. Early indications showed that this had been effective and delays attributable to social care or people waiting for care packages were minimal. This was also a person-centred approach as it allowed continuity of care for people and served to stabilise the domiciliary care market.

- However, domiciliary care providers felt that the commissioning of 15 minute visits meant that their support was very task orientated with a focus on people's ill health rather than an enablement approach. In addition, they felt it had led to an increase in safeguarding referrals for medicines errors. This was reflected by CQC inspectors who told us that when they found breaches in the Health and Social Care Regulations, these were often around the administration of medicines.

Contract oversight

- The management and monitoring of contracts was underdeveloped particularly with regard to residential provision. This was across both health and social care commissioning. We found that commissioners tended to be reactive and responded when things went wrong or services failed however there were not robust mechanisms in place for monitoring the quality of services in a way that would provide early warnings and enable proactive management.

- The quality of domiciliary care, residential and nursing home care services in Bradford was poorer than other areas. This has a big impact for people, as domiciliary care and residential care providers have a significant role in determining the quality of life for people who receive their services, whether they are being cared for in their own home or if they have moved into the residential service which has become their new home. The Care Act guidance[1] describes the role of the local authority as critical to achieving high-quality, personalised care and support through its commissioning and its broader understanding of the market. As at December 2017, less than half (42%) of the nursing care homes in Bradford that had received a CQC rating had been rated as good compared to 59% across comparator areas and 62% nationally. There was a greater disparity with residential care services with 48% rated as good compared to 72% across comparator areas and an England average of 75%. Analysis of re-inspections as at December 2017 showed that, the ratings of 16% of adult social care locations deteriorated, compared to 13% across comparator areas and the England average of 12%. The independent provider market had not been an integral partner in the system and this impacted on the ability of the system to shape the market around local needs and the quality of the lives of people who live in Bradford.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting peoples' independence?

We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high-quality care and promote people's independence.

We found that resources were targeted at promoting people's independence and preventing hospital admissions. System leaders were able to agree joint priorities around the use of the iBCF that aligned to their overall strategy and felt assured that their spending was targeted on these priorities. However, although the impact was clear in terms of numbers of people flowing through the system without delay, more work was needed to evaluate the outcomes for people.

- Money from the iBCF had been invested in extending capacity in the homecare market and enabling providers to offer a competitive wage. In addition, the social care precept was used to increase funding to homecare providers to stabilise the sector. System leaders had agreed to focus on reablement to assist people out of hospital and reduce the likelihood of readmission. Analysis of Adult Social Care Outcomes Framework (ASCOF) data indicated that this had been effective.

---

[1] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#chapter-4

- System leaders reported in their iBCF return that the iBCF grant demonstrated "protection of services for the residents of Bradford". They stated that the allocation of iBCF monies had enabled frontline services to respond to the pressures in the system over the winter period. Their own data showed that during December 2017, there were only three people delayed for a total of six days where the delay was the sole responsibility of social care.

- The Public Health team was looking at what they could commission together with the VCSE sector as there were programmes that duplicated. There was a commitment to looking at how they invested in the VCSE sector however there needs to be support for VCSE organisations to become stronger at evaluation and building sustainability.

- We did not get a clear sense of how quality outcomes were tested across the system. Although data indicated that the system was working effectively in terms of flow, there were not measures in place to ensure that people also had a high quality experience of care.

Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in their usual place of residence

Are services in Bradford safe?

With their focus on keeping people Happy, Healthy at Home, system leaders understood that people needed to feel safe. There were services in place to ensure that people felt safe and protected from harm through the use of telecare equipment and support from community navigators. Risk stratification systems had been developed and the rate of attendances at A&E for people over 65 was in line with the England average. Leaders were seeking to improve and were evaluating this work.

There was innovative work underway to identify people who might be at risk, working with the independent sector, and the Medicine Service at Home ensured that people's medicines were reviewed regularly and managed safely. However, the commissioning of fifteen minute visits by domiciliary care workers had resulted in an increase in medicines errors and safeguarding referrals related to this.

- There were systems in place to ensure that people could be protected from avoidable harm

in their own homes. For example, there was support to ensure that people's medicines were managed safely through the Medicine Service at Home (MESH). This service ensured that people who were at risk owing to the number of medicines they were prescribed or other identified risks had their medicines reviewed. The MESH service was under contract to undertake 6000 reviews and was able to undertake reviews in people's own homes. The service could be easily accessed by GPs, secondary and community care providers as well providers of domiciliary care. This meant that there were regular reviews and checks in place for people who might receive medicines for different conditions that could have contra-indications, and that medicines were managed safely. System leaders told us that although the MESH service had initially been costly, it was being utilised to its full potential and had resulted in long-term gains; one of which had been a reduction in the prescription of sedative medicines.

- However, the commissioning of 15-minute homecare visits compromised the safety of medicines administration. Domiciliary care agency staff and VCSE workers told us that because they needed to be fast, staff had to work in a very task orientated way. Often, they were the only person that the person using the service would see in a day, and they experienced difficulties with managing medicines and supporting the person in such a short time frame. This had led to increased numbers of medicines errors and related safeguarding concerns.

- The Safe and Sound service could be accessed by anyone who was assessed as "needing help to feel safer, more protected and independent in their own home". People living in Bradford and needing this support could refer themselves for an assessment, or the referral could come through the GP or health services. The service provided a pendant for people to get support in the case of a fall or other emergency, and there was also support for a wider range of issues that might concern people who feel vulnerable such as help dealing with bogus callers and medicines reminders.

- There was a safeguarding adults policy in Bradford that sat within a wider partnership. The West and North Yorkshire and York Safeguarding Adults Project Group set out their multi-agency policy and procedure in December 2015 which described the framework for how agencies should respond to allegations of abuse and neglect. Bradford's Safeguarding Board described its own vision as "Making Safeguarding Personal" supported by six principles. The first two principles were empowerment and prevention, which reflected the local focus on prevention. At the time of our review, we were told that this policy was due to be refreshed.

- System leaders were looking at a range of ways to identify people who were frail, had complex needs or were at risk of deterioration in their health or social care situation. GPs

identified the top 2% of patients considered to be at risk and some ensured that regular reviews were offered by a practice nurse or advanced nurse practitioner (ANP) to support them to avoid hospital admissions. Further work was underway through ANHSFT which was looking at using risk stratification to proactively identify people with complex needs and build a model of support around them. They described one person who had had multiple admissions owing to an exacerbation of a physical illness. This person also cared for their spouse. An ANP worked with the person to build a plan for the maintenance of their physical condition and a community navigator through Age UK supported them with plans around their low mood and sense of responsibility as a carer. The community navigator supported them to obtain a mobility scooter and also an afternoon of support per week for their spouse. This meant that the person felt that they could safely resume social activities and be assured that their loved one was safe. They had subsequently only had one hospital admission within a twelve-month period. However, system leaders felt that this community model could be further developed as the rate of referrals was lower than expected. At the time of our review this was being evaluated.

- There were other innovative ways of working with partners to ensure that people who might be at risk or living with conditions that could make them feel vulnerable were identified and safeguards put in place. For example, the Public Health team had started to work with the local water supplier, to maximise opportunities to share data so that support could be targeted. These suppliers would have information about people who might have mobility problems or require support to maximise their benefits. In return, the local authority could share information about people who might need additional assistance with things like bins. With this awareness, suppliers could be partners in flagging risks or concerns. The work was in its early stages and stakeholders were looking at how this could be developed further and in line with regulations around information governance.

Are services in Bradford effective?
System leaders were designing integrated health and social care systems that reflected their strategic vision and their focus on enabling people to remain in their chosen home for as long as possible. There was a focus on enabling people to be part of their communities and reducing social isolation. Work was underway to ensure that people from harder to reach communities were able to access services at an earlier stage. Information technology and information sharing was well-developed with IT systems in place to facilitate this. However, there was still work to be done to fully embed this across health and social care. The health and social care workforce collaborated around the needs of the person requiring services and the redesign of the locality based model recognised that primary care was often the doorway to services for people. Staff across the health and social care system were committed to making this work however there was a need to ensure that the knowledge and support of care staff in the independent sector was equally valued.

- The Public Health team was focused on promoting the health and independence of people so that they could remain at home. They were maximising opportunities around housing and recognised that people had very different needs and were looking at ways to meet these. This work was linked to one to one support and signposting offered by community connectors. The community connector service enabled people to access support and information in their own local communities, which reduced social isolation as people could be part of their communities and remain confident in their own homes. There was work underway to include community connectors from an Eastern European background as health and social care leaders had identified that people from these backgrounds did not engage willingly with preventative social care services which meant that they were more likely to start using services when they were at crisis point. An event had also been scheduled to be held in February 2018, shortly after our review, in which health and social care staff in Bradford with an operational or strategic role were invited to a conference to further develop and improve the local response to people from these communities.

- We heard from people we spoke with, and saw from case studies, that people's needs were assessed holistically to support them to remain independent for as long as possible. We saw that multidisciplinary meetings were based around the person's needs. However, ASCOF data showed the percentage of older people accessing long-term social care support who were receiving direct payments to enable them to manage their own care packages was very low at 5.7% in Bradford in 2016/17 compared to the average across comparator areas (17.8%) and the England average (17.6%) and had declined slightly over the previous two years. This shortfall had been recognised by system leaders and work was underway to address this. A partnership group had been set up with a group of voluntary organisations to look at direct payments, funded care and the development of Individual Service Funds (ISFs). The work around ISFs was still at an early stage but it was being developed alongside independent providers with support from the Association of Directors of Adult Social Care (ADASS) and Think Local Act Personal (TLAP). Conversely, the rate of direct payments for NHS CHC per 50000 adults across Bradford CCGs was above the England average in Q1 2017/18 and the rate of personal health budgets was broadly in line with the England average

- Systems were designed around a philosophy of "asset based community management". This meant that, in line with the preventative agenda, systems were designed so that people could have as much control as possible over their own care. This was known in Bradford as "assisted self-care"; for example, people were able to refer themselves directly to a physiotherapist without having to go via a GP. The Public Health team were leading on work around warm homes, targeting their support on where the greatest need was, however there were concerns raised by people we spoke with about the impact of reduced funding in this

area and that some people may have risks to their health because of a lack of heating or hot water. There was a district nurse complex health team and a long-term conditions team to help people to avoid admissions. Their focus was on people who were at home and unable to access GP or other services.

- Care homes in Airedale had commissioned a GP provider to undertake regular ward rounds. We were told that this had reduced hospitals admissions. Our data showed that people living in care homes in Bradford were less likely than those in similar areas to attend hospital with avoidable conditions such as urinary tract infections and decubitus ulcers (pressure sores). However, although they were in line with comparators around pneumonia and other lower respiratory tract infections, they were higher than the England average. Work with GPs was being developed more widely through the Primary Care Home model (PCH) which linked GPs to the localities in Bradford. The PCH was being designed to work across the health and social care sector as well as the VCSE sector built around primary care hubs, as it was recognised that people often first came into contact with health services through their GPs.

- These plans were well developed with the full support of the GPs who understood their roles as an integral part of the community based model and as sitting at the heart of an integrated care model. The commitment to supporting GPs to undertake this work had been reflected in the average GP funding per patient which our analysis showed had been higher in 2014/15 and 2015/16 than similar areas and the England average.

- System leaders ensured that staff across health and social care understood the vision of Happy, Healthy at Home, and were embedding the skills required to support this through their workforce development. Staff were receiving training on new ways of delivering on personalisation agenda. System leaders told us that staff were encouraged to "change the conversation" and identify more empowering support for people. There was also training for staff around support offers such as "virtual wards" which enabled people to receive medical care at home and encouraging staff across health and social care to consider alternatives that would enable and empower people to remain in the setting of their choice. Training around dementia care planning had been implemented across health and social care, and mental health staff and occupational therapists supported extra care housing staff with training.

- However, although staff were willing to work in new ways, we heard from many groups of frontline staff and leaders that workforce capacity was an ongoing issue. Frontline staff that we spoke with understood that sharing information and collaborative working improved outcomes for people, however care workers in the independent sector did not always feel that their roles were respected in the same way by health professionals and that this led to missed opportunities for sharing important information about the people for whom they provided care.

- Although systems for sharing information were not yet fully embedded across Bradford, they were well developed. We saw systems in place to support information sharing and collaboration between care workers, GPs and social workers which also included families and people using services. A system was being trialled at the time of our review with 150 people receiving care in their own homes, which enabled them to hold their own care packages on computer tablets in their homes. They could use this to review their care plans, raise concerns and receive live notifications, for example if their care worker was running late. GPs could access the information if needed and people would not have to tell their story repeatedly. There was a single IT system in place used by GPs, BDCFT, ANHFST and at the A&E department of BTHFT. This facilitated better information sharing and where the A&E department could access GP records, symptom management could be put in place reducing the need for hospital admissions.

Are services in Bradford caring?

There was good support for people who used services and their carers to be involved in discussions and planning their care. However, for people who lacked the capacity to make decisions, consideration was not always given to their holistic needs and the wishes of their family members. A new team had been implemented in the local authority to provide support and advice to partners and we saw evidence of the success of this team, however further work was needed to embed the principles of the Mental Capacity Act across the system.

Carers received support and advice and there was further work going on to ensure that people who cared for others were identified and receiving support. The commissioning of short visits meant that care workers could not always support people in a kind and caring way as they often did not have time to have meaningful conversations with them or deliver the care in the way that they needed it.

- We saw from case studies we looked at and heard from people we spoke with that people were at the centre of their care and support when services were being put in place. There was evidence that assessments were undertaken holistically by multidisciplinary teams and that the assessment reflected people's choices and cultural preferences. Assessments included family members and there was input from voluntary organisations. System leaders were further developing a needs assessment which would bring information and resources together and enable plans to be developed around wider determinants than the person's health needs.

- Some frontline staff felt that there was sometimes a tendency to see a person as a "diagnosis" rather than a person. This was being addressed by system leaders and would require a cultural shift. For example, district nurses had received training to have more holistic and empowering conversations with people to identify their needs and goals.

- The electronic system that was being piloted with domiciliary care agencies would enable domiciliary care workers to share information electronically with people who use their services, their families and their GPs in an emergency. This enabled people to be involved in managing their own care packages and with permission, families could access care records to share information or provide assurance. This meant that family members who did not live close by could, with permission, access records to get assurance around issues such as whether their loved ones were having their medicines on time or eating well.

- We saw that people were involved in making decisions about their care however work around the Mental Capacity Act 2005 (MCA) needed to be further embedded. We found that staff in the health sector and the social care independent sector did not fully understand the MCA and there was a risk that people's wishes could be disregarded by staff who were risk averse. There had been a significant backlog of Deprivation of Liberty Safeguards (DoLS) awaiting authorisation and a team of best interest assessors with an MCA lead had been established. This had been successful and the team's role had extended into advisory and training, supporting partners and providers with advice regarding the law, ensuring that people's rights and wishes were understood and respected in accordance with the MCA. For example, we heard about a couple who had been separated when one had been placed on anticipatory medicines which are given to people who are at the end of life and placed in a residential setting. However, the person had recovered but remained in the care home. The best interests assessor was able to establish that the person's own home had not been considered as an option for them to receive care and, although their condition meant that they could not verbally express themselves, they were able to demonstrate their objection to the care setting. The person's spouse also clearly wanted them home however health services had struggled with supporting the family to make a decision based on their wishes rather than their medical needs. Through the proper application of the MCA and the DoLS process this person was enabled to return to their own home.

- We saw from case studies we looked at and people we spoke with that there was good support for carers offered by the Integrated Carers Service which was commissioned through Carers' Resource. Carer drops-ins were arranged to offer support to people and an opportunity to discuss any concerns. In addition to the drop-ins, carers could call into the centre at any time if they needed any help. This helped to build up relationships and trust and provide people with an advocacy service if needed. Staff were very knowledgeable and showed compassion when speaking about their roles and responsibilities. They stated there were lots of unidentified carers and they were working on trying to identify more. Public engagement events were held and GPs were supporting the service in trying to identify where there was need. Carers were able to have a wellbeing review and the resource centre liaised with other organisations to ensure that carers had the support they needed such as support with benefits.

- ASCOF data for 2016/17 showed that the proportion of carers who were satisfied with their experience of care and support was slightly below the England average at 37.4% (England average 39%), however the proportion of carers aged 65 and over (who are more likely themselves to be caring for older people) that were satisfied was slightly better than the England average at 42.1% (England average 41.3%).

- The proportion of carers who reported in 2016/17 that they had as much social contact as they would like was higher in Bradford than the England average, both total and carers aged 65+.

- We saw that staff respected people's individual cultural and religious needs. However, the commissioning of home care services did not always enable staff to deliver care in a kind and compassionate way. We heard that fifteen minute visits were being commissioned and this meant that staff were often rushed. Domiciliary care staff and VCSE providers told us that home care was provided in a very task orientated way owing to the short visits. They told us that care could be provided without the care worker talking to the person as they would need to focus on issues such as checking medicines. An example was given of a visit from a care worker who was supposed to provide lunch for a person and ran out of time, serving the meal partially frozen.

Are services in Bradford responsive?
There was a wide range of services for people living in Bradford to support them through the health and social care interface. These services were joined up across health and social care and there was a holistic approach to managing people's care pathways. There was a focus on enabling people to receive support in their usual place of residence through the use of telemedicines, the Bradford Enablement Support Team, a 'virtual ward' and the complex care team.

The VCSE sector was valued and played a significant role in supporting people with low level needs that enabled people to live as independently as possible and avoid hospital admission. Health and social care professionals were proactive in linking people to services including VCSE services around social prescribing. However, there were multiple ways of accessing services which people found confusing and could result in missed opportunities for people. People who were not eligible for local authority funding had particular difficulties with accessing information and support.

- We were told that systems were in place to enable people to access services easily. There was a single point of access through a call centre taking up to 200 calls a day for health and social care. Local authority leaders told us that this reflected the principle of 'home first'

agreed in the Happy, Healthy at Home strategy. However, we found that there were multiple 'single points of access' for a number of services such as the mental health rapid response service and the community nursing team, which could be confusing. At a forum we attended with people from BME communities, everyone we spoke with felt there was not enough information available in regard to contact numbers of services that may be able to help.

- There was a need to ensure that all people received the same level of support to access information about services, regardless of whether they were eligible for funded support. People we spoke with in focus groups told us that there were not the same levels of support for people who were able to fund their own care. For example, one person we spoke with told us that their parent was living with dementia and needed to fund their own support. However, owing to their condition they were unable to arrange this. Although they had assets through their property they did not have the means to maintain it, and were found without heating or hot water. In addition, owing to their anxiety levels, they were contacting emergency services throughout the night.

- System leaders valued support from the voluntary sector and recognised the important role they played in enabling people to stay happy and healthy at home. Carers' Resource had a point of contact that people could call for support with practical problems. If Carers' Resource could not provide support they would signpost people to relevant services and they also confirmed that very often they had to help people navigate through the system. This meant that people had different experiences of services. One person we spoke with described difficulties in finding out how to access equipment and adaptations at home; not knowing who to contact and not feeling listened to had impacted their confidence. However, another person who was living abroad had raised concerns through the contact centre about an older family member which resulted in the person's boiler system being repaired so that they had access to heating and hot water and were less likely to become unwell through poor living conditions.

- VCSE providers told us that there was good low-level preventative support available for people, for example lunch clubs and checks on people living alone. This was often managed within communities and providers felt that this was well managed in Bradford. When people were diagnosed with dementia, they were signposted to Age UK for support and we were told that professionals engaged well with this service. An organisation was commissioned to provide the community connector service and evaluation undertaken in January 2017 showed that 82% of contacts were related to anxiety, low moods and social isolation. Their own data over the period of March to October 2017 also showed a reduction in GP appointments and A&E attendances. However, only 26% of people using the service at the time of the evaluation were aged 65 and over and there was more work to done around targeted support for older people.

- Access to GPs and district nurses was variable. We heard in particular, accessing a GP out of hours could be difficult. Analysis of data from September 2017 showed that 1.3% of GP practices across Bradford local authority offered full provision of extended access to pre-bookable appointments on weekday mornings, evenings and over weekends although we were told that there were plans in place to develop this. Across comparator areas, 43% of GP practices surveyed reported offering full provision and across England the percentage was 30%. Patient weighted analysis of provision of extended access to GPs showed fewer registered patients in Bradford could access pre-bookable GP appointments outside of core contractual hours (37%) than across comparators (64%) or England (55%).

- Domiciliary care providers told us that in some areas, an inability to get a GP or district nurse to attend a person at home for an issue such as a suspected urinary tract infection meant that they would need to rely on emergency services. Although the majority of people we spoke with felt that when they were able to see their GPs, they were listened to and received the support that they required, there were some examples of older people feeling that their age was a barrier to being heard. We heard from one person who had supported an individual as an advocate. Both the advocate and the individual they supported felt that the GP did not listen to them when they attended with an infection. Following a hospital admission, the person had required life-altering surgery. While we were not shown evidence that the wrong decisions had been made, the person was left feeling that if they had been listened to, they would have had a better outcome.

- There was good access to occupational therapy support and domiciliary care providers were able to refer directly which reduced delays for people waiting for these services.

- ANHSFT provided telemedicines through its Digital Care Hub. Their telehealth service won a national award in December 2017 and supported 500 care homes across the country, 48 of which were in Bradford. The telemedicines service enabled care homes to seek advice via remote video consultations and helped to prevent hospital admissions. For people who were at the end of their lives, a 'Gold Line' gave 24-hour access for people to receive urgent support and advice in their own homes so that they could die in their preferring setting.

- There were other arrangements to ensure people could be assessed and seen in their usual place of residence. A 'virtual ward' enabled people to receive consultant led care at home and was of particular benefit to people living with dementia who would experience less stress and confusion being cared for at home. This was developed through BHTFT and was a joined-up approach to care involving the hospital, community services, primary care services and adult social care. Staff we spoke with were proud that this initiative had won the 'Improving Value in the Care of Frail Older Patients' category at the Health Service Journal (HSJ) Value in Healthcare Awards in May 2017.

- Community matrons received additional training to support families around particular needs such as respiratory issues which could have a wider impact on a person's health. They would also liaise with the intermediate care hub and the virtual ward to support people to stay at home. However, some staff raised concerns that there was a bigger cohort of people whose level of support had not yet tipped into the group of people identified as high risk, and that these people probably has less proactive management of their conditions.

- The Bradford Enablement Support Team (BEST) was a local authority led service which provided short-term support for people at home to help prevent hospital admissions. The service was inspected by CQC in March 2017 and rated as good overall. We found that assessments were person-centred and our inspectors reported that "there was an exceptional promotion of maintaining good health and continued support for people who used the service throughout their care and afterwards". During our review, we were given an example of a carer who had gone into hospital. The BEST was able to provide support to their family member who was living with dementia. This gave comfort and assurance to the carer, and the family member did not have to leave home and receive care in another setting while their carer was unwell.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in Bradford safe?

When people were in crisis and required clinical interventions, there were systems and process in place to ensure that they were safe. Staff across all sectors received regular training and there was a culture fostered through daily meetings that enabled staff in the acute setting to raise concerns, confident that they would be acted upon. Staff did not always understand issues such as self-neglect and the MCA which could impact on the safety and liberty of people using services. Although acute trusts did not always meet the target for A&E waiting times, their performance was usually better than the England average. However national information returns about bed occupancy levels were found to be incorrect which meant that we could not assured that these were being safely managed.

- There were arrangements in place to ensure that risks were managed when people were in crisis and required hospital support. At one hospital, we were told that there was a "safety huddle" twice daily which staff told us was an opportunity to escalate any issues of concern.

Staff were confident that these concerns would be listened to and acted on. Both acute trusts and BDCFT reported in the annual safeguarding report for 2016/17 that awareness of safeguarding had continued to be a focus for staff training. System leaders at BDCFT told us that they were considering how to collect learning from issues of concern that had been raised and which did not meet the threshold for safeguarding investigations but which they felt could contribute to learning and safer practice.

- System leaders at ANHSFT told us they had done a lot of work on patient flow and as part of the 'safer' tool were analysing the time that the person spent in hospital, taking into account best practice literature and learning from outside the area. They were encouraging a mind shift among clinical and healthcare professions prompting them to ask questions such as "why a hospital bed and why not the person's own bed?''. This was aimed at preventing the rapid muscle loss and mobility difficulties that can occur when older people are unable to get out of bed. Staff were to encourage people to get dressed, mobile and eating well. Systems and processes were being put in place to drive this forward in a way that would ensure buy-in from staff. This was a proactive way of driving a cultural shift.

- More work was needed on training health and social care staff in the MCA, where there was a potential impact on the safety of people lacking capacity and living in Bradford. For example, there were some older people who undertook activities which could be considered unsafe, for example the hoarding of papers in their homes which provided fire and falls hazards. Sometimes there was little support for these people as their behaviour was described as "a lifestyle choice". However, it was not clear that meaningful discussions were held to enable people to understand the risks and to make informed decisions. Wider discussions needed to be held around the safety and quality of housing and whether the "lifestyle choice" was in fact a result of other issues, for example people being unable to take bins out and being too embarrassed to ask for help.

- When people needed to attend A&E, there were services in place to identify people who had complex needs and could be supported to avoid a hospital admission. The frail elderly team saw people arriving at A&E at both hospitals very rapidly and could arrange services to get them home without an admission.

- Both of the main acute trusts had met the 95% A&E waiting times target in 2014/15 and ANHSFT had also met the target in 2015/16; however, during 2016/17 there was a decline in performance but ANHSFT continued to perform better than the England average during 2016/17, with 91.2% of people seen within four hours, compared to the England average of 89.1%. BTHFT was performing slightly worse than the England average with 88.5% of people seen within four hours.

- National guidelines suggest that optimal bed occupancy levels in hospitals are no more than 85%. It is recognised that hospitals with average bed-occupancy levels above 85% risk facing regular bed shortages and that the quality of care maybe compromised. NHS trusts are required to submit a quarterly return to NHS England. Over 2016/17 and in the first quarter of 2017/18 these returns showed that bed occupancy levels at ANHSFT were generally in line with the optimal level and below the England average. However, data submitted about the bed occupancy levels for BTHFT showed they were extremely low with the average for Q1 2017/18 at 62%. We found that this data was incorrect and system leaders told us during the review that their daily reports showed the bed occupancy levels were above 90%. The Winter Review Report for 2016/17 showed that last winter bed occupancy levels at BTHFT were at 94.8% and at ANHSFT they were at 94.6%.

Are services in Bradford effective?
System leaders had supported the development of services at the hospital 'front door' aimed at reducing admissions. Although the data had yet to demonstrate whether these were effective, they streamlined the process for people ensuring that they could be soon by appropriately skilled staff. There were some innovative approaches such as specialist waiting areas for people living with dementia, or who had mental health needs, to reduce the levels of stress they might experience in an unfamiliar environment.

Health and social services staff were co-located on wards which meant that discharge planning could be put in place earlier and with a holistic approach to people's needs. Although training on dementia had been rolled out, this was yet to be fully embedded in practice by all staff. Further work was also required to roll out the 'red bag scheme' to reduce the likelihood of losing important information that people brought into the hospital with them.

- The CCGs had provided funding to the hospitals to put systems in place to ensure that people who arrived at A&E were seen by the right person. Streaming at the Bradford Royal Infirmary was effective in diverting 25% of people attending A&E away from the department into the GP led unit. There were processes for triaging people before admission to A&E which enabled staff to send people to the correct area in the department. The design of the department ensured that people could move through it in a smooth and logical way, making best use of space and resources and staff available. At Airedale General Hospital, a Frail Elderly team supported the medical assessment unit with the goal of ensuring as many people as practicable could return home on the same day. Both hospitals had quieter areas designed for people who lived with dementia or mental health needs and were awaiting treatment which meant that they were less likely to become distressed.

- There was a specialised ward for people with orthopaedic fractures which ensured that people with a fracture could go straight there avoiding A&E. This structure also recognised

that people had different needs at the different stages of their journey; for example, a surgeon would undertake the operation but older people would be cared for and supported by a geriatrician.

- There was other work underway to develop the skill mix of staff and ensure that the flow into and through acute services was more effective. Funding to alleviate winter pressures had been used to support an advanced paramedic role in the ambulance service however at the time of our review this was yet to be rolled out. Ambulance staff were able to make referrals to the MAIDT to avoid admissions. There was good work around empowering clinicians to be less risk averse including use of senior clinicians on the diagnostic unit. A liaison psychiatrist was available to attend A&E when required to undertake assessments and there was a social worker based in A&E which meant that when older people attended A&E their needs could be assessed holistically taking into account both health and social care needs. However, our data showed that these initiatives were yet to make an impact. Although the rate of attendances at A&E of people aged over 65 was very slightly below the England average, the rate of emergency admissions once people presented at A&E was higher than the England average with 27,899 admissions per 100,000 population aged 65 plus in Bradford between September 2016 and August 2017 compared to the England average of 25,009.

- Social workers were co-located within hospital wards which enabled a multidisciplinary approach to care and discharge planning. Meetings to support people with dementia were multi-organisational. There was joint working with neurology and there was a joint tender between health and social care underway at the time of our review for stroke care following discharge from hospital. Training had been rolled out across the hospitals so that staff could better understand the different needs of people who were living with dementia and who could often only express themselves through behaviour rather than verbally. The CCGs were supportive of this approach and the dementia lead had put templates and support in place for hospital staff. However, system leaders had further work to do to ensure that this was embedded in practice. We heard from people whose family members were living with dementia and had had a difficult experience. Two people told us about their family members being moved around hospital wards without discussion or notice which could be distressing for people who struggled to understand new environments.

- Although there were examples of collaborative working on the wards, the sharing of information required further development. ANHSFT used SystmOne which could be accessed by other partners such as GPs and social workers. However, we found that the 'red bag' scheme had not yet been rolled out. This scheme ensured that when people were admitted from care homes, their information travelled with them in a safe and secure way. Care home providers told us that information was often lost in transit to and from the hospital

and there had been instances of important documentation such as Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms going missing.

Are services in Bradford caring?

Although people received care that was assessed in a holistic way, there were missed opportunities to enable people and their families to voice their needs about their own care. There were some good practices to support the dignity and wellbeing of people using services such as the Butterfly Scheme for people living with dementia. However, families and care workers were not routinely involved in discussions about people's preferences and needs.

- Although there were systems in place to ensure a holistic approach to managing people's needs when they were in hospital, staff did not always ensure that the person was at the centre of their care and support planning. Some staff told us that legal literacy around MCA and human rights needed to improve and could be a block in the system. They felt that there was a challenge in getting colleagues across the system to see that their role is beyond the physical repair of the person. This was reflected in feedback we received from a wide variety of sources, from people who used services, from residential and domiciliary care providers and from VCSE staff. However, members of the local authority's MCA team felt that there was increasing awareness across the system. There was a retendering process underway to bring the advocacy service together and this would see improvements in support for people as it had previously been commissioned through a number of agencies.

- We heard that when people were in hospital, communication with families and care workers was sometimes poor. When a person was taken to hospital or another setting, domiciliary care workers told us that they were not routinely notified that a person had been admitted or asked for information about how to manage their needs. In most circumstances, if people had the support of family members this would not be a concern. However, if a person lived on their own, the lack of information sharing could have an impact. We heard one example of where a care worker had to initiate their emergency plan as the person they supported had not responded. This resulted in the police breaking the door while the person had been safe in hospital.

- ASCOF data for 2016/17 showed that compared to similar areas, a higher proportion of carers in Bradford felt involved or consulted in discussion about the person they care for than the England average. However, when we spoke with people, we found that families were not always involved in discussions about a person's care, when very often their information could be important. For example, we heard from a family member whose parent had been admitted to hospital as an emergency. They were told to wait in a corridor outside their parent's room while they went through the admissions process and staff were dismissive of the family member's attempts to share information. Not only was this distressing for the

family member, it put the person at risk as they were living with dementia and had some specific needs which they could not communicate. However, when the person's family member subsequently raised a complaint about the treatment they and their parent had experienced, they told us that complaints staff had been compassionate and caring in their response.

- ANHSFT subscribed to the 'Butterfly Scheme'. This involved training for staff in the support of people who lived with dementia and there were 'Butterfly' champions on every ward. There was a member of Carers' Resource who visited the hospital regularly to provide support to people and their families. These initiatives ensured that the hospital stay was less distressing to people who were living with dementia.

Are services in Bradford responsive?

People who were in crisis and had to wait for support from emergency services told us that they often had to wait for long periods of time. Although work was underway to increase the skills of paramedics, people were still more likely to be taken to hospital if an ambulance was called. However, there were systems in place to support people in crisis in a wide variety of ways, rather than relying on traditional hospital bed care. Virtual wards enabled people to receive medical consultant-led support in their own homes and there was a good join of up the different initiatives such as the reablement team with community health teams and the virtual ward which enabled services to be wrapped around the person. There was very good support for people who were at the end of the lives as, with training, families were empowered to support their loved one so that they could die in their preferred place.

- There were systems in place so that if a person was in crisis their care could be managed in the setting that was best suited to their needs. There was a multi-agency intermediate care hub that enabled people to be assessed so that they wouldn't be admitted through A&E by default. Through this people could access beds in a social care setting or nursing home, or an intermediate care bed in hospital. There was also a First Response Mental Health service that people could access in the community if they were in crisis, however residential care providers felt that the service was not always able to respond in a timely way and people sometimes reached crisis point before support was put in place.

- In focus groups, people using services and independent providers told us that they often had to wait a long time for an ambulance. Some people told us they had waited in excess of four hours. Our analysis showed that the proportion of 999 calls attended by Yorkshire Ambulance Service NHS Trust that did not result in transport to hospital between August 2017 and July 2017 was consistently below the England average. The ambulance service was encouraging the take-up of a programme for paramedics which would increase their skills and enable them to treat more people in their own homes. Residential care providers

told us that they undertook falls assessments prior to calling emergency services to reduce the burden on services and support their residents to stay out of hospital if possible. Domiciliary care providers told us that sometimes they would need to wait with their clients for an ambulance for up to four hours. This increased the risk to the person waiting for support and for other people the care agency supported as it created difficulties providing staff for other people waiting for care.

- We heard that in Airedale, technology in the form of video consultations could be used when people became unwell so that they could be supported to receive treatment in some care homes. People could also be admitted directly to an assessment ward if this had been arranged by a GP. However, we were told that this was not always effective, for example a care home provider told us that on one occasion they had tried to arrange for the admission of one of their residents and were told that the ward was full which meant that the following day the person attended A&E.

- System leaders told us about safeguards in the system to support the families of people when they reached crisis point for example putting care support in place for an individual when the carer became ill. The BEST team was able to provide support seven days a week and 24 hours a day to ensure that people who were dependent on carers could receive support if their carer was in hospital.

- The virtual ward was well-established following its implementation in 2015. There was joined up work across the system to enable people to receive consultant-led care in their own homes. The virtual wards were monitored in the same way as hospital wards and there was support around managing long-term conditions such as COPD. The virtual ward also worked with the rapid response social care reablement team who were able to assess people within a two-hour time frame. For example, we heard that during our review a person had been visited by a physiotherapist and an occupational therapist so that the person who had been in crisis did not have to be admitted to hospital.

- At peak times district nurses visited hospital wards to assess whether people receiving care in hospitals could be discharged to receive care in their own homes. This initiative followed learning from a previous year when services were at crisis point. System leaders learnt that hospital staff were not always aware of the level of support that could be offered by district nurses in the community. By having these conversations on the ward and enabling clinicians to be assured about the management of people's care, people were able to be discharged from hospital earlier.

- We saw that hospitals recognised the importance of promoting wellbeing on the ward so that people's physical health did not deteriorate owing to lack of activity. People were

encouraged to get dressed and to be active where possible. However, there were some missed opportunities to promote independence such as enabling people to administer their own medicines. This would support them to regain their independence and enable them to manage their medicines following discharge from hospital without requiring support to do so. This was not routinely encouraged as staff were under pressure and it was quicker for them to administer medicines themselves.

- There was very good wrap-around support for people who were at the end of their lives and their families. In addition to the Gold Line, which provided advice and support 24 hours per day, families could be trained in the administration of anticipatory medicines. This meant that families could support their loved ones to be comfortable at the end of their lives and if they were in pain or distress they would not have to wait for support from healthcare staff.

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence

Are services in Bradford safe?
There was good partnership working with the VCSE sector to enable people to return home from hospital safely. This ensured that people had safe and warm homes to return to and that their ongoing needs were assessed and supported. This would reduce the likelihood of people returning to hospital. People were able to return home sooner which meant that they were less vulnerable to hospital acquired infections or reduced mobility. However, further development of hospital discharge processes was needed, particularly around communication with care agencies and the management of medicines.

- There was good use of interagency working and the VCSE sector to ensure that when people were discharged from hospital, their discharge was managed safely. The Home From Hospital service was led by Carers' Resource and supported people to return safely to their own homes. This involved ensuring that people were returned to a safe and secure environment and supported assessments for ongoing care and treatment. The team undertook an initial checklist of immediate practical things to ensure the person had food and heat.

- The Home from Hospital team also sought advice from professionals such as dieticians to

make sure that the hampers they provided had nutrients required to support recovery and then in turn helped volunteers to have conversations with the person about nutrition and hydration. The initial work would be followed up by further assessment of need for services such as befriending, support with benefits as well as practical health issues such as sight, hearing and dentistry.

- The Home From Hospital service provided information to people to promote their ongoing safety. For example, at the time of our review they were supporting people with awareness about postal scams as they had identified this as a risk.

- However, there were some gaps in the system that impacted on the safety of a person's discharge from hospital. VCSE providers found that there were some risks to people who were being discharged as hospital services did not always check that support was in place for people to return home, for example if people told them they received homecare they did not ensure that care providers were aware that the person was leaving hospital. This reflected what we were told by domiciliary care providers who said that hospital staff did not always check with providers that the package of care remained in place. The payment of a 30-day retainer to domiciliary care providers meant that people could have consistent care providers following discharge from hospital however people did not always understand when the period had ended and there was a risk that hospitals could send people home without a care package in place.

- Independent domiciliary, residential and nursing care providers told us that they routinely experienced problems with medicines when people were discharged from hospital into their care. Sometimes information about medicines was not sent home with the person as well as other important information such as DNACPR information. Occasionally medicines would be sent on to a person in a taxi several hours after they had left hospital. Care and hospital staff we spoke with shared these concerns and felt that the system would benefit from a universal approach on discharge medicines management. Discharge planning that included pharmacy staff in a timely way would reduce some of the risk. One person we spoke with had waited for medicines for more than four hours in a discharge lounge with their parent who had been placed on a fast track end of life care pathway. During this four-hour period staff did not check the person to see if they required food, hydration or pain relief.

- Analysis of stays in hospital for older people living in Bradford showed performance was better than the England average. Our analysis showed that in Bradford, a significantly low percentage of older people admitted as emergencies stayed in hospital longer than 7 days. This meant that people living in Bradford had a lower risk of developing infections and reduced mobility associated with longer hospital stays. The rate of emergency readmissions of older people within 30 days of discharge from hospital in Bradford had fluctuated around

the England average in recent years but was generally lower than the average across comparator areas.

Are services in Bradford effective?
There was good integrated multi-agency working to support people on their return home from hospital. For planned admissions, there was advance discharge planning in place. Health and social care staff worked collaboratively to share information, however some systems were still paper based and relied on out of date technology. While arrangements within health and social care systems for discharging people from hospital were effective, domiciliary care and care home providers did not always receive the right information in a timely way to help them support people when they were admitted or returned to the service.

- There was a holistic approach to managing people's needs when they were discharged from hospital. The community connector service managed by a VCSE organisation ensured that there was social prescribing so that people could get a wider range of support on their return home. They liaised with health and social care agencies to manage practicalities such as dressing changes and benefits advice. People who went into hospital for elective surgery were identified at an early stage so that discharge planning could be put in place for their return home. This meant that people could have more choice and control over their care and support planning.

- Services were designed to support the flow through the system from hospital to home. The MAIDT worked collaboratively with health and social care staff to create fast and effective discharge plans. They undertook daily visits to wards to support the discharge process, and complex discharge team meetings with multidisciplinary working were held twice weekly and allowed for complex discharges to be effectively managed. At the time of our review the MAIDT was a relatively new service, but staff felt that it was already having positive impact. System leaders were working on developing this further, looking at how to move to more asset based approaches to assessment and practice building on people's strengths and abilities as they returned home.

- The multidisciplinary approach to discharge meant that people who returned home from hospital were supported by a workforce who had the right range of skills, including those in the VCSE sector. Staff we spoke with felt that they worked well with other multidisciplinary professionals and had built up relationships with them across the system which enabled them to discuss people's issues and resolve them as a team.

- Although health professionals and social care professionals had shared access to information through SystmOne (apart from BTHFT which only utilised this in A&E), information sharing on discharge from hospital was problematic, particularly when care home

providers and domiciliary care providers relied on the information. A trusted assessor model had not been implemented and there was a lack of trust from providers which needed to be overcome in order to manage this. Some providers felt that information provided when people left hospital was not always correct.

- Information we gathered from 18 registered managers of adult social care services regarding the flow of information on discharge from hospital suggested that receipt of discharge summaries in Bradford is mixed and when they are provided, they are usually in paper format with secure email or shared electronic systems rarely or never being used. Responses also indicated that the timeliness, accuracy and comprehensiveness of discharge summaries varied. One respondent noted that issues around confidentiality needed to be improved to enable better information sharing. This could be supported by consent arrangements with people using services.

- We found that although there was good collaborative working between staff this wasn't always supported with the best use of technology. For example, we found that the MAIDT relied on paper form filling which was then shared with colleagues via fax machine. This made the process onerous and time consuming and there was a risk that information could go missing. This was raised as an issue by staff but we also saw a particular example where a person who was due for a 'fast-track' discharge as they were at the end of their life, had their discharge from the ward delayed as the fax machine had broken.

Are services in Bradford caring?
We saw that when people returned from hospital to their home or a new place of residence, they were supported in a way that centred on their needs. People who received care at home could usually continue receiving care from providers who had previously provided their care and understood their needs. There was support from the VCSE sector to help people adapt to new conditions and build care and lifestyle choices that recognised their strengths and wishes.

- When people returned home, there were services in place that ensured that their care was coordinated around their needs. The complex care multi-agency partnership was a multidisciplinary health-led team that comprised medical and nursing staff as well as psychology, therapy, personal support navigators and carer support navigators. People who would benefit from this support were identified either at home or hospital. Five support navigators worked alongside the clinical team. They coordinated follow-up services and tried to prevent readmission, providing wrap-around care to these people that followed them on their journey. Life preferences and choices were discussed with people using services and their relatives to manage their expectations and carers were given support.

- Staff we spoke with felt that there was still work needed work to address people's

expectations and choices about new care settings, including enabling "honest" conversations with people and their families. This was flagged as issue across the West Yorkshire STP footprint. System leaders were working with NHS England to seek best practice that would enable them to better manage this as sometimes people could remain in hospital longer than they needed to, owing to disagreements about subsequent care settings.

- We saw that there was good support for people to make decisions about their future plans, particularly when the illness that had led to the hospital admission resulted in significant life changes or the person needing a new place of residence. We saw an example of a person who was living with dementia and their spouse wanted to support them to make a decision to return home. This was reviewed with a social worker and the best interests team. Staff noticed that, although the person could not express their feelings verbally, when they returned home on visits, they were more settled. At the time of the review steps were being put in place for the person to return home on a permanent basis.

- We saw examples of support from the VCSE sector that enabled people's choices to be placed at the heart of care planning. For example, the Age UK support for people who were diagnosed with dementia provided a person-centred approach to people whose lives were undergoing change. One person they supported had been discharged from hospital following a chest infection. They had been diagnosed with multiple sclerosis and were registered blind. The support worker discussed the impact of their condition on their lifestyle and together they planned ways to maximise the person's independence through the installation of equipment in their home. There was also district nurse put in place for support with catheter care. This meant the person was less reliant on their spouse with increased independence, dignity and quality of life.

- System leaders had used iBCF funding to pay a retainer to homecare agencies when a client required hospital treatment, for a period of up to 30 days. This was welcomed by care agencies and people who used their services as it meant that people could have continuity of care from care workers that they trusted. It alleviated the stress that some older people might experience with building new relationships, and allowed them to continue being cared for by people who had been providing personal care, sometimes for long periods before they went into hospital.

Are services in Bradford responsive?
There were a number of systems and options in Bradford to support people to return to their usual place of residence when they were fit to be discharged from hospital. We saw that reablement was effective as people were less likely to return to hospital within 91 days than people who lived in similar areas. People's future care needs could be assessed and considered once they were out of hospital and joint working between the health and social care

and VCSE sector meant that a single assessment could be undertaken. However, if people were unable to return to their own homes and needed nursing or residential care, their choices were limited by a lack of quality provision. This meant that people might be starting a new phase of their lives in services that needed to improve.

- There were systems in place to enable services to respond to people's needs following a period of crisis so that services could be delivered in the setting that was best for the person. The Care @ Carers' Resource service could be contacted by staff in A&E to support people to return home if their discharge from hospital took place between 9am and 8pm. The service could provide up to ten hours of care while other services were put in place and was linked to the Home from Hospital team which was also managed by Carers' Resource. There was also support from the Virtual Ward. This wraparound support was put in place around a single assessment which meant that people did not have to repeatedly tell their story to multiple agencies.

- The case studies that we looked at showed that arrangements for discharging people from hospital were timely and effective with involvement from families and the person's needs being considered in a holistic way. Discharges from hospital were supported in a variety of ways that fitted around the person. For example, the frail elderly team supported the discharge of around 66 people per month and had extended to a seven-day service. We saw that 22% of discharges following emergency admissions of older people occurred at weekends which meant that people who were found fit for discharge from hospital at a weekend did not have to wait until the following Monday before they could go home. Bradford discharged a higher percentage people from hospital at weekends than any of its comparator areas.

- The BEST provided reablement for a period of up to six weeks for people who were discharged from hospital. Analysis of ASCOF data showed that the proportion of people aged over 65 who were discharged from hospital and received reablement was, at 2.6% in 2016/17, slightly lower than the England average of 2.7% and lower than the average across comparator areas of 3.6%. However, this figure had been increasing in Bradford over the previous five years. Where older people did receive reablement services in Bradford they were effective, as a higher percentage (87.8%) were still at home 91 days after their discharge from hospital, compared to comparator areas (78.4%) and the England average (82.5%).

- The BEST also supported the discharge to assess process which was recognised as good practice in the high impact change model. It enabled people to make decisions about their future care outside of the hospital environment. We saw from data supplied by system leaders that, on an average day, 250 people were supported by the BEST.

- The system had made budget provision to ensure continuity of care for people returning home within 30 days of admission which meant they had the benefit of continuity of care from their usual domiciliary care provider as a retainer was paid to safeguard existing arrangements. In addition to the improved outcomes for people in respect of continuity of care support and relationships, it also meant that people were less likely to wait in hospital while a care package was recommissioned.

- The focus on packages of care in the community, intermediate care and the use of the VCSE sector meant that fewer people were delayed in their discharge from hospital. Our analysis showed that the number of people who stayed in hospital longer than they needed to was significantly lower than comparator areas and the England average. In Bradford, the average number of delayed days per 100,000 population aged 18+ between July and September 2017 was four, compared to 11 in similar areas and the England average of 13. The rate of delayed transfers in Bradford had been significantly lower than the England average in each month of our analysis from June 2015 to September 2017.

- We heard from people we spoke with that although people didn't stay longer in hospital than they needed to, sometimes delays happened because people being cared for could not agree on a residential service. The quality of care home services in the Bradford district was poorer than in similar areas and the England average. This limited people's ability to choose good care, particularly as people who wanted to receive care from a provider that was rated as good would be required to pay a top up even if they were entitled to social care funding. Of the seven residential services that were owned by the local authority, only two were rated as good. There was a risk of poor outcomes for people who had to choose new homes and live their lives in a setting that had CQC had identified as requiring improvement.

- We heard from social care providers that patient transport was not always effective and that people could experience delays and missed appointments. On the day of our visit to an extra care service someone had been waiting from 6am for transport to a 7.30am outpatient appointment. By 8am the transport had not arrived and this missed appointment could cause delays and risks to the person's health.

- Although system leaders told us that they needed to improve the timeliness of continuing healthcare assessments, we saw that across the three CCGs, assessments were completed in a more timely way than the England average.

Maturity of the system

What is the maturity of the system to secure improvement for the people of Bradford?

- There was a clearly articulated vision for the transformation and development of services for people living in Bradford. This vision could be articulated by system leaders, elected members and frontline staff. There was a well-developed joint strategy which was aligned with commissioning intentions. Delivery had begun on a number of strategic strands around helping people to avoid hospital admissions and to facilitate early discharge and progress could be measured by agreed metrics and results.

- The high level of trust between leaders in the system meant that their ability to have honest conversations was one of their drivers for success. These relationships had developed and improved over time, and leaders who joined the system had shared values which enabled continued success.

- There was a transparent and uncomplicated joint governance structure in place which enabled shared processes and decision making. The Health and Wellbeing Board was mature and had overarching oversight of the delivery of the transformation plan with operational, strategic and performance management boards sitting below it. This enabled elected members and people living in Bradford to hold leaders to account. The structure of the boards and the sub-groups sitting below it meant that there was shared decision making and accountability across health and social care and the VCSE sector was valued as an equal partner.

- There was a culture of trust between system leaders and improved relationships among frontline staff. There was a strong focus on collaborative working to meet the needs of the population and leaders needed to extend this work to build relationships with providers in the independent sector.

- Leaders worked collaboratively to shape the care market so that it would be sustainable and meet the needs of the local population. Although there had been some innovative and courageous funding decisions to build stability in the homecare market, there was still more work to be done to develop the quality of services and encourage the shaping of the independent care market to be able to support those with more complex needs.

- Resources were used collaboratively and targeted at high-risk cohorts to prevent crises and protect the wellbeing of people living in Bradford. We saw that planning of expenditure

around the BCF and the social care precept was designed to facilitate the smooth and prompt flow of people through health and social care services. It enabled integrated working and supported the development of a community led model. We saw that leaders were willing to make investments in structures and systems that support people who were at higher risk of needing services and were assured that this would produce long-term gains.

- Although there was a system-wide approach to workforce development, there were pressures across the system. Through the integrated workforce plan, system leaders had begun to look at shaping the workforce to support an integrated system. However, this work was at an early stage. System leaders were exploring ways of developing the local workforce to build career pathways for health and social care staff and reduce the workforce shortages in the system.

- Shared records and information governance was well developed in Bradford as information could be accessed across most primary and secondary healthcare and social care services. There were some barriers which were being addressed and there was a digital roadmap in place to describe this. There were innovative digital solutions in use to reduce the need for GP and hospital attendances. Further development was required around the design of some processes which relied on outdated methods for communication.

- The focus on prevention underpinned the strategic vision for Bradford through the Happy, Healthy at Home agenda. There was evidence that pathways across primary, community and secondary care supported the wider objectives of health maintenance and this would be further developed with the implementation of locality models. GPs, health and social care staff and VCSE providers worked together to support people to stay healthy and independent for as long as possible.

Areas for improvement

We suggest the following areas of focus for the system to secure improvement

- System leaders need to address issues around quality in the independent social care market with a more proactive approach to contract management and oversight.

- Building on good relationships that exist between stakeholders such as VCSE organisations and GP alliances, this needs to be extended to the independent care sector.

- Leaders need to ensure that outcomes are person-centred and caring in line with the vision and strategy.

- NICE guidance[2] recommends that, apart from some exceptions, domiciliary care visits should not be shorter than half an hour. The commissioning of 15-minute domiciliary care visits needs to be reconsidered as concerns had been raised about the provision of care being task focused rather than person-centred and leading to an increased risk of medicines errors.

- There needs to be clearer signposting systems to help people find the support they need, particularly for people who funded their own care.

- Although good work was in place with the local authority MCA and best interest assessment team, system leaders need to ensure that staff in health services and independent social care provider services have a better understanding of people's rights and are able to understand the lifestyle choices that people make. System leaders need to address the fact that some people's experience is not consistently good and person-centred.

- There is potential to build primary care capacity and to maximise the impact of the primary care home model; the commissioning approach to primary care needs to maximise the outcomes from the two at scale GP models emerging in Bradford

- Although information sharing and governance was well-developed, system leaders need to consider how to streamline processes when people are discharged from hospital with less reliance on paper based systems.

- Medicines management when people have left hospital needs to be improved to reduce the time people have to wait for their medicines and to ensure that social care providers and people returning to their own homes have a clear understanding of the medicines they have been prescribed.

---

[2] https://www.nice.org.uk/guidance/ng21/chapter/Recommendations#delivering-home-care