City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Strategic Director of Adult Social Care & Health to the meeting of Executive to be held on Tuesday 9 April 2024

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Subject: Review of Intermediate Care Services

Summary statement:

Intermediate care services are provided to people after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between hospitals and where people normally live, and between different areas of the health and social care system – community services, hospitals, GPs, and adult social care.

The review of intermediate care is a workstream of the Bradford District & Craven Partnership's Healthy Communities Programme. A rapid review was completed in December 2022 and throughout 2023, system partners have worked together to design a blueprint to implement the review's recommendations.

This paper sets out the design for the future of sustainable intermediate care services in Bradford District and Craven, focuses on timely services in a 'home first' model of care and proposes some changes to Bradford Council's contribution to the overall model, including reducing the number of care home beds through the closure of two short-stay care facilities and increasing capacity in the council's BEST enablement care service.

EQUALITY & DIVERSITY:

A full equality impact assessment is being completed by all system partners on the wider intermediate care review and implications for patients in line with the national Home First policy which has been consulted upon by the Department for Health and Social Care. Individual equality impact assessments and local consultations have been conducted by services.

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Portfolio:
Healthy People and Places

Overview & Scrutiny Area:
Health & Social Care Overview & Scrutiny Committee

1. SUMMARY

This report sets out ambitious plans for our health and care partnership to transform intermediate care (IMC) services in Bradford District and Craven. We have drawn on our District Plan and strategies as a Health and Care Partnership; approaching this challenge as one system, committed to the sustainability of all partners.

The sustainability of our intermediate care offer and how we could maintain the performance around low delays in hospital but enhance performance around the outcomes for people when they returned home are at the forefront of the blueprint we have designed. The recommendations include disinvesting in short stay care home beds and investing in community-based enablement care services.

2. BACKGROUND

What is intermediate care?
Intermediate care is defined as 'a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, and premature admission to long term residential care, support timely discharge from hospital, and maximize independent living'. For this report, the term 'intermediate care services' refers to all those services that offer special care and support, whose aim is to support people's recovery, rehabilitation and reablement. Intermediate care can be provided to people in different places, and by a variety of professionals. Services are time-limited, normally no longer than six weeks, offered free of charge and often last as little as one or two weeks, personalised to the individual's needs and recovery.

Models of Intermediate Care
Intermediate care is a function rather than a discrete service, so it can incorporate a wide range of different services, depending on the local context of needs and other facilities available. Four broad service models of intermediate care have evolved:

- **Bed-based services** are provided in an acute hospital ward, a community hospital, residential care home, nursing home, standalone intermediate care facility or local authority facility.
- **Community-based services** provide assessment and health and care interventions to people in their own home or in a care home where they live.
- **Crisis response services** are based in the community and are provided to people in their normal residence with the aim of avoiding hospital admissions.
- **Reablement services** are based in the community and provide assessment and interventions to people in their normal residence. These services aim to help people recover skills and confidence to live at home and maximise their independence (step up and step down from hospital).

Most of our intermediate care services are supporting people with 'frailty'. Frailty is typically assessed in older populations. Identifying frailty in adults aged under 60 years may also have value, if it supports the delivery of timely care. The principles underpinning the design and delivery of intermediate care are:

- A more integrated approach to planning, funding, and delivery of all four models above, including shared assessments that are accepted across all services, is likely to achieve better use of resources and outcomes.

- Capacity should be planned across the whole patient flow. There should be a balance between 'step-up' services (designed to prevent hospital admissions) and 'step-down' services (to enable timely hospital discharge). Step-up capacity is essential to support admission avoidance but can come under pressure as places are filled.

What do people want?
People have the right to expect that their journey from hospital back to the place they call home will support them to be as independent as possible. If they need it, a dedicated intermediate care service will be available for them as close to them as possible, with the right environment to maximise their independence. Our focus is therefore on getting people home, or enabling them to stay at home, with the right level of care and support.

Our services will support people who would otherwise face an unnecessarily prolonged or inappropriate hospital stay. No-one should underestimate the importance of being at home. For most people being able to stay at home when we are ill, or frail is what we would truly wish. That independence, in turn, is likely to keep us as well as we can be and reduce costs to the system.

Care, when delivered at home, not only leads to better outcomes for the individual, but is also a better use of resources. Our current resources will therefore be reshaped towards more home-based, strengths-based care and support, and with less reliance and expenditure on bed-based provision.

What is national policy?
New *Hospital Discharge and Community Support Guidance* was issued in April 2022. There is evidence to show that patients recover better at home once their treatment in hospital is complete. Patients who stay in hospital longer than is necessary may face issues including:

- 35% of 70-year-old patients experience functional decline during hospital admission in comparison with their pre- illness baseline; for people over 90 this increases to 65%
- 48% of people over the age of 85 die within one year of hospital admission

People should not be routinely discharged to a community step-down bed simply to free an acute hospital bed, nor should they routinely be discharged to a community bed simply because home-based care is not available.

Home First / Discharge to Assess. Section 91 of the Health and Care Act 2022 came into force on 1 July 2022. It revokes procedural requirements in Schedule 3 to the Care Act 2014 that require local authorities to carry out long-term health and care needs assessments, in relevant circumstances, before a patient is discharged from hospital.

Section 91 is defined as 'Where people who are clinically optimised and do not require an acute hospital bed but may still require care, services are provided with short-term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person'.

Support services should be time limited – up to 6 weeks. In the best systems, the average appears to be 2 weeks. Assessment for long-term care needs is then undertaken when the actual level of care required can be more accurately assessed. Discharging people to the most appropriate place to meet their needs requires active risk management across organisations to always reach a reasonable balance between safety, and independence.

What services do we currently have in Bradford District?
A summary of the services available across our District can be found at Appendix A.

These include:

- 161 short-stay beds in community hospitals or local authority care homes
- 155 'virtual ward' beds to provide clinical intervention in their own home
- 2-hour urgent community response to avoid hospital admission
- BEST enablement service for up to 160 people at any one time
- Multi-Agency Support Team (MAST) in Emergency Departments
- Multi-Agency Integrated Discharge Teams (MAIDT) in our hospitals

For intermediate care to work effectively, the NHS and Bradford Council need to jointly commission a combined set of services, into which people can be placed to support their recovery back at home. This requires a common understanding of the services commissioned; the likely demand on those services, and the outcomes that those services are achieving in relation to helping older people return home.

Performance
Bradford adult social care performs well in having a low number of older people permanently admitted into care homes from hospital. But Bradford does not perform as well in terms of the number of people who receive intermediate care who are still at home 91 days after their hospital stay. This is likely to be because we have not been targeting intermediate care most effectively and have been using intermediate care beds to discharge people quickly as a staging post to permanent care home beds. This will change with our new care pathway design.

How do we compare?
In comparison to West Yorkshire, Bradford District and Craven (BDC) has a high level of Intermediate Care services across all four models listed above, as well as a wide-ranging supporting infrastructure. Bradford Council's in-house reablement offer (BEST) is comprehensive and operating effectively at reducing delays to transfers of care and keeping people out of hospital. Our neighbours visit us to see the 'Bradford model' with a view to replicating many of our arrangements.

Our neighbouring Partnerships have a mixed model of NHS, Local Authority or jointly funded bed provision. All areas are looking to reduce their reliance on bedded facilities in favour of integrated community services. Leeds has just completed the diagnostic phase of an intermediate care redesign programme, with the aim to keep more people at home and reduce reliance on bed-based care.

Wakefield has developed a capacity and demand model, using information to unlock transformation. Wakefield (population 350,000) aims to have 48-68 beds at the end of transition to a new model, double the current number. The Partnership also needs

to double community reablement capacity, with a view to releasing the equivalent of 65 beds (through people having a reduced length of stay / no admission to hospital).

The National Audit for Intermediate Care (2018) states that the mean number of beds per 100,000 population was 23 in BDC in December 2023. Excluding the population of Craven this means:

- Population registered with a Bradford district GP: 600,000
- Number of community beds for our population against this mean =138
- Current beds (NHS = 69 and Social Care = 179 exc. 5 long stays) = 248

As a system, we had 110 beds more than might be expected prior to the closure of Woodward Court and the mothballing of Norman Lodge and Thompson Court local authority short-stay care homes. Closing / mothballing these beds has reduced our bed-base by 105 beds.

Bradford District and Craven Health and Care Partnership performs well in terms of not having people still in hospital when they are fit to be discharged. The community teams are able to 'pull' people out of hospital to home. The admission prevention work, which will also reduce pressure on beds, is less easy to quantify.

3. OTHER CONSIDERATIONS

The key principle of a local Intermediate Care offer is for partners to jointly plan and deliver discharge and recovery services from acute hospitals and community rehabilitation settings that are affordable within existing budgets available to NHS commissioners and local authorities. People should be discharged to the right place, at the right time and with the right support that maximises their independence and leads to the best possible sustainable outcomes.

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As the concept and delivery of Intermediate Care has evolved over time, there is no commonality of approach or single operating model nationally. The design of Intermediate Care at a local level is often the result of local estate and staffing arrangements, funding settlements and ad-hoc innovation. In most cases it has not been grounded in a local needs analysis.

Factors underpinning effective cooperation across the NHS, social care, and the voluntary sector include:

- strong relationships and trust between colleagues across different sectors;
- a shared understanding of the problems of delayed discharge and the benefits that successful discharge can yield; and
- collaborative working to design, test and iterate new approaches.
- Bradford district and Craven emerges as an innovative exemplar site, demonstrating continuous improvement in relation to how we work together as a health and care partnership.

Opportunities and way forward

Strategic direction: our intermediate care function should be managed in an integrated way. Integration can and should exist at several levels – strategic, operational and performance management. Partners should consider how capacity across the system is being used to support people in their own homes and consider how resources can be best used to support this, strongly promoting and implementing a 'home first' model as the default goal.

The Partnership has established a significant domiciliary care reablement offer. A range of telehealth, telemedicine and telecare including equipment to support people at home. There are opportunities to build on this successful model of technology enabled care. The Partnership was highly bed reliant as a model. The discharge process exposes the interdependence of hospital performance on community care, social care, and the voluntary sector – underscoring the need to invest in those services, and their critical importance for NHS recovery.

The Partnership has trialled reducing the current bed base to a level more in line with the national average through the mothballing of facilities with no great detriment to system performance.

Commissioning of services

The Partnership should consider formalising the integrated commissioning of services to work as joined up operating models, with a view to reducing admissions to hospitals and reducing costs to the system overall. This includes mechanisms that support clear planning, delivery, and monitoring of the effectiveness of local discharge and recovery, rehabilitation and reablement arrangements.

Better Care Fund

A single pot of money is key to removing unhelpful organisational and individual behaviours in the system because it shifts the focus from a question over who is paying to asking, 'how do we best support the person?' This ultimately leads to delivering better outcomes that cost less overall. The alternative is that we will see an expansion of investment in hospital beds to accommodate ever-increasing demand in the system - but the trade-off will be that fewer people are successfully supported at home or in their communities.

The proposed shift of culture to a reablement focused system, discharging patients in a timely manner to regain their independence in the community, is our recommended way forward. We will shorten the length of time before people's first review at home to optimise their care pathway. The impact of this would be to reduce the length of stay in hospital, prevent associated deterioration, prevent the use of discharge to assess beds and support the older population to remain well and in their own homes rather than accessing long term care.

Delivery

The role of social care is to seek the best outcomes for the person. Not to reduce delays at the expense of poorer outcomes for people. During the pandemic, the focus was on moving as many people as possible out of hospital as quickly as possible. The emphasis may have shifted to an expectation to continue to expedite

discharge to clear a bed rather than the person needing a spell in bedded or community enabled care. Discharge to Assess should be implemented in ways that are true to the original aims of the Discharge to Assess approach and not used as a shorthand for any attempt to speed up hospital discharge.

Our Blueprint
In the context of financial challenges facing both health and care partners, and evolving models of best practice, we know we need to reduce, stop, and/or change our offer. In Bradford District and Craven, we are fortunate to have all the component parts to develop and deliver a comprehensive intermediate care offer.

As a Partnership we will re-model the following Intermediate Care Services into a comprehensive, affordable, offer:

- Accommodation-based Council and NHS bedded services (now 82 short-stay council beds over two sites and 71 NHS community beds over 4 sites);
- Community-based services, including the Virtual Wards (155 beds by March 2024), Crisis Response Services, and BEST Reablement Services; and
- A more comprehensive statutory and VCSE infrastructure that supports people being discharged from our hospitals with a range of support needs, and admission avoidance, keeping people well at home.

Our approach is 'Home First', providing people with support at home or intermediate care. Wherever possible, people will be supported to return to their home for assessment to avoid the over-prescription of care. Going home is the default pathway (with alternative pathways for people who cannot go straight home).

4. FINANCIAL & RESOURCE APPRAISAL

One catalyst for the review of intermediate care was the identified over-provision of short-stay care homes beds funded by the local authority, which is unusual and has become financially unsustainable for Bradford Council. Provision of such a high number of beds was also counter to the national strategy of 'Home First'.

The short-stay care facility at Woodward Court in Allerton was mothballed in February 2023 after problems with the fabric of the building. The Council's Executive agreed to close this facility in April 2023. System partners agreed to the mothballing of Thompson Court care facility in Crossflatts from January 2024 due to under-occupancy, to see if the system could cope with a smaller number of beds. This does not appear to have affected performance around the requirement for short-stay beds.

Due to positive changes made to other care pathways since then to enable 'Home First', occupancy at Norman Lodge care facility in Odsal has dropped to around 50% of available beds so partners agreed to the mothballing of that facility to assess system resilience. It closed to new admissions from 19 February and system performance is manageable with few people waiting for onward care packages.

The two-remaining short-stay care facilities operated by the council will be Valley View Court, Oakworth and Beckfield, Bolton Woods Road totalling 85 beds. This is close to the national average and will be funded from within the Better Care Fund.

The decision to close Woodward Court and the recommendation to permanently close Thompson Court and Norman Lodge will save approximately £4.1m in 2024-25 from the adult social care budget and will be used to mitigate existing departmental budget pressures. In 2026/27, an estimated £1.1m budget will be required to fund the new Saltaire Care Facility capital scheme, exclusive of the current revenue budget for Beckfield, which will close once Saltaire is operational. The table below shows the breakdown of the revenue saving from the closed homes.

Closed In-House Residential Homes

	2024/25	2025/26	2026/27	2027/28
Expenditure	**£000s**	**£000s**	**£000s**	**£000s**
Employees	4,960	4,960	4,960	4,960
Premises	56	56	56	56
Transport	3	3	3	3
Supplies & Services	57	57	57	57
Total Revenue Expenditure	**5,076**	**5,076**	**5,076**	**5,076**
Income				
Total Revenue Income	-217	-217	-217	-217
Net Financial Impact	4,859	4,859	4,859	4,859
Additional costs associated with Supernumerary Staff	759	759	0	0
Further Budget Required for Saltaire Scheme (Estimate)	0	0	1,100	1,100
Revised Financial Impact (Saving)	**4,100**	**4,100**	**3,759**	**3,759**

The above financial saving does not take into account additional savings within Corporate Services related to premises, utility and catering associated with the closure of the three residential homes. The table below shows the revenue expenditure budget for the remaining two homes (Valley View and Beckfield), which will be fully funded from the existing resources (Better Care Fund). The calculations assume Saltaire residential home will open 2026/27.

Remaining In-House Residential Homes

	2024/25	2025/26	2026/27	2027/28
Expenditure	**£000s**	**£000s**	**£000s**	**£000s**
Employees	4,644	4,644	5,764	5,764
Premises	46	46	57	57
Transport	3	3	3	3
Supplies & Services	47	47	54	54
Total Revenue Expenditure	**4,741**	**4,741**	**5,878**	**5,878**
Income				
Total Revenue Income	-694	-694	-738	-738
Net Financial Impact	**4,047**	**4,047**	**5,140**	**5,140**

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

Given the gradual reduction in short-stay beds across the system and corresponding changes to discharge pathways out of our two hospitals in order to assess performance and resilience, there are no significant risks arising out of the implementation of the proposed recommendations.

6. LEGAL APPRAISAL

The Council has various duties under the Care Act 2014 which the Directorate believes that these proposals comply with. Under S3 1)A local authority must exercise its functions under this Part with a view to ensuring the integration of care and support provision with health provision. It is believed that these proposals will assist in this duty.

Under S5 Promoting diversity and quality in provision of services
(1)A local authority must promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person in its area wishing to access services in the market (a)has a variety of providers to choose from who (taken together) provide a variety of services; (b)has a variety of high-quality services to choose from. It is not believed that the "mothballing" of resources referred to will breach this duty as there is a choice of alternative provisions within the Borough.

Finally, it has a duty under S18 to meet needs for care and support. It is understood that those individuals referred to in paragraph 4 of the report will have their needs for care and support met by alternative provisions.

7. OTHER IMPLICATIONS

7.1 SUSTAINABILITY IMPLICATIONS

- Other than a smaller and more efficient buildings estate there are no other sustainability implications from these recommendations.

7.2 TACKLING THE CLIMATE EMERGENCY IMPLICATIONS

- These recommendations should result in a less buildings-based offer and with improvements to the efficiency of the council's buildings estate.

7.3 COMMUNITY SAFETY IMPLICATIONS

- There are no community safety implications from these recommendations.

7.4 HUMAN RIGHTS ACT

- Any decisions taken around people's hospital discharges and onward services are taken alongside people with their allocated social care practitioners with full adherence to humans right legislation and mental capacity law.

7.5 TRADE UNIONS

Staff from Woodward Court and Thompson Court were offered reasonable comparable alternative job roles within Bradford Council with no compulsory redundancies. We are now endeavouring to offer staff at Norman Lodge the same, though roles may not be completely comparable, and this may not be possible for all staff. We have therefore issued Unions with a Section 188 notice in case we are not able to find suitable alternatives and/or redundancies are necessary. We have worked closely with trade unions and staff groups to communicate and find collective solutions.

7.6 WARD IMPLICATIONS

- Local members have been made aware of these changes.

7.7 AREA COMMITTEE LOCALITY PLAN IMPLICATIONS

- There are no implications for locality plans.

7.8 IMPLICATIONS FOR CHILDREN AND YOUNG PEOPLE

There are no implications for children and young people.

7.9 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

There are no data protection and information security matters arising from these recommendations.

8. NOT FOR PUBLICATION DOCUMENTS

- Not applicable.

9. RECOMMENDATIONS

- Members are asked to comment and agree the blueprint for intermediate care in Bradford District and Craven.
- Members are asked to agree the permanent closure of Thompson Court Care Facility in Crossflatts and Norman Lodge Care Facility in Odsal.

10. APPENDICES

- Appendix A – Local Intermediate Care Delivery Model

11. BACKGROUND DOCUMENTS

Hospital Discharge and Community Support Guidance 2022

APPENDIX A

Local intermediate care delivery model

This section considers a long list of local services across the four types of intermediate care to give an overview of the delivery model in use (in line with the broad models on page 2).

1. Bed-based services (161 short stay beds)

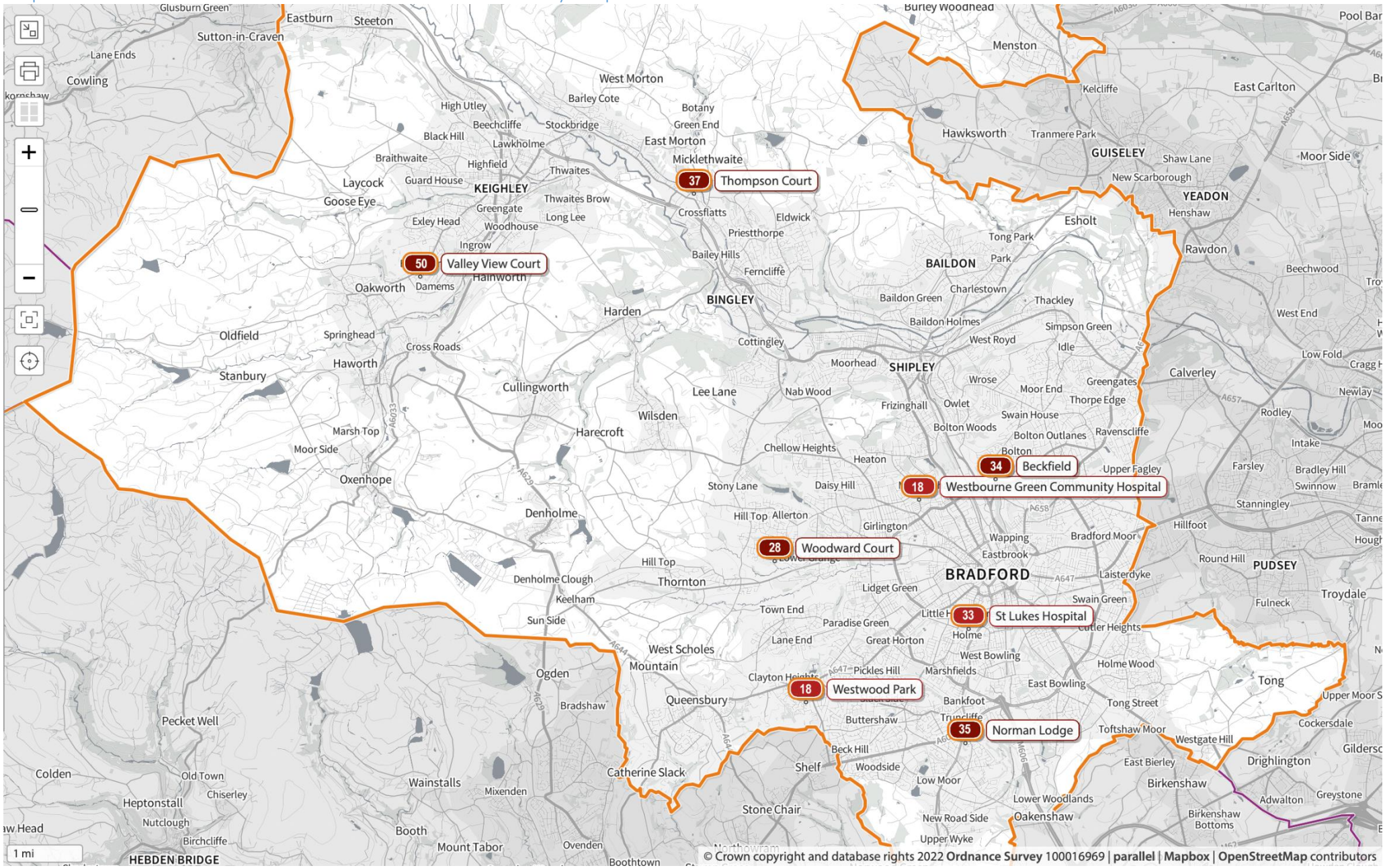
Definition: service is provided within an acute hospital, community hospital, residential care home, nursing home, standalone intermediate care facility, independent sector facility, Local Authority facility or other bed-based setting.

Table: Bradford district and Craven Intermediate care beds

Provider	Unit Name	Location	Maximum no. beds	
			Short stay	Long stay
ANHSFT TOTAL Castleberg		BD24 0BN Settle	**10**	**0**
BTHFT	St Luke's Hospital	BD5 0NA Little Horton	33	0
	Westbourne Green	BD8 8RA Heaton	18	0
	Westwood Park	BD6 3NL Queensbury	18	0
BTHFT TOTAL			**69**	**0**
CBMDC	Beckfield	BD2 4BN Bolton	34	0
	Norman Lodge*	BD6 1EX Odsal	35	0
	Thompson Court*	BD16 2EP Bingley	36	0
	Valley View Court	BD22 7NU Oakworth	48	2
CBMDC TOTAL			**82**	**2**
BDC HCP TOTAL			**161**	**2**

*Beds at Thompson Court and Norman Lodge were mothballed from January 2024 and April 2024 respectively as new community-based processes were implemented to get people 'Home First'.

Map: CBMDC bedded units and Bradford district NHS Community Hospitals



2. Community-based services

Definition: community-based services provided to service users in their own home / care home with a focus on rehabilitation. Predominantly staffed by health professionals.

Bradford Elderly 'Virtual Ward'

There are 155 virtual 'beds', known as a Virtual Ward, across Bradford district (75 Frailty, 50 Multi-Specialty, 30 Tech Enabled). This includes step-up and step-down pathways, which predominantly deliver care, support, and interventions to people with frailty. A Virtual Ward is a safe and efficient alternative to NHS bedded care that is enabled by technology. Virtual Wards support people who would otherwise be in hospital to receive the acute care, monitoring, and treatment they need in their own home. This includes either preventing avoidable admissions into hospital or supporting early discharge out of hospital.

The service delivers face to face care in a patient's own home. This enables patients to be discharged home quickly once reviewed on the elderly assessment ward, meaning that medical, nursing and therapy programmes can start at home within 2 hours of discharge. This multidisciplinary team (MDT) approach also supports admission avoidance. Patients are assessed in community by primary care staff, via 111, via ambulance crews or in the emergency department. Once referred a patient is reviewed at home within 2 hours. A plan of care may include a medical plan, the prescribing of medication, point of contact blood testing, reablement and a therapy plan.

Airedale and Craven Community Collaborative Teams ANHSFT

The Community Collaborative Teams (CCTs) aim to prevent avoidable admission to hospital and facilitate an early discharge. The service provides intermediate care in patient's homes and within inpatient assessment beds located at Castleberg Hospital. Staff working within the CCT include Advanced Clinical Practitioners, Urgent Community Response Practitioners, Nurses, Physiotherapists, Occupational Therapists, Mental Health Nurses, Assistant Practitioners, Social Workers, Voluntary and Community Services and Community Support Workers. The team work closely with Primary Care, Yorkshire Ambulance Service and Community Matrons, along with other community services.

3. Crisis Response services

Definition: assessment and short-term interventions to avoid hospital admission

2-hour Urgent Community Response

Urgent Community Response (UCR) is the collective name for services that improve the quality and capacity of care for people through delivery of urgent, crisis response care within two-hours and/or reablement care responses within two-days. A two-hour response is typically required when a person is at risk of admission (or re-admission) to hospital due to a 'crisis' and it is likely they will

attend hospital within the following 0-to-24-hour period, without intervention to prevent further deterioration and where the response can keep the person safe at home/usual place of residence. The two-hour crisis response standard is designed to reduce avoidable hospital admissions.

The Elderly Virtual Ward and the CCTs deliver our 2-hour UCR service in partnership with Bradford Council and North Yorkshire County Council. In Bradford, BDCFT unplanned care team also pick up catheter care, diabetes care and end of life support as services that are not provided by the Elderly Virtual Ward. Bradford Council provides the Bradford Enablement Support Team (BEST), which works in collaboration with the Elderly Virtual Ward services to deliver the social care elements.

BEST Rapid Response

The service provides short term support to people who cannot easily care for themselves, because they are ill or disabled, with an aim to help people to maintain their independence and stay in their own home. The BEST 2-hour social care service includes a falls response service as being part of the integrated community response service. Additional equipment and training for lifting people who have fallen is used by BEST teams and care homes to reduce the need for conveyance to hospital by ambulance.

MAST – Multi-Agency Support Team

The MAST team is a team of VCS organisations based across both hospitals delivering interventions and health messaging in Emergency Departments (ED) and across some wards to support the health system and provide support around the some of the identified 'pressure points' in the system. The team works across the ED and wards as appropriate identifying patients at all stages of their admissions from triage to the ward who would benefit from a mental health, older person's services, or alcohol interventions.

MAST links into existing community resources in localities, including social prescribing. MAST includes Home from Hospital, supported discharge, alcohol support workers, Mental Health peer support workers and Age UK support workers.

4. Reablement services

Definition: Community-based services provided to service users in their own home / care home with a focus on reablement. Predominantly staffed by care professionals.

The Bradford Enablement Support Team (BEST)

Bradford Enablement and Support Team (also known as Bradford Home Support) is registered to provide personal care and support to people at home. The service provides short term support to people when they are discharged from hospital or in response to a social care crisis. Because of the type of service, the numbers of people supported can vary from day to day and at any given time the service supports around 150 - 200 people, allocated to community teams by resource planners.

On the day of visiting the service the caseload was 198 people. New packages are reviewed by an Enablement Coordinator at 72 hours. All staff delivering 'daily cares' have smart phones and a roll out of high-specification tablet devices is underway.

Home Support Reviewing Team

The HSRT was established within BEST following a pilot in 2018, to regularly review packages of care and, where possible, reduce the level of care required. The teamwork with independent providers of home support to enable them to continue supporting people when their needs change either after a stay in hospital or in their place of residence. The HSRT hold a caseload of c350 cases at any one time and continue an overview of enablement packages brokered to the independent sector. The HSRT can complete Fast Track checklists and have an agreed pathway to screen and refer for CHC assessment with the Decision Support Tool (DST) completed by a Social Worker.

6. Supporting Infrastructure

This section outlines the wider services supporting admission avoidance and discharge.

Multi Agency Integrated Discharge Team (MAIDT) ANHSFT and BTHFT

The MAIDT (Hospital Discharge Team) in both hospitals are multi-agency teams operating a discharge to assess model 7 days a week. The MAIDT brings together dedicated health and social care professionals and members of the voluntary and community sector (VCS) who work to ensure patients with complex needs can be discharged from our hospitals on the correct pathway in a safe and timely way. Transfers take place every day. At ANHSFT, complex referrals are escalated via the Multi-Agency Referral Hub (MARH).

Intermediate Care Hub BTHFT

The Intermediate Care Hub receives referrals from primary care, Yorkshire Ambulance Service, the Emergency Department and Same Day Emergency Care for people who require an immediate MDT approach to their care. The step-up model operates 7 days a week for people aged over 65 where there is a sudden change in a person's needs/functioning, or they are unwell and the level of health and social care or support cannot be met by community health services. The discharge to assess model reviews people within 2 hours offering a comprehensive geriatric assessment and point of care diagnostics. A Rapid Response social care package and 'Just checking' installation can be used to enable improved safety.

Bradford Council Bed Bureau

The Bed Bureau aims to enable more effective and efficient discharge of patients particularly to support discharge planning around complex cases. It is used to manage everyday flow and performance management, facilitating 50-90 discharge packages per week and 40-90 reviews. BEST and Trusted Assessors are moving to a stand-alone system 'APC' that will allow staff to log 'live'

data, see the full-service user record, access training, and inform planning and monitoring of service delivery and outcomes.

Residential and Nursing Home beds

Local Authority	Homes	Maximum beds	Occupied	Admittable
Bradford	113	3,922	3,125	639
Craven	18	583	476	73
Total	133	4,505	3,601	712

Note: beds may not be admittable for a variety of reasons. Source Capacity Tracker 18/11/22

On average, homes are at 80% capacity and have been for the last few years. This is slightly less for Older People, with mental health / physical disability / learning disability slightly higher. The national Capacity Tracker provides a breakdown by home but is only as good as information provided by homes in terms of an accurate day to day picture.

Digital Care Hub including Immediate, MyCare24 and Goldline

The Immediate Hub is available to all care homes (including Bradford Council bedded units), providing access to advice and support to homes as well as for individual patients, often with a variety of long-term conditions. The team has full access to service users' care records, allowing them to give comprehensive clinical assessments, guidance on condition management, and ongoing monitoring. In addition, an Immediate Portal allows GP practices and other community clinicians direct access to care homes through the telemedicine laptop, enabling proactive ward rounds and triage/assessment using high-definition video.

MyCare24 COPD

MyCare24 provides proactive monitoring and support service for people with moderate/severe/very severe Chronic Obstructive Pulmonary Disease supporting 6,000 patients with COPD. People on the caseload have access to a 24-hour support team that can be contacted remotely should a person find it difficult to manage their health condition at home.

Goldline

Goldline is a nurse-led, 24/7 telephone and video consultation service. Goldline provides a dedicated single point of contact for patients who are on the nationally recognised Gold Standards Framework (GSF). The GSF offers gold standard care for people with a serious illness who may be in their last year of life. The service has been specifically designed to help GSF patients live as well as possible before they die. Current case load of around 2,231 patients a year and handling over 1,200 calls per month.

Safe and Sound

Safe and Sound supports technology enabled care. The team can put a person in contact with friends or family in an emergency or send the Rapid Response team to help and assist. The response team will assess a situation, take the appropriate action, and advise what needs to be done should something happen at home, such as a fall. Safe and Sound is a combination of what was previously known as Careline and Telecare. It is 24 hours a day, 7 days a week, 365 days a year service.

Enhanced Health in Care Homes (EHCH) Direct Enhanced Service (DES)

The EHCH model moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents. A care home premium set at national level is paid to Primary Care Networks for each care home bed in its catchment (Appendix C). All CBMDC beds have additional GP practice support.

Home Care

Home care is the range of services put in place to support an individual to live independently in their own home and is available to those that require additional support with day-to-day household tasks, personal care or any other activity that allows them to maintain their quality of life and independent living. Locally, the majority is provided by the private sector or, for a short-term period, by BEST. Home Care commissioned by Bradford Council includes:

- 82 home support providers in the district;
- 50 of which CBMDC regularly contract packages of care with; and
- 2,674 service users currently receiving 48,595 hours.

Approximately 5,000 staff are delivering home support services.

Trusted Assessors

A Trusted Assessor carries out 'Home First' short term support assessments of hospital patients to consider what the patient's needs are to allow them to go home, to a care home or to a council bedded facility. The Trusted Assessor Model is based on having a dedicated person, trusted by care homes and all agencies, who is wholly focused on carrying out hospital-based assessments. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way. They make clear and transparent recommendations and proposals as to the future destination of care in the best interests of the person following the completion of an assessment. Trusted Assessors are based in both local hospitals reaching into wards.

Home from Hospital

The Home from Hospital team is part of Carers' Resource, supporting people when they return home from hospital or are at risk of hospital admission. The service makes sure people have everything they need to stay well and independent, regain confidence and re-adjust to living at home, and avoid a return to hospital. The service offers flexible weekly visits to give emotional support and help with a variety of tasks such as finding solutions for shopping, providing nutritional information, help with benefits, form filling, reducing social isolation and promoting self-care. The service supports up to 90 people per month post discharge.

Bradford and Airedale Community Equipment Service (BACES)

BACES is a formal partnership arrangement between Bradford Council and the ICB. The service provides a wide and varied range of nursing and 'aids to daily living' equipment e.g., profiling beds, hoists, specialist mattresses, commodes etc. to help support people leaving hospital following discharge, or to prevent a hospital admission.

BRICSS (Bradford Respite and Intermediate Care Support Service)

BRICSS was established to address the complex medical and social care needs of homeless people being discharged from hospital and prevent the 'revolving door' of admissions. The service helps people who are leaving hospital, and have nowhere safe to live, access short term reablement or supported housing. Clinical care is provided by Bevan GP practice.

ASIST – Alcohol Specialist Intervention Support Team (Bradford Royal Infirmary)

The ASIST role is performed by a team of specialist alcohol support workers, who liaise closely with the MAST, Psychiatric Liaison Nurses (PLN), and staff on the wards at BRI.

The focus of the ASIST role is to deliver timely, motivational interventions at the bedside to patients admitted to hospital for alcohol related reasons. The ASIST service has an initial focus on harm reduction, to help the people to reduce their alcohol consumption or achieve abstinence to minimise hospital admissions. The service aims to reduce admissions with a goal of no readmissions within the 6 months following engagement with the service.

Hospices

There are two hospices in the area, Marie Curie Hospice (Barkerend) and Sue Ryder Manorlands Hospice (Oxenhope). They offer services including inpatient care; day services; community services and rehabilitation. Hospices provide care for people from the point at which their illness is diagnosed as terminal to the end of their life, however long that may be.

Carers Resource

Carers' Resource supports unpaid carers. A carer is anyone who looks after a family member,

friend, or neighbour who, due to disability, physical or mental health condition, illness, frailty, or addiction, cannot cope without their support. The service provides information, advice, and support to carers, to the people they care for and to professionals who work with them.

A significant reason for readmission to hospital within 91 days is 'carer strain'. A pilot is underway whereby the Carer's Assessment is delegated to Carers Resource and then recorded. Taking a strengths-based approach, the person then becomes a 'supported carer', with links to Carer Navigators.

Wellbeing Hubs

Wellbeing hubs have been established provided managed by the VCS Alliance in six areas across Bradford district and Craven. A referral pathway via MAST is established which includes Emergency Departments and those on Pathway 0. The Wellbeing Hubs link with existing family hubs and safer places (mental health alternative crisis services) in communities.