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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Agenda for a meeting of the Health and Social Care Overview and Scrutiny Committee to be held on Thursday, 6 October 2022 at 4.30 pm in Council Chamber - City Hall, Bradford

Members of the Committee – Councillors

LABOUR	CONSERVATIVE	LIBERAL DEMOCRATS	Green
R Jamil Humphreys Godwin Wood A Ahmed	A E Coates J A Glentworth	A Griffiths	C R Hickson

Alternates:

LABOUR	CONSERVATIVE	LIBERAL DEMOCRATS	Green
S Akhtar Shabir Hussain U H Khan J Lintern Mohammed	P W Clarke P G Sullivan	A Naylor	C Whitaker

VOTING CO-OPTED MEMBERS:
Susan Crowe - Bradford District Assembly Health and Well Being Forum
Trevor Ramsay - i2i Patient Involvement Network, Bradford District NHS Foundation Care Trust
Helen Rushworth - Healthwatch Bradford and District

Notes:

- This agenda can be made available in Braille, large print or tape format on request by contacting the Agenda contact shown below.
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- If any further information is required about any item on this agenda, please contact the officer named at the foot of that agenda item.

From:
Asif Ibrahim
Director of Legal and Governance
Agenda Contact: Asad Shah
Phone: 01274 432280
E-Mail: asad.shah@bradford.gov.uk

To:

A. PROCEDURAL ITEMS

1. ALTERNATE MEMBERS (Standing Order 34)

The City Solicitor will report the names of alternate Members who are attending the meeting in place of appointed Members.

2. DISCLOSURES OF INTEREST

(Members Code of Conduct – Part 4A of the Constitution)

To receive disclosures of interests from members and co-opted members on matters to be considered at the meeting. The disclosure must include the nature of the interest.

An interest must also be disclosed in the meeting when it becomes apparent to the member during the meeting.

Notes:

(1) Members must consider their interests, and act according to the following:

Type of Interest	***You must:***
Disclosable Pecuniary Interests	*Disclose the interest; not participate discussion or vote; and leave the me <u>unless</u> you have a dispensation.*
Other Registrable Interests (Directly Related) ***OR*** *Non-Registrable Interests (Directly Related)*	*Disclose the interest; speak on the it <u>only if</u> the public are also allowed to but otherwise not participate in the discussion or vote; and leave the me <u>unless</u> you have a dispensation.*
Other Registrable Interests (Affects) ***OR*** *Non-Registrable Interests (Affects)*	*Disclose the interest; remain in the meeting, participate and vote <u>unless</u> matter affects the financial interest o being (a) to a greater extent than it affec financial interests of a majority of inhabitants of the affected ward, a (b) a reasonable member of the pu knowing all the facts would believe would affect your view of the wide interest;*

in which case speak on the item only public are also allowed to speak but otherwise not do not participate in th discussion or vote; and leave the me unless you have a dispensation.

(2) Disclosable pecuniary interests relate to the Member concerned or their spouse/partner.

(3) Members in arrears of Council Tax by more than two months must not vote in decisions on, or which might affect, budget calculations, and must disclose at the meeting that this restriction applies to them. A failure to comply with these requirements is a criminal offence under section 106 of the Local Government Finance Act 1992.

(4) Officers must disclose interests in accordance with Council Standing Order 44.

3. INSPECTION OF REPORTS AND BACKGROUND PAPERS

(Access to Information Procedure Rules – Part 3B of the Constitution)

Reports and background papers for agenda items may be inspected by contacting the person shown after each agenda item. Certain reports and background papers may be restricted.

Any request to remove the restriction on a report or background paper should be made to the relevant Strategic Director or Assistant Director whose name is shown on the front page of the report.

If that request is refused, there is a right of appeal to this meeting.

Please contact the officer shown below in advance of the meeting if you wish to appeal.

(Asad Shah - 01274 432280)

4. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

Any referrals that have been made to this Committee up to and including the date of publication of this agenda will be reported at the meeting.

B. OVERVIEW AND SCRUTINY ACTIVITIES

5. UPDATE ON PRIMARY CARE - GENERAL PRACTICE 1 - 38

The Associate Director Primary Care will submit a report (**Document "H"**) which provides members with an update on Primary Care – General Practice since the last report provided to this committee in September 2021.

Recommended –

Members of the Health and Social Care Overview Scrutiny Committee are asked to note the contents of Document "H" detailing the current developments in primary care both nationally and locally.

(Parveen Akhtar Associate Director – Primary Care)

6. ASSESSMENT AND DIAGNOSIS OF AUTISM IN ADULTS IN BRADFORD DISTRICT AND CRAVEN: UPDATE ON PROGRESS AND CHALLENGES 39 - 66

The Bradford and Airedale Neurodevelopment Service (BANDS) was commissioned to provide triage, assessment and diagnosis for both ASD and ADHD for adults (over 18) in Bradford, Airedale, Wharfedale and Craven.

The Bradford District and Craven Health and Care Partnership will submit a report (**Document "I"**) which provides an update to the report delivered to this Committee in March 2022. The March 22 report described the Adult Autism pathway, shared experiences of patients through case studies, and summarised the plan for improvements to the assessment and diagnosis of autism spectrum disorder (ASD) in adults in Bradford, District and Craven.

Recommended –

Members are asked to note the revised plan for a sustainable BANDS adult autism service which responds to issues of recruitment difficulties, referral issues and rapidly increasing demand.

(Walter O'Neill)

7. HOME SUPPORT REVIEW: UPDATE AND COMMISSIONING INTENTIONS 67 - 116

The Strategic Director of Health and Wellbeing Adult Services will submit a report (**Document "J"**) which provides an update on the Home Support Review, and an overview of the department's intentions to commissioning intentions.

Recommended –

We would welcome the view of members and their constituents either at the meeting or the following workshop in late October.

(Alex Lorrison – Joint Commissioning Manager)

8. HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE DRAFT WORK PROGRAMME 2022/23 117 - 122

The report of the Interim City Solicitor (**Document "K"**) presents the Committee's work programme 2022/23.

Recommended –

(1) That the Committee notes the information in Appendix A and considers any amendments or additions it may wish to make.

(2) That the Work Programme 2022/23 continues to be regularly reviewed during the year.

(Caroline Coombs – 01274 432313)

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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Bradford District and Craven Health and Care Partnership to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 6 October 2022 H

Subject: Update on Primary Care - General Practice

Summary statement:

This report and appendices provide HOSC members with an update on Primary Care – General Practice since the last report provided to this committee in September 2021.

The report contains an update on the following key areas:

- Summary
- Background
- Core local systems and nation planning priorities
- National Primary Care Review (The Fuller Report)
- Covid 19 update
- Primary Care Enhanced Access
- General Practice Primary Care Core Access
- Primary Care General Practice Workforce
- Workforce Development and Care Navigation
- Primary Care Workforce Health and Wellbeing
- Community Partnerships
- Addressing Health Inequalities

We would also like to acknowledge the tremendous efforts our General Practice and system partners are making to continue to deliver primary care services, including moving back to business as usual, whilst delivering the Covid-19 autumn booster programme, within the current workforce challenges and increase in patient needs for access to primary care.

Portfolio:

Healthy People and Places

Report Contact: Parveen Akhtar
Associate Director – Primary Care
Phone: 07795346286
E-mail: parveen.akhtar@bradford.nhs.uk

1. Summary

This report and appendices provide HOSC members with an update on Primary Care – General Practice since the last update provided to this committee in September 2021.

The report contains an update on the following key areas:

- Summary
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- Primary Care Workforce Health and Wellbeing
- Community Partnerships
- Addressing Health Inequalities

2. Background

2.1. Since the last primary care update to HOSC, under the new Health and Care Act 2022, CCGs were abolished, and Integrated Care Systems (ICS) became live from the 1st of July 2022. Under these new arrangements Bradford District and Craven Health and Care Partnership has been established and is delegated by our West Yorkshire ICS to lead at Place level. Both systems have an explicit purpose to improve health outcomes for their whole populations. The new legislative framework is designed to enable decisions to be taken as close as possible to their local populations for maximum benefits and outcomes delivered by working through multi-partnership arrangements.

Previously primary care – general practice was delegated by NHSE to the CCGs, under the new arrangements these primary care – general practice delegations have been assigned to the West Yorkshire ICS (WYICS) who in turn have delegated this responsibility to Bradford and Craven Health and Care Partnership.

The Health and Care Act 2022 has also directed that Pharmacy, Optometry and Dentistry (POD) should also be delegated to the ICS from 1st April 2023. Work is on going via design workshops on how and what functions of the PODs will be delegated from NHSE to WYICS and then down to Place.
(This report does not detail in full the WYICS arrangements as these have been presented to the committee in previous reports.)

3. Core local systems and national planning priorities

3.1. National

The NHSE Planning Guidance published for 2022-23 identified the following 10 key priorities:

1. Workforce investment, including “strengthening the compassionate and inclusive culture needed to deliver outstanding care”.
2. Responding to covid-19.
3. Delivering “significantly more elective care to tackle the elective backlog”.
4. Improving “the responsiveness of urgent and emergency care and community care capacity.”
5. Increasing timely access to primary care, “maximising the impact of the investment in primary medical care and primary care networks”.
6. Maintaining “continued growth in mental health investment to transform and expand community health services and improve access”.
7. Using data and analytics to “redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities”.
8. Achieving “a core level of digitisation in every service across systems”.
9. Returning to and better “pre-pandemic levels of productivity”.
10. Establishing integrated care boards and collaborative system working, and “working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places”.

These priorities have been embedded into the CCGs and now the ICSs delivery plans. All these priorities link back into primary care, but key focus will be on numbers 5 and 10.

3.2. Local

Bradford District and Craven, Health and Care Partnership have set with partners 5 key strategic priorities for 2022 – 2024.

Based around the following:

- Purpose - Inverting the Power to Act
- Population – Recovery from Covid
- Place – Prevention of ill health

- Partnership – Workforce and Organisational Development
- Spotlight – Children and Young People

These strategic priorities will support us and our system partners to focus on local areas to improve health outcomes. By working in partnership, we can share a common purpose and get greater value through the best use of resources and reduce duplication. Therefore, the health and care partnership have ambitions to an agreed 1% shift of funding to invest towards early intervention and prevention.

Review all our programmes including Act as One programmes, such as, Aging well, diabetes, better births, children and young people's wellbeing, healthy hearts, Access to health and care. We will be reviewing these programmes to ensure that they are still aligned with our key strategic priorities and that they do not overlap or duplicate other work programmes.

4. National Primary Care Review (The Fuller Report)

Amanda Pritchard – Chief Executive of the NHS commissioned Professor Claire Fuller to lead on the review of primary care and how it could be supported within the Integrated Care Systems (ICS).

Following the review, a report was published titled "Next steps for integrating primary care: Fuller Stocktake report in May 2022.

An overview of the report findings is detailed below:

Dr Fuller has set out a vision for the future of primary care, with practical actions that ICS and national leaders can take to work with primary care to make the changes needed to deliver this vision. The vision focuses on four main areas:

- neighbourhood teams aligned to local communities.
- streamlined and flexible access for people who require same-day urgent access.
- proactive, personalised care with support from a multi-disciplinary team in neighbourhoods for people with more complex needs, and more ambitious and joined-up approach to prevention at all levels.

Informed by wide-reaching engagement, the vision builds on what is already working in primary care, while recognising work is needed to create stability within general practice to deliver change. It outlines the need for a system-wide approach to workforce, data, and estates to make more effective use of capacity and capability.

<u>The vision for the future of primary care:</u>

Integrated neighbourhood teams

Systems should support primary care to build on the primary care network (PCN) structure by coming together with other health and care providers within a local community to develop integrated neighbourhood teams at the 30,000-50,000 population level. This will help to realign services and workforce to communities and drive a shift to a more holistic approach to care.

This means putting in place the appropriate infrastructure and support needed to build these multi-disciplinary teams, so they can proactively tailor care to meet the needs of particular communities and individuals in their local population, with a particular focus on the most deprived 20 per cent of their population (Core20PLUS5).

Streamlined access

To improve access, primary care should be supported to offer streamlined access to urgent, same-day care and advice from an expanded multi-disciplinary team and given the flexibility to adapt their service to local need. Data and digital technology should be optimised by systems to connect existing fragmented and siloed urgent same-day services, empowering primary care to build an access model for their community that gives patients with different needs access to the service that is right for them. This will also create resilience around GP practices by connecting patients to the practitioner who meets their need, rather than increasing GP referrals to additional services, increasing practices' capacity to deliver continuity of care.
Personalised care for those who need it, people should be able to access more proactive, personalised support from a named clinician working as part of a multi-professional team. To achieve this, development of neighbourhood teams providing joined-up holistic care to people who would most benefit from continuity of care in general practice (such as those with long-term conditions) should be supported and delivered in partnership with system partners and primary care.
This model of care should offer greater shared decision-making with patients and carers and maximise the role of non-medical care staff, such as social prescribers, so people get the care they need as close to home as possible.

Helping people to stay well for longer

There should be a more ambitious and joined-up approach to prevention for the whole of health and care with a focus on the communities that need it most. System partners should work collectively across neighbourhood and place to share expertise to understand what factors lead to poor health and wellbeing and agree how to work together proactively to tackle these.

This means building on what primary care is already doing well to improve local community health: working with communities, effective use of data, and relationships with local authorities while harnessing the wider primary care team including community pharmacy, dentistry, optometry, and audiology, as well as non-clinical roles.

Creating the environment for change

The report also includes steps that can be taken to create the right environment for change:

Locally driven change

- Local decision-making should be maximised to enable the delivery of improved support at a local level. NHS England and NHS Improvement (NHSEI) should consider what investment could be devolved to ICSs as part of the implementation of the wider recommendations.

- NHSEI should also consider combining and simplifying central programme and transformation budgets for primary care.
- Creating the capacity

Workforce

- Workforce capacity remains a huge pressure on primary care. There must be a continued focus on recruiting and retaining GPs and the wider primary care workforce, alongside optimising current capacity with a long-term, system-wide workforce strategy that includes primary care.
- The report welcomed progress made in recruitment through the Additional Roles Reimbursement Scheme (ARRS). However, it recognised there needs to be improvements in supervision, development, and career progression. Systems and national leaders also need to support PCNs to deliver the ARRS offer post-2024.
- More work is also required to make primary care more attractive to staff by addressing work-life balance, parity with other NHS career paths, and making a portfolio career more accessible. Training and education to encourage career development should be rolled out across primary care, from clinical to managerial and reception roles.

Estates

- Estates that are not fit for purpose can impact how well providers can collaborate. Therefore, there needs to be greater weighting of capital investment to primary care estates, informed by a detailed review of physical space within systems to build a one public estate approach.
- NHSEI and the Department of Health and Social Care should consider what flexibilities and permissions should be afforded to systems to build estates capability.

Data and digital

- Shared data and digital capabilities can play a big part in joining up services and help the whole health and care system to deliver care informed by local knowledge.
- A shared patient record, interoperability and system-level data analysis capabilities are essential to planning and delivering service in a coherent way.
- ICSs should develop coherent plans to data sharing and cross-system IT infrastructure, supported by NHSEI.
- Building sustainability

Infrastructure

- To ensure the right environment for improvement, there needs to be stability in general practice across all parts of the country. This can be achieved by:
    - utilising at-scale providers, such as GP federations, to enable general practice to work with other providers
    - providing support where there are gaps in provision or services which are deemed inadequate by the Care Quality Commission.

- back-office support such as HR, finance and organisation development to be delivered by at-scale providers such as GP federations or NHS trusts.

- At a national level, there should be consideration of the contractual and funding levers needed to create the right environment for integration and improving local health outcomes.
- At a system level, there needs to be accountability for delivery of integrated primary care reflected in the ICS accountability framework. This should include tailored support to practices to improve and, where appropriate, actively commission new providers of integrated list-based primary care that includes a focus on quality improvement.

Leadership and representation

- The report outlines the importance of primary care leadership and representation across the whole system. It states that investing in
-
- leadership at PCN, place and system level will be the difference between success and failure in integrating primary care.

The report finishes with a framework for shared actions focusing on 15 areas that holds both NHS England and ICSs to account for delivery. These are detailed in **Appendix K** - (The Fuller Review of Primary Care and framework for actions)

5. Covid 19 - Update

5.1. Phase 3 Covid -19 update- Bradford District and Craven Strategic Approach:

5.2. As reported in previous reports primary care – general practice and our 12 PCNs have played an integral part in supporting the Covid-19 vaccination and booster programmes. Though Covid-19 infections are down nationally to combat the risk of another widespread epidemic it is important that we continue to deliver the autumn Covid-19 booster programme, *3rd covid -19 vaccinations along with the winter flu vaccinations.
**3rd covid vaccination is for those aged 5 and over who had a severely weakened immune system when they had their first 2 doses, will be offered a 3rd dose before any booster doses.*

The JCVI has identified the following priority groups for the Covid-19 booster:

- Residents in a care home for older adults and staff working in care homes for older adults.

- Frontline health and social care workers

- All adults over 50 years of age

- Persons aged 5 to 49 years in a clinical risk group

- Persons aged 5 to 49 years who are household contacts of people with immunosuppression

- Persons aged 16 to 49 years who are carers

All our PCNs have either opted in or are working in collaboration with another PCN to deliver this year's booster programme.

Appendix A – Outlines our PCNs arrangements and location of the sites for the delivery of the booster programme.

Appendix B – Shows that as a system we have administered a total of 284,353 covid-19 boosters or 3rd vaccinations indicating 73.2% of our eligible population, with approximately 97% representing all patient cohorts that have received a vaccination.

5.3. **Long Covid:**

Long Covid continues to have an impact on our population. As per NICE/SIGN/RCGP guidance, 'Long COVID' is a commonly used term to describe:

- ongoing symptomatic Covid-19: signs and symptoms of Covid-19 from 4 to 12 weeks
- post-Covid-19 syndrome: signs and symptoms that develop during or after Covid-19 and continue for more than 12 weeks and are not explained by an alternative diagnosis

NHSE in July 2021 up to March 2022, introduced to primary care – general practice an Enhanced Service with financial support to manage patients presenting with Long Covid symptoms, including developing pathways and learning from these complex conditions. NHSE have renewed the Long Covid Enhanced Service from the 1st April 2022 for 12 months and all our practices have signed up to deliver this service.

Currently, our data systems have identified 88 patients with a diagnosis of Long Covid, however we are aware from local conversations that the patient numbers are likely to be higher than reported and data will improve as practices get used to the new clinical coding.

5.4. **Practice Closures during Covid-19**

We previously reported that 4 of our practices (branch sites) were still unable to open due to either workforce capacity or operating under safe covid conditions. We are pleased to report that all our practices and branch sites are now open and accessible to patients.

5.5. **Support to care home residents**

We know that older residents are more vulnerable and at risk of covid-19 and breakouts in care homes can have a devastating affect not only on individuals, their families but also place urgent care and hospital admissions under strain. This year

NHSE have asked PCNs to prioritise care home residents for the booster programme and complete by the 29th of November 2022 to reduce the risk of a Covid-19 breakout in our care homes, keep residents safe as well as supporting the winter impact and pressures on urgent care.

6. Primary Care – Enhanced Access

6.1. In March 2022 NHS England and Improvement (NHSEI) published requirements for the contractual arrangements providing access to primary medical care services outside of core hours (8:00am to 6:30pm) to transition to Primary Care Networks (PCNs) from 1 October 2022.

This requires a transition from previous commissioning arrangements for equivalent services. In Bradford District and Craven, the existing contractual arrangements for appointments outside of core hours consist of:

a) CCG Commissioned Extended Access Service (defined as 7 days a week before 8.00am and between 6.30pm to 8.00pm)

b) PCN Funded Extended Hours Access Service (defined as working week before 8.00am and between 6.30pm to 8.00pm)

Locally these two services have been merged and delivered as a single access scheme providing a 7-day GP appointments service. This includes appointments offered before 8am or from 6:30pm to 8pm on weekdays and is inclusive of service provision on weekends and Bank Holidays.

The new national requirements formally merge these arrangements into the single Enhanced Access service to be delivered by PCN's in Network Standard Hours i.e., 6.30pm to 8pm Mondays to Fridays and 9am to 5pm on Saturdays, from the 1st October 2022.

6.2. **New PCN Enhanced Access Requirements**

Enhanced Access has been introduced to the PCN DES from October 2022. Requirements for the PCNs from 1st October 2022 can be summarised as:

a) 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays (network standard hours).
b) A minimum of 60 minutes of appointments per 1,000 PCN adjusted populations per week.
c) GP cover during the network standard hours.
d) Appointments must be bookable in advance and same day.
e) Must deliver a mixture of in person face to face and remote.
f) PCNs must deliver general practice services, including appointments for planned care like screening, vaccinations (including COVID-19 vaccinations and boosters) and immunisations, health checks and PCN services.

g) Appointments must be delivered by a multi-disciplinary team of healthcare professionals.
h) Must make available to NHS 111 any unused on the day slots during the Network Standard Hours.
i) PCNs must actively communicate availability of Enhanced Access appointments to patients.
j) Sites at which face-to-face services are to be provided must be at locations convenient to access for patients.

These criteria are important to note again now as some of the new requirements will see a change to access, particularly on Sundays and Bank Holidays that no longer form part of the PCN Network Standard Hours. Nationally feedback has been DNA rates are high during these periods leading to the change in national policy.

Appendix C – Details new Enhanced Access arrangements from the 1st October 2022.

7. General Practice - Primary Car Access during core hours

7.1. General practices are contractually required to deliver core primary care services and makes these accessible to their patients from the hours 8.00am to 6.30pm Monday to Friday.

7.2. This includes same day urgent and pre-bookable appointments. Since the pandemic primary care -general practice has seen a significant increase in demand. However, following a return to pre-pandemic appointment levels for 2021 / 2022, the number of GP appointments delivered shows a moderate increase into 2022 / 2023.

As of June 2022 (359,297) appointments were delivered in Bradford District and Craven an increase of (14,767) on the previous year and an increase of almost 60,000 appointments in comparison to pre-pandemic levels

The mode of delivery for appointments also shows an increase in Face-to-Face appointments. 231,057 appointments have been delivered Face-to-Face an increase of 10,338 appointments, approximately 60% of total appointments are currently delivered Face-to-Face.

Practices are currently transitioning from NHSE's directive of 'Total Triage' as established in the Covid response, i.e., remote appointments as a precursor to Face-to-Face appointments, to models of service delivery that accommodate increased patient preference for direct in person appointments, whilst still maintaining covid safe environments.

Workforce pressures to meet service demand remains a pressure point for Primary Care. Though appointment levels have increased by approximately 60,000 appointments in comparison to pre-pandemic the Full Time Equivalent GP staffing rates have remained at 0.6 per 1,000 patients for the same period.

E-consults continue to be used more so by the younger cohort of patients and have achieved a steady state since first introduced during the beginning of the Covid pandemic. ICS is looking to procure a new e-consult software model later in the year.

The following **Appendices D to I** and **Appendix J** gives a further breakdown of the various types of access data:

- **Appendix D** GP appointment

Appendix D – shows total appointments delivered within primary care as of June 2022, which is the last published national data set. Though we have seen an overall increase of additional (14,767) appointments compared to last year (7,904) of these appointments delivered from December 2021 to March 2022 were because of additional *****winter access funding being made available centrally, which enabled GP practices to take on additional staff and locum GPs.

*******There is no indication at the time of writing this report that any further winter access funding will be made available to primary care for 2022.*

- **Appendix E** Mode of GP Appointments

Appendix E – shows mode of GP appointment types, over 60% of all appointments were delivered face to face, followed by telephone consultations. As per patient demand and change in national direction of offering all patients a face to face if they so wish we are seeing a steady increase.

- **Appendix F** Time Taken from Booking to Receiving an Appointment

Appendix F - details time taken from patients requesting and booking an GP appointment. A significant number of our patients can book a same day appointment, whilst those waiting over the 2 weeks wait time is below a 1000.

- **Appendix G** GP Online Consultation / e-Consult Data

Appendix G – Shows e-consult usage and rates per 1000 population, there has been some decline compared to last summer, this in part is due to more patients requesting and seen by either face to face or telephone appointment.

- **Appendix H** Consults by age

Appendix H – shows patients using e-consult by age. Those aged between 25 to 64 appear to by the highest users of this method of contacting general practice and receiving information via e-consult. We will be exploring this further, but it could be due to younger age group being more comfortable using technology and working age patients who may find it more convenient to fit around their working hours.

- **Appendix J** – Patient 111 Calls (April 21 to June 22 Data)

Appendix J – Shows call made to the 111 service, 53.2% of these calls are non - urgent and patients referred into primary care.

As part of the new access arrangements, we are working 111 call handlers to be able to directly book patients into general practice appointments slots as well as our enhanced access providers systems.

8. Primary Care general practice workforce

8.1. Primary Care general practice workforce continues to be a challenge. Despite national and regional recruitment campaigns there are not enough GPs coming into the system and those that are do not see our Place as an attractive proposition. **Table 1** below shows the GP to Patient Ratio on the previous CCG footprints.

Compared to the same time last year Bradford District and Craven is down by 2 GPs. However, these figures are taken from a national data set which we are aware has recording issues, as well as including locums into these overall figures.

Table 1

GP to Patient Ratio

Bradford District and Craven Health and Care Partnership ACTasONE

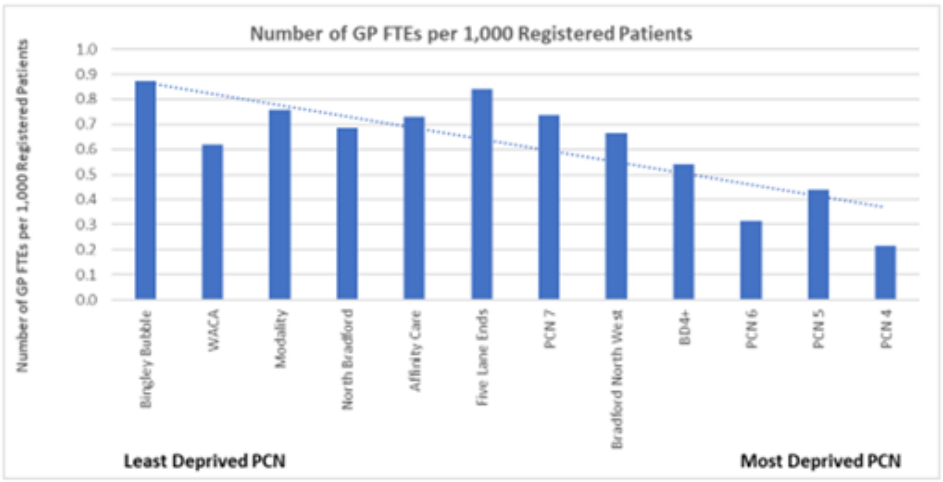
	Total GPs FTEs			Total Registered Patients			Number of GP FTEs per 1,000 Registered Patients		
CCG	Dec-21	May-22	Jul-22	Dec-21	May-22	Jul-22	Dec-21	May-22	Jul-22
Bradford District & Craven CCG	406.6	405.5	404.5	647970	650982	651895	0.6	0.6	0.6
Leeds CCG	557.8	541.7	539.6	908875	909779	908742	0.6	0.6	0.6
Wakefield CCG	244.7	233.7	228.8	383381	389187	389787	0.6	0.6	0.6
Kirklees CCG	233	234.4	232.7	449540	451128	451426	0.5	0.5	0.5
Calderdale CCG	114.9	109.9	109	222299	222705	223027	0.5	0.5	0.5

West Yorkshire Health and Care Partnership

Table 2 below also demonstrates that the more deprived a PCN the less likely it is able to attract and retain full time GPs

Table 2

GPs per PCN



We have commissioned our local Health Education England, Training Hub team over the next 12 months to carry out a review of our current GPs and Practice Managers, modelling how many are likely to leave general practice through retirement or other planned moves. This will then enable us to work with system colleagues and primary care on future workforce capacity and develop future development and recruitment plans.

8.2. **Additional Role Reimbursement Scheme (ARRS)**

Under the Primary Care Network DES, PCNs are able to recruit to additional new roles under the ARRS to further boost and compliment the primary care workforce and free up GP time for those patients that need to be seen by a GP, whilst the wider ARRS workforce can focus on patients with low level needs.

The following ARRS are shared amongst the practices within a PCN and are nationally funded at 100% apart from Mental Health Practioners which are 50% nationally funded via the ARRS scheme and 50% via the Mental Health Foundation Trust.

- Clinical Pharmacist
- Pharmacy Technician
- Social Prescribing Link Worker
- Health and Wellbeing Coach
- Care Co-ordinator
- Physician Associate
- First Contact Physiotherapists
- Dieticians
- Podiatrists
- Occupational therapists
- Mental Health Practitioner
- Paramedic
- Nursing Associate

Our ARRS allocation based upon our PCNs population size is approximately £7.8m, the table 3 below shows current ARRS roles that are employed within our PCNs, with data taken from the national ARRS reporting portal which is usually a few months behind actuals.

Table 3

Role/FTE	Social Prescriber Link Worker	Pharmacist	Physio	Physicians Associate	Paramedic	Pharmacy Technician	Podiatrist	Occupational Therapist	Nursing Associates	Trainee Nurse Associate	Practice Manager	Practice Nurses
Bradford District & Craven	4.0	28.1	2.8	8.3	5.7	2.0	0.0	2.5	1.0	3.0	112.7	136.0

However, despite the additional investment PCNs are struggling to find enough capacity in the labour workforce market to meet demand. Primary care estates are another key issue in being able to accommodate the ARRS roles.

We are working PCNs and at ICS level to develop our future estates strategies that can support a future integrated primary and community care service.

8.3. **Promoting Additional Primary Care Roles and news ways to access**

Making use of Winter Access funding from NHS England, the Access to Primary Care communications campaign is an insight-led campaign across Bradford District and Craven to support colleagues working in primary care by increasing public awareness of the ARRS and range of services at GP practices, and how they can be accessed. The campaign aims to support general practice teams and improve patient care by increasing the public's understanding of the different services offered by healthcare professionals at GP practices and encouraging patients to access these services via the most suitable routes.

The campaign has been developed with colleagues at Magpie, a creative behaviour change agency. Together, we have worked with patient groups and primary care staff across Bradford District and Craven to co-create the most effective campaign approach and messaging.

Patients identified that the campaign needs to;

- Show the different ways in which GP practices can be accessed
- Remove the mysticism around how triaging works
- Frame Primary Care staff as a team of specialists
- Show real routes to care that meant people avoided taking time away from work or children out of school
- Reinforce the expertise of Primary Care staff and raise awareness of some of the common medical problems that they're trained to deal with
- Address our audience in an empathetic tone

Patients participating in the research overwhelmingly used (and preferred) the phrase 'GP Practice'. The resulting campaign, 'It's a GP Practice thing', which

showcases the multi-disciplinary roles within GP practices and how each role can help patients, has been built on behavioural science.

The campaign will launch in early October 2022 and will feature images of local staff to reflect the local communities. Materials which will be made available to practices will include posters and leaflets, as well as digital images and a video how-to guide for accessing practice online services, which will be shared via social media, websites and screens in practice waiting areas. The materials have been carefully designed to ensure accessibility for varying levels of literacy and for those whose first language is not English and will be translated into a number of key local community languages.

9. Workforce Development and Care Navigation

Making use of Winter Access funding from NHS England, Conexus, a GP federation in Wakefield, were commissioned to review Care Navigation across Bradford District and Craven and identify future training needs to ensure a consistent approach across all practices. Since 2016, Conexus has successfully developed a safe, sustainable, and scalable care navigation model that has been rolled out nationwide. Care navigation is a tried and tested model of care that improves access to primary care services for patients whilst also reducing pressure on GPs. It allows frontline staff to provide patients with more information about local health and wellbeing services, both within and outside of primary care, in a safe, effective way. Care navigation offers the patient 'choice, not triage' to access the most appropriate service first, which - as is well evidenced - is not always the GP. Over 30% of practices in England and 27% of practices in Wales have care navigators who have been trained by Conexus Healthcare.

Conexus began with an initial stocktake, using a survey shared with practices and data from the Care Navigation dashboard to understand how Care Navigation was being implemented across Bradford District and Craven Place. Following this, and in consultation with Primary Care colleagues, Conexus has developed a bespoke package of training to refresh and enhance previous Care Navigation training and up-skill frontline General Practice primary care staff.

Conexus are currently working with PCNs to determine a delivery plan with training commencing from October 2022, to suit practice and PCN needs. The training available is designed to empower all staff and practices to deliver care navigation consistently and robustly and will include provision of essential skills training i.e., how to support and advise patients, conflict resolution and management, assertiveness skills, communications skills etc.

Conexus will also work with PCNs to validate and update Care Navigation templates to facilitate Care Navigators in sign-posting and referring patients to the most appropriate service to meet their needs in a timely and efficient manner. Using Care Navigation rather than referring all patients directly to a GP by default improves patient care by making best se of the wider clinical workforce in primary care, ensuring access to the member of staff with the most suitable skills to meet patient

needs and is often quicker than waiting for a GP appointment. It will also support and develop particularly our front-line staff on how to communicate more effectively with patients, being mindful of the patient's circumstances, whilst making best use of available both clinical and other resources.

As part of our PCN and Primary Care Organisational Development Plan we will further build on this work to create a more sustainable and resilient workforce.

10. Primary Care workforce – Health and Wellbeing

Primary Care faces the challenges of staff being absent due to the affects of Covid, as well the stress and pressures of working within primary care general practice. Both locally and nationally incidents of abuse and violence to staff from patients is on the increase and at an WYICS level and national there has been a targeted campaign of "zero tolerance to NHS staff".

We have also worked with YORLMC colleagues to develop health and wellbeing offers for GPs and practice nurses and are exploring other ways of supporting general practice staff.

Nationally the number of referrals to the "Health Practioner Programme" (this is a programme) to support GPs who are struggling to continue to practice has increased by a third over the last 16 months.

We are consistently working with our Local Medical Committee (LMC) colleagues to look at ways we can protect and support our staff.

11. Community Partnerships

Community Partnerships were established across Bradford and Craven in 2017/18, bringing together representatives from statutory health and care providers, voluntary sector organisations, Local Authority neighbourhood teams and others. The intention was to work on prevention, bring focus to the wider determinants of health and adopt an asset-based approach in local communities.

There are 12 Community Partnerships within the Bradford district (plus 1 in Craven). They are based on groups of GP Practice populations of around 50k and are co-terminus with Primary Care Networks (PCN's).

Community Partnerships have a clear potential to address Health Inequalities at the level of local populations and the conclusions of two recently commissioned local reports (Hambleton and Farrer) support this approach. In addition, the Fuller Stocktake into Primary Care advocates the development of neighbourhood approaches by PCN's. At the same time, the Core 20 + 5 framework for tackling health inequalities (which recognises the impact of deprivation on health outcomes alongside the needs of particular groups) together with the redefined 5 Place Based Partnership priorities (including Healthy Communities) provide the overarching context for prioritisation and planning in the coming months.

Whilst this is all consistent with the work undertaken in the past 12/15 months, there is now an opportunity to pick up the pace. The next steps will, therefore, involve the following:

Work to further develop Community Partnerships will be overseen by the new Healthy Communities Board and will sit alongside other community initiatives including those, such as Care Coordination, where PCN's will be key players.

- Close working with enabling programmes, such as Living Well and Reducing Inequalities Alliance, as well as other priority areas such as MHLDN.

- The development of Locality based collaboratives building on existing work to align Community Partnerships with Locality footprints. This will create greater potential for both more integrated service planning and delivery as well as local accountability. It will offer greater opportunities for enhanced partnership working at scale around defined shared priorities and the ability to connect better with the wider determinants of health and wellbeing through Locality Planning arrangements.

- A series of Locality based workshops is being organised, beginning in October. These will follow on from the initial meeting of the new Healthy Communities Board. They will bring together the key health, care and VCS stakeholders in each Locality and will give impetus to joint prioritisation and planning arrangements.

There is additional resource to support this work in the form of Core 20 + 5 implementor posts for the 6 Community Partnerships with the most deprived populations and Community Partnership/Locality development posts for each of the 5 Localities.

12. Addressing Health Inequalities

12.1. Health Inequalities Premium

As part of the 'Fairer Funding' review of all locally commissioned services, the Health Inequalities Premium (HIP) contract and service specification were recently refreshed and renewed with practices. The thirty-five practices which were identified as having the greatest risk of health inequalities were included in the HIP contract to incentivise initiatives to reduce health inequalities. The practices were identified using a calculation based on Index of Multiple Deprivation (IMD) scores, as well as a funding matrix which considers factors not included in the Carr Hill formula (this is the national formula on price per a patient in general practice), such as deprivation, ethnicity, life expectancy, poverty, long term condition prevalence, polypharmacy and Covid 19.

Practices may choose to focus on any of the metrics from the Bradford District and Craven priority list. A mapping exercise has been carried out to identify alignment and overlap between local HIP priorities and other ICS and national primary care metrics. Practices have been encouraged to focus on a HIP initiative which aligns with Core20Plus5 priorities, which is a national NHS England and NHS Improvement approach to support the reduction of health inequalities, focussing on the 20% most deprived population, plus other key minority groups, for example, people with a learning disability and autistic people, people experiencing homelessness. Core20Plus5 identifies 5 areas of clinical focus:

- Maternity
- Severe Mental Illness
- Chronic Respiratory Disease
- Early Cancer Diagnosis
- Hypertension
- and a local priority indicator focused on children and young people.

The aim of the HIP is to improve patient care by encouraging practice to work even more closely with its most vulnerable communities and provide additional support to individuals to improve health outcomes. Some examples of initiatives that have been proposed by practices are:

- Increasing cervical screening rates
- Reducing rates of smoking in pregnancy
- Increasing uptake of flu, pneumococcal and covid-19 vaccines
- Support improvements for patients with diabetes
    - Increasing annual health checks for people with serious mental illness or learning disabilities.

Community Partnerships and PCNs across the patch are at different stages of their development and how they work with each other and localities to reduce health inequalities, improve health outcomes and life expectancy in our most deprived areas.

The PCNs delivery plan up to 2023 in Appendix I lists its 5 overall objectives including its priority is to focus on addressing health inequalities.

Table 4 below details our 12 PCNs and population size covered.

Table 4

Locality (former CCG's)	PCN	Raw List Size	Locality List Size
Airedale, Wharfedale & Craven	Modality	87,232	
	WACA	75329	162,561
Bradford City	PCN 4	46181	
	PCN 5	56079	
	PCN 6	54131	156391
Bradford District	Affinity	59341	
	Bingley Bubble	44004	
	BD4+	41460	
	Bradford North West	50690	
	Five Lane Ends	34710	
	Bradford South	62945	
	WISHH	36324	329474
	Total	**648426**	**648426**

13. Members may wish to comment on the contents of the report.

14. Recommendations

Members of the Health and Social Care Overview Scrutiny committee are asked to:

Note the contents of this report detailing the current developments in primary care both nationally and locally.

15. Background documents

None

16. Not for publication documents

None

17. Appendices

17.1. **Appendix A**: Autumn Winter Covid Campaign
17.2. **Appendix B**: Covid Vaccinations
17.3. **Appendix C**: 1st October PCN Enhanced Access Summary
17.4. **Appendix D**: GP Appointments
17.5. **Appendix E**: Mode of GP Appointments
17.6. **Appendix F**: Time taken from booking to receiving an appointment
17.7. **Appendix G**: GP Online Consultation /e-Consult Data
17.8. **Appendix H**: Consults by age
17.9. **Appendix I**: Summary of PCN Objectives 2021/22 and 2022/23
17.10. **Appendix J**: Patient 111 Calls (April 21 to June 22 Data)
17.11. **Appendix K**: Fuller Review and Framework for Shared Actions

Appendix: A

Autumn Winter Covid Campaign

Bradford District and Craven Health and Care Partnership
ACTasONE

The government have accepted final JCVI advice which states the following people should be offered a COVID -19 booster vaccine this autumn:

residents in a care home for older adults and staff working in care homes for older adults
frontline health and social care workers
all adults aged 50 years and over
persons aged 5 to 49 years in a clinical risk group, as set out in the Green Book
persons aged 5 to 49 years who are household contacts of people with immunosuppression
persons aged 16 to 49 years who are carers

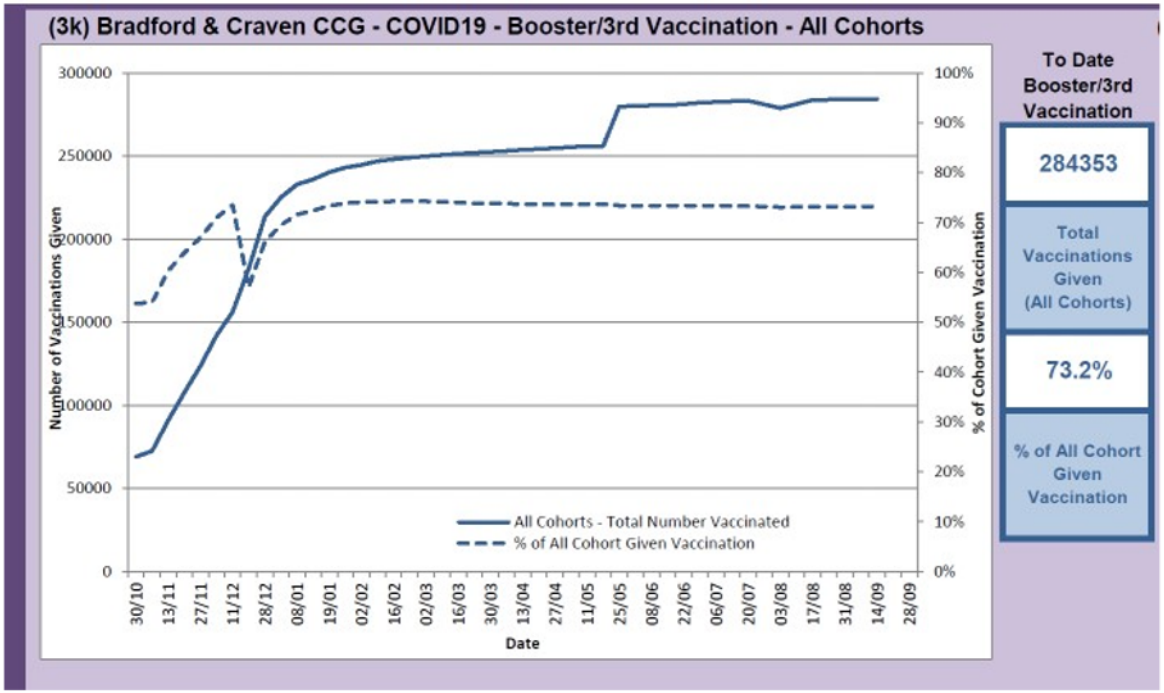
Locality (former CCG's)	PCN	Autumn Winter Covid Campaign	Designated Site
Airedale, Wharfedale & Craven	Modality	Opt in	Silsden Surgery
	WACA	Opt in	Ilkley MP, Townhead MP
Bradford City	PCN 4	Opt in	Whetley Medical Centre
	PCN 5	Opt in	Barkerend
	PCN 6	Opt in	Woodroyd Medical Centre
Bradford District	Affinity	Opt in	Shipley MP
	Bingley Bubble	Collaboration agreement pending	TBC
	BD4+	Opt in	Low Moor MP
	Bradford North West	Opt in	The Ridge MP
	Five Lane Ends	Collaboration agreement Affinity	Shipley MP
	Bradford South	Opt in	The Ridge MP
	WISHH	Collaboration agreement Affinity	Shipley MP

Appendix: B

Covid Vaccinations

Bradford District and Craven Health and Care Partnership

ACTasONE



Appendix: C

1st October PCN Enhanced Access Summary

PCN	Model of delivery	Minutes / Hours Required:	Hub Locations:	Primary Medical Care Services included in the delivery model:	Indicative proportion of Face-to-Face appointments:	Evidence of Patient Engagement:	Non-Network Standard Hours Included:
Affinity	PCN Model	3,662.9mins / 61.05 hrs	Shipley Health Centre (North PCN) The Willows Medical Practice (West PCN) Sunnybank Medical Practice (South PCN)	GP Nurse Screening Pharmacy Vaccinations Mental Health	50%	PCN Patient Survey and Patient Council meetings.	Potential to include non core hours provision 7am to 8am.
AWC Modality	PCN Model	5,513.42 mins / 91.89 hrs	Fisher Medical Centre (Craven) Farfield Group Practice (Airedale) Silsden Medical Practice (Wharfedale) Central Hall (Keighley Community Hub)	GP Nurse Screening Pharmacy Vaccinations Mental Health Community Outreach	53%	Health Inequalities award (engagement with faith centres, colleges, community centres). PCN Patient Survey SMS to all patients. Social Media posts.	No

WACA	PCN Model	4,449.23 mins / 74.15 hrs	Ilkley Medical Centre (Wharfedale) Townhead Surgery (Craven) Ling House Surgery (Airedale) Dyneley House Surgery (Craven) Varied additional community outreach	GP Nurse Screening Pharmacy Vaccinations Mental Health Community Outreach	50%	PPG WACA Extended Access Patient Survey GP Patient Survey	Sunday mornings included as alternative to Saturday afternoon. This provision confirms overall required minutes are met.
PCN	**Model of delivery**	**Minutes / Hours Required:**	**Hub Locations:**	**Primary Medical Care Services included in the delivery model:**	**Indicative proportion of Face to Face appointments:**	**Evidence of Patient Engagement:**	**Non Network Standard Hours Included:**
Bingley Bubble	BCA Subcontract	2,544 mins / 42.41 hrs	Bingley Medical Practice Saltaire & Windhill (Idle Medical until renovations completed)	GP Nurse Screening Pharmacy Vaccinations Mental Health Physio	55%	Place based Patient Survey (results pending) Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.

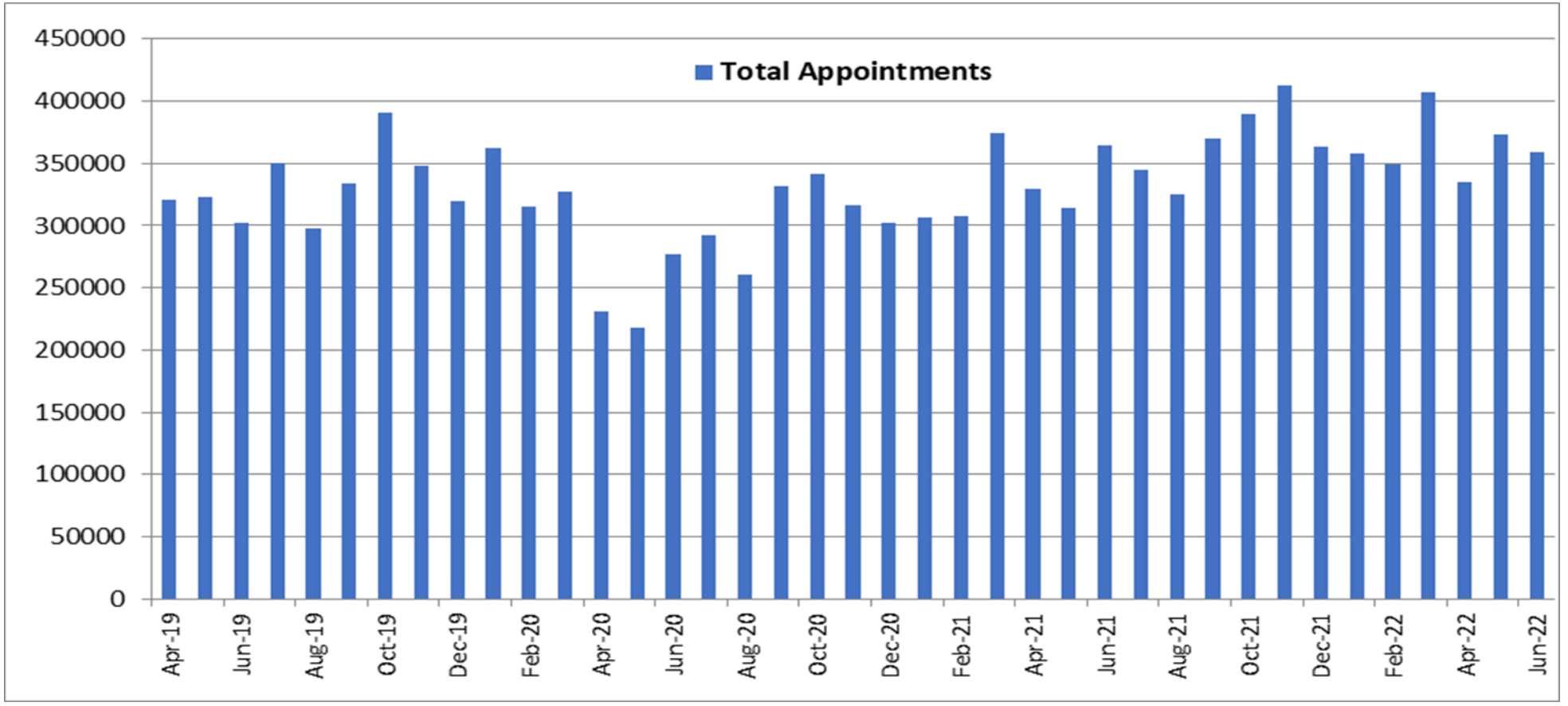
BD 4+	BCA Subcontract	2,909.97 mins / 48.50 hrs	Bowling Hall Medical Practice Hillside Bridge Medical Practice (weekends)	GP Nurse Screening Pharmacy Vaccinations Mental Health Physio	68%	Place based Patient Survey (results pending) Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.
Bradford North West	BCA Subcontract	3,092.11 mins / 51.54 hrs	Ashwell Medical Practice Picton Medical Practice (weekends)	GP Nurse Screening Pharmacy Vaccinations Mental Health Physio	68%	Place based Patient Survey (results pending) Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.
PCN	**Model of delivery**	**Minutes / Hours Required:**	**Hub Locations:**	**Primary Medical Care Services included in the delivery model:**	**Indicative proportion of Face to Face appointments:**	**Evidence of Patient Engagement:**	**Non Network Standard Hours Included:**

Five Lane Ends	BCA Subcontract	2,239.18 mins / 37.32 hrs	Moorside Medical Practice Saltaire & Windhill (Idle Medical until renovations completed)	GP Nurse Screening Pharmacy Vaccinations Mental Health Physio	60%	Place based Patient Survey (results pending) Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.
PCN 4	BCA Subcontract	2,864.70 mins / 47.75 hrs	Picton Medical PracticePicton Medical Practice (weekends)	GPNurseScreening PharmacyVaccinationsMental HealthPhysio	64%	Place based Patient Survey (results pending)Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.
PCN 5	BCA Subcontract	3,637.72 mins / 60.63 hrs	Barkerend Medical Practice Hillside Bridge Medical Centre (weekdays and weekend)	GP Nurse Screening Pharmacy Vaccinations Mental Health Physio	75%	Place based Patient Survey (results pending) Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.

PCN	Model of delivery	Minutes / Hours Required:	Hub Locations:	Primary Medical Care Services included in the delivery model:	Indicative proportion of Face to Face appointments:	Evidence of Patient Engagement:	Non Network Standard Hours Included:
PCN 6	BCA Subcontract	3,178.79 mins / 52.98 hrs	Park Grange Medical Practice Picton Medical Practice (weekends) Little Horton Lane Medical Centre (Core Hours)*	GP Nurse Screening Pharmacy Vaccinations Mental Health Physio Paediatrics (core hours) Health Inequalities clinic (core hours)	91%	Place based Patient Survey (results pending) Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.
Bradford South (PCN 7)	BCA Subcontract	3,987.29 mins / 66.45 hrs	The Ridge Medical Practice (main site) Picton Medical Centre (weekends)	GP Nurse Screening Pharmacy Vaccinations Mental Health Physio	77%	Place based Patient Survey (results pending) Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.
WISHH (North Bradford PCN)	BCA Subcontract	2,172.60 mins / 36.21 hrs	Saltaire & Windhill (Idle Medical until renovations completed), (weekdays and weekends)	GP Nurse Screening Pharmacy Vaccinations Mental Health Physio	64%	Place based Patient Survey (results pending) Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.

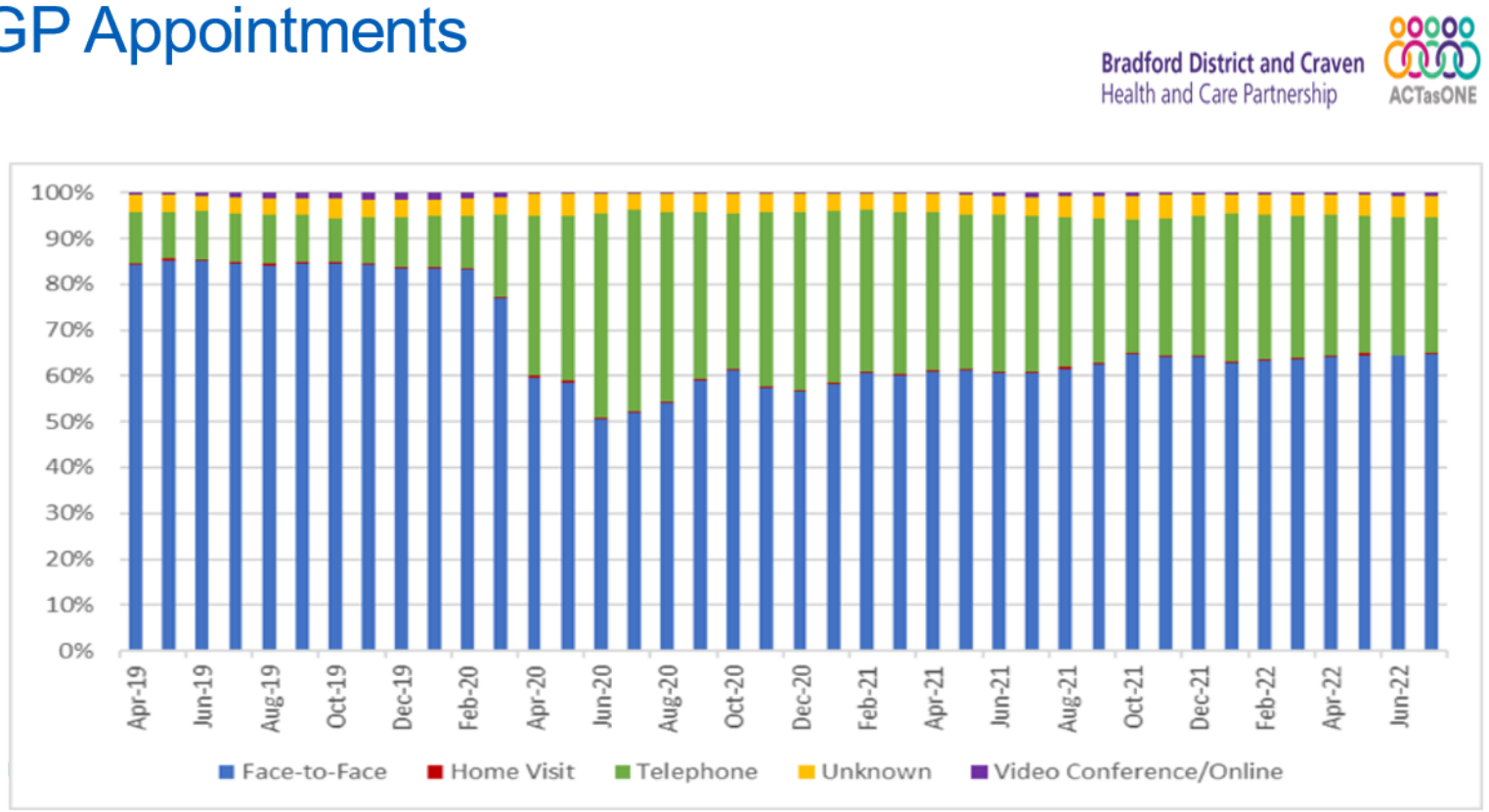
Appendix: D

NHS Digital GP appointment snapshot for Bradford District and Craven and GP appointment data presented in a bar chart (Source NHSD)



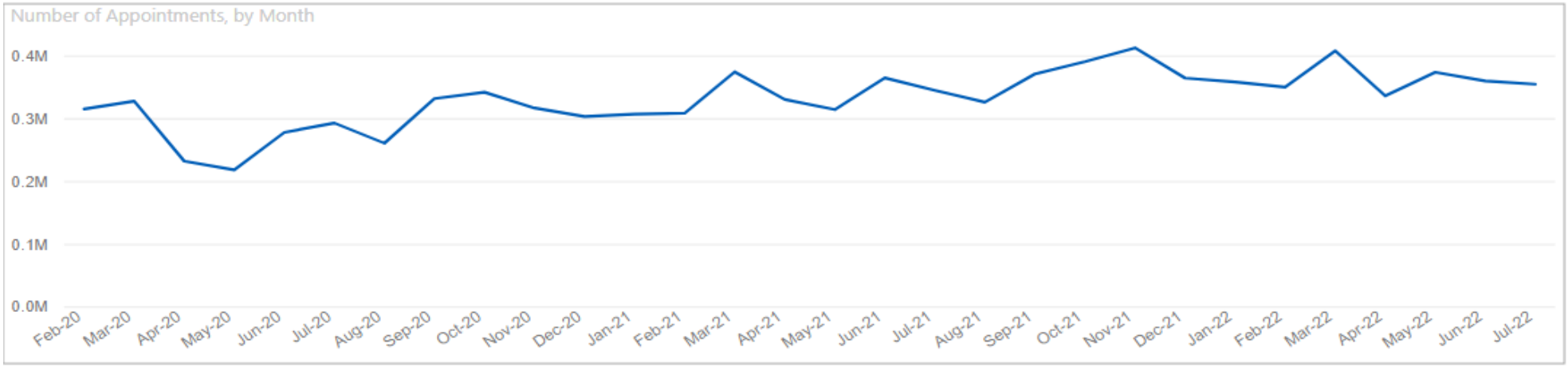
Appendix: E

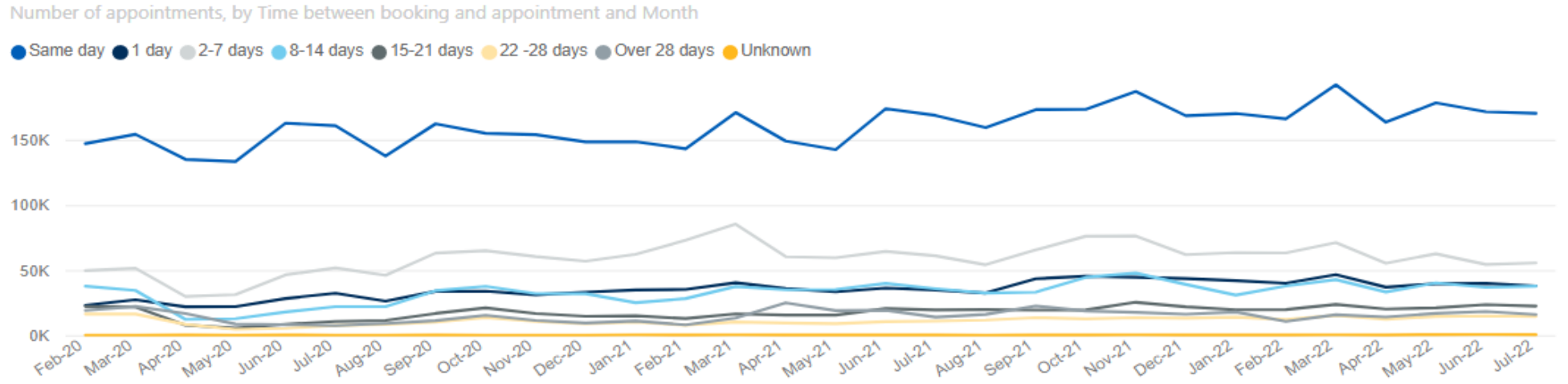
Mode of GP Appointments



Appendix: F

Time Taken from Booking to Receiving an Appointment

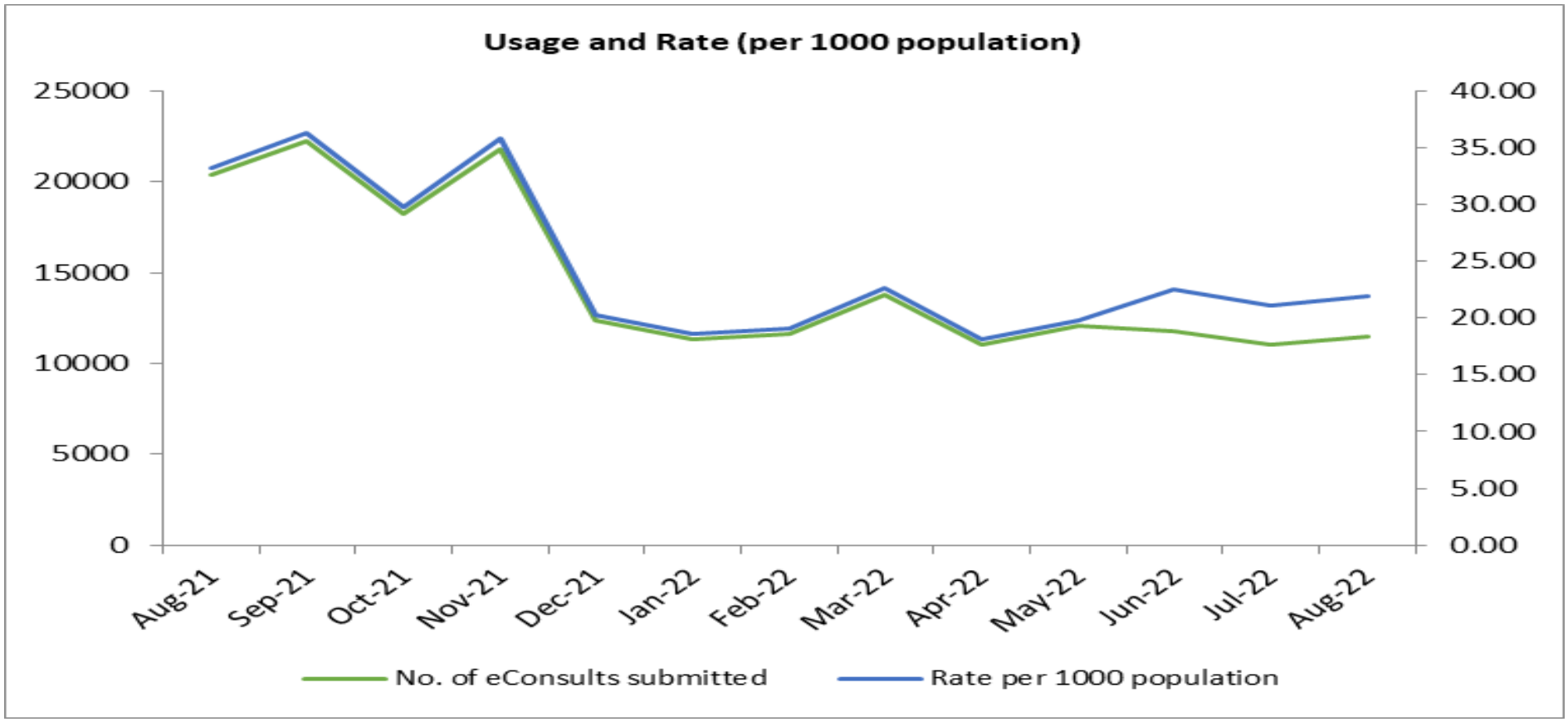




Appendix: G

GP Online Consultation / e-Consult Data

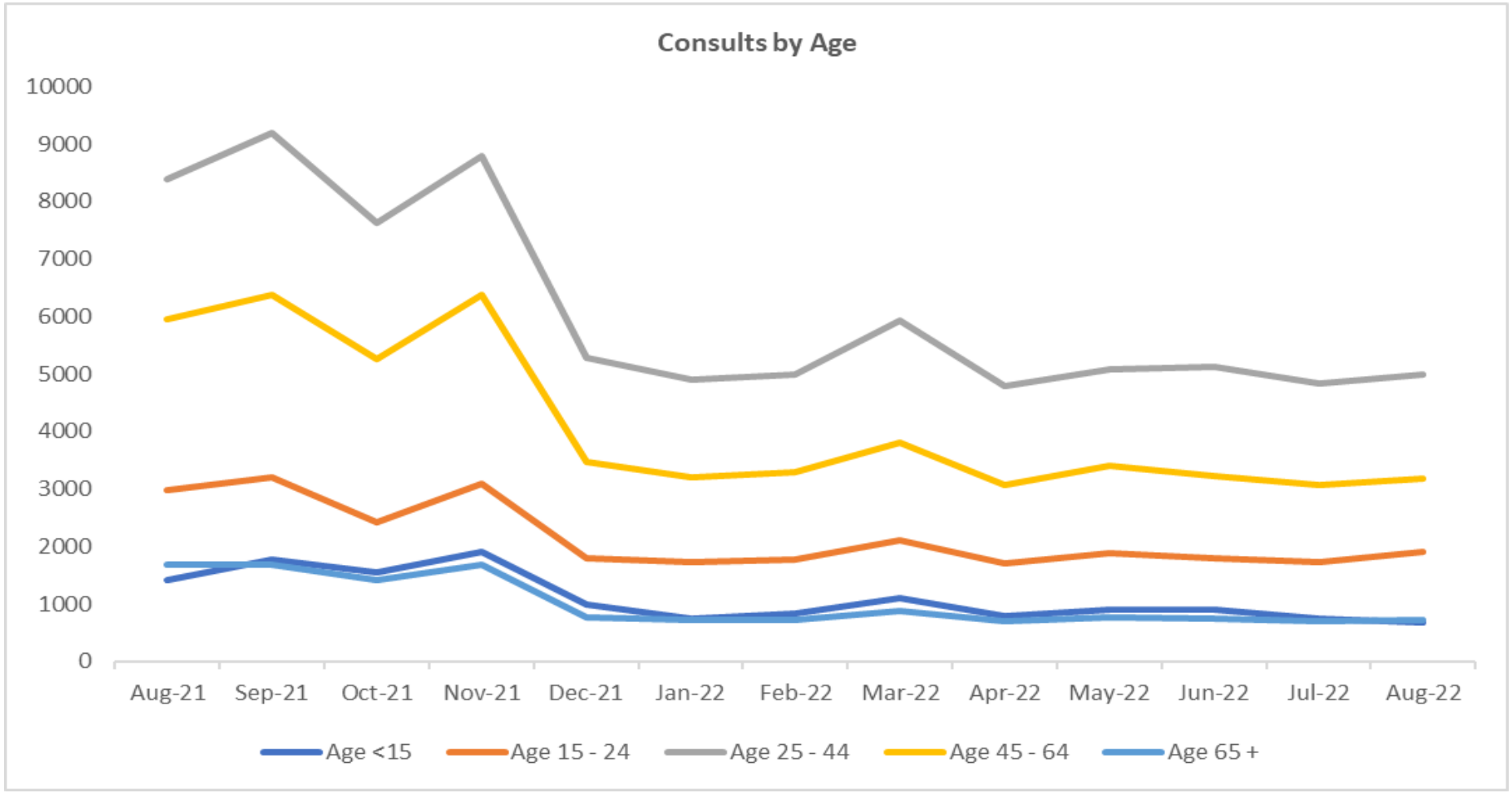
1.) Usage (11,472) and Rate of Submissions (21.91):



*Data does not include AWC Modality PCN GP Online Consultation submissions

Appendix: H

2.) Consults by Age:



Appendix: I

Summary of PCN Objectives 2021/22 and 2022/23

The table below sets out the 5 key objectives for PCNs in 2021/22 and 2022/23, and how different elements of the Network Contract DES will support them.

Key Objectives. Aligned to general practice priorities, LTP priorities and NHS response to Covid-19	**Service requirements** New requirements introduced in a phased way will support the key objectives	**IIF Indicator areas of focus** Financial indicators to improve and reward performance against DES Service requirements and wider NHS priorities

1. **Improving prevention and tackling health inequalities** in the delivery of primary care – PCNs will be required to identify high need local populations and tailor services to them, as well as address inequalities in rates of diagnosis for cardiovascular disease and cancer.	• Tackling Neighbourhood Inequalities
	• CVD Diagnosis and Prevention
	• Early Cancer Diagnosis
	• Personalised Care
		• Progress towards the national ambitions for:
		  ○ Learning Disability Health Checks
		  ○ Flu vaccinations to at-risk groups
		  ○ Closing the hypertension diagnosis gap
		  ○ Personalised care interventions e.g. social prescribing
		• More complete recording of ethnicity in patient records

2. Support **better patient outcomes in the community through proactive primary care** – including delivery of the Enhanced Health in Care Homes and Anticipatory Care services through multidisciplinary teams, offering more personalised services which will help people avoid unnecessary hospital admissions	• Tackling Neighbourhood Inequalities • Anticipatory Care • Enhanced Health in Care Homes (EHCH) • Personalised Care	• Delivery of key elements of the EHCH model and associated moderation of care home resident emergency admissions • Moderated admissions for ambulatory care sensitive conditions (ACSCs)
3. Support **improved patient access** to primary care services – implementing a PCN-based approach to extended access provision, and rewarding PCNs who improve the experience of their patients, avoid long waits for routine appointments and tackle the backlog of care resulting from the Covid-19pandemic	• Extended Access service requirements • Delivery of all new services will support improved access for particular cohorts.	• Improved patient experience of accessing general practice • Reduction in the proportion of patients waiting longer than two weeks for a routine general practice appointment • Improved provision of online consultations • Increased utilisation of Specialist Advice services, and

		community pharmacist consultations
4. **Deliver better outcomes for patients on medication** – including through the delivery of Structured Medication Reviews to priority patient cohorts, and through targeting prescribing behaviours known to improve patient safety.	• Structured Medication Reviews and Medicines Optimisation	• Improved provision of SMRs to priority groups • Targeted prescribing behaviours known to improve patient safety • Supporting more preventive treatment of asthma through increased use of inhaled corticosteroids.
5. Help **create a more sustainable NHS** - through reducing the carbon emissions generated by asthma inhalers.	• Structured Medication Reviews and Medicines Optimisation	• Encouraging clinically appropriate inhaler switching to low-carbon alternatives

Appendix: J

Patient 111 Calls (Apr21 to June 22 Data)

Bradford District and Craven Health and Care Partnership

ACTasONE

Total Number of Calls (In Hours)	Call Rate (Number of Calls per 1,000 Population)	Call Disposition											
		Ambulance		A&E		Primary Care		Another Service		Self Care		Unknown	
		No	%	No	%	No	%	No	%	No	%	No	%
74649	115.0	6698	9.0%	13613	18.2%	39696	53.2%	6199	8.3%	7523	10.2%	820	1.1%

West Yorkshire Health and Care Partnership

Appendix: K

Fuller Review and Framework for Shared Actions

1	**Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices.** This should be for all patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority. Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face.	ICSs
2	**Assist systems with integration of primary and urgent care access,** specifically looking at the role of NHS 111, and considering the development of new metrics and standards on urgent and routine access, and introduce as planned, the new patient-reported experience measure for access to general practice.	NHS England
3	**Enable all PCNs to evolve into integrated neighbourhood teams,** supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors. Secondary care consultants – including, for example, geriatricians, respiratory consultants, paediatricians and psychiatrists – should be aligned to neighbourhood teams with commitments reflected in job plans, along with members of community and mental health teams. With teams collocated within neighbourhoods, to extend models of personalised care, embed enhanced health in care homes and develop a consistent set of diagnostic tests. At place level, bring together teams on admissions avoidance, discharge and flow – including urgent community response, virtual wards and community mental health crisis teams. Focus on community engagement and outreach, across the life course. Proactively identify and target individuals who can benefit from interventions in neighbourhoods, committing to delivering neighbourhood teams first for Core20PLUS5 populations. Co-ordinate vaccinations, screening and health checks at place level, in accordance with national standards.	ICSs
4	**Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams**, across their functions including digital, data, intelligence and quality improvement, HR, finance, workforce plans and models, and estates. Specifically put in place sufficient support for all PCN clinical directors and multiprofessional leadership development, and protected time for team development. Baseline the existing organisational capacity and capacity for primary care, across system, place and neighbourhood levels, to ensure systems can undertake their core operational and transformation functions.	ICSs

5	**Develop a primary care forum or network at system level**, with suitable credibility and breadth of views, including professional representation. Ensure primary care is represented on all place-based boards.	ICSs
6	**Embed primary care workforce as an integral part of system thinking, planning and delivery.** Improve workforce data. Support innovative employment models and adoption of NHS terms and conditions. Support the development of training and supervision, recruitment and retention and increased participation of the workforce, including GPs.	ICSs
7	**Include primary care as a focus in the forthcoming national workforce strategy to support ICSs to deliver this report (NHS England).** Recognising this is not currently funded, commit to future rollout of the NHS Staff Survey in primary care. Examine further flexibilities, and better communicate existing flexibilities, in the Additional Roles Reimbursement Scheme. Specifically consider, with DHSC and HEE, how the scheme should operate after March 2024, including the role of ICSs in working with national colleagues and PCNs in delivering it. Review the GPs Performers List to enable other appropriately qualified clinicians to contribute more easily as part of the primary care workforce.	DHSC with NHS England and HEE
8	**Pivot to system leadership as the primary driver of primary care improvement and development of neighbourhood teams in the years ahead.** Move to greater financial flexibility for systems on primary care. Bring together existing national primary care funding wherever practicable. Beyond 2023/24, maximise system decision-making on any future discretionary investment, beyond DDRB and pay uplifts.	NHS England
9	**Improve data flows** including by (i) solving the problem of data-sharing liability, issuing a revised national template; (ii) working with system suppliers on extract functionality; (iii) improving data to support access (actions 1 and 2 above), and (iv) helping to identify population cohorts to be targeted by neighbourhood teams.	NHS England
10	**Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care**, taking a 'one public estate' approach and maximising the use of community assets and spaces.	ICSs
11	**DHSC and NHSE should provide additional, expert capacity and capability to help offer solutions to the most intractable estates issues,** and practical support to work through them, as well as building ICS estates expertise. DHSC and NHSE should consider what flexibilities and permissions should be afforded to systems to allow shaping and influencing of the physical primary care estate, including through reviewing the Premises Cost Directions. DHSC	DHSC and NHS England

	should ensure that primary care estate is central in the next iteration of the Health Infrastructure Plan.	
12	**Create a clear development plan to support the sustainability of primary care and translate the framework provided by *Next steps for integrated primary care* into reality, across all neighbourhoods.** Ensure a particular focus on unwarranted variation in access, experience and outcomes. Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities. Support primary care where it wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers. Tackle gaps in provision, including where appropriate, commissioning new providers in particular for the least well-served communities.	ICSs
13	**Work alongside local people and communities** in the planning and implementation process of the actions set out above, ensuring that these plans are appropriately tailored to local needs and preferences, taking into account demographic and cultural factors.	ICSs
14	In support of systems, **set out how the actions highlighted for NHS England will be progressed.**	NHS England
15	DHSC and NHS England should rapidly undertake further work on the **legislative, contractual, commissioning, and funding framework** to enable and support new models of integrated primary care. This work should also consider how to improve equity in distribution of resource and ultimately improve health outcomes.	DHSC and NHS England

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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Bradford District and Craven Health and Care Partnership to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 6 October 2022

I

Subject:

Assessment and Diagnosis of Autism in Adults in Bradford district and Craven: Update on progress and challenges

Summary statement:

The Bradford and Airedale Neurodevelopment Service (BANDS) was commissioned to provide triage, assessment and diagnosis for both ASD and ADHD for adults (over 18) in Bradford, Airedale, Wharfedale and Craven.

This report and appendices provide an update to the report delivered to this Committee in March 2022. The March 22 report described the Adult Autism pathway, shared experiences of patients through case studies, and summarised the plan for improvements to the assessment and diagnosis of autism spectrum disorder (ASD) in adults in Bradford, District and Craven.

Portfolio:

Healthy People and Places

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1. Summary

The Bradford and Airedale Neurodevelopment Service (BANDS) was commissioned to provide triage, assessment and diagnosis for both ASD and ADHD for adults (over 18) in Bradford, Airedale, Wharfedale and Craven.

This report and appendices provide an update to the report delivered to this Committee in March 2022. The March 22 report described the Adult Autism pathway, shared experiences of patients through case studies, and summarised the plan for improvements to the assessment and diagnosis of autism spectrum disorder (ASD) in adults in Bradford, District and Craven.

In particular, the report detailed the plan agreed at the MH, LD and ND Programme Board which focussed on 3 key areas:

1. Continue to strengthen the Autism Assessment Pathway (adults) through expanding existing BANDS service to increase capacity and patient throughput
2. Engage with NHS and independent providers for rapid, short term, expansion in capacity for clinical assessments
3. Engage with ICS to explore system approaches to ASD assessment and diagnosis

At the Committee meeting it was agreed that, by March 2023 the BANDS service would deliver:

- 100 assessments through SWYFT
- 100 assessments through the Independent sector
- 56 assessments through core BANDS service

It was also agreed that commissioners and BANDS managers will return to this Committee to share progress and/or changes to the plan;

- Oct 2022 - informal session and briefing note
- March 23- Report to full committees on performance – demonstrate at least 80% of projected assessments are completed. Demonstrate a plan for sustainability and continued improvement of service.

This update to the Committee provides details on the progress, challenges and revisions made to plans since March 2022. Recognising the Committee has new members and a new Chair, some information from previous reports is included for information and context.

2. Background

Autism is a lifelong neurodevelopmental condition, the core features of which are persistent difficulties in social interaction and communication and the presence of stereotypic (rigid and repetitive) behaviours, resistance to change or restricted interests. The way that autism is expressed in individual people differs at different stages of life, in response to interventions, and with the presence of coexisting conditions such as learning disabilities (also called 'intellectual disabilities').
People with autism also commonly experience difficulty with cognitive and behavioural flexibility, altered sensory sensitivity, sensory processing difficulties and emotional regulation difficulties. The features of autism may range from mild to severe and may fluctuate over time or in response to changes in circumstances. (NICE Clinical guideline [CG142])

1% of the general population is estimated to have autism and 50% of those to have intellectual disability. For Bradford the autistic only population is calculated at 3,147 by 2025 (Pansi dataset).

In response to section 2 of the Autism Act 2009, the Department of Health published 'Fulfilling and Rewarding Lives', The Strategy for adults with autism in England (2010) https://webarchive.nationalarchives.gov.uk/ukgwa/20170207052351/https://www.nao.org.uk/wp-content/uploads/2009/06/0809556.pdf
The Government's vision is that 'All adults with autism are able to live fulfilling and rewarding
lives within a society that accepts and understands them. They can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them makes the most of their talents". It outlines five quality outcomes:

1. Adults with autism achieve better health outcomes
2. Adults with autism are included and economically active
3. Adults with autism are living in accommodation that meets their needs
4. Adults with autism are benefiting from the personalisation agenda in health and social care, and can access personal budgets
5. Adults with autism are no longer managed inappropriately in the criminal justice system

The Bradford and Airedale Neurodevelopment Service (BANDS) was commissioned in 2015 to provide triage, assessment and diagnosis for both ASD and ADHD for adults (over 18) in Bradford, Airedale, Wharfedale and Craven. The value of the contract has increased from £98,000 in 2015 to £152,000 in 2021. N.B. The NHS commissioning budget for BANDS, Adult Autism assessment, diagnosis and support service is 50% of the total BANDS budget - £75,000 p.a. Core staffing consists of:

Lead Autism Clinician	x1	FTE
Autism HCA	x1	FTE
Admin	x 0.5	FTE

Nice guidance states that the local autism partnership should lead on the development of a multi professional pathway and be responsible for ensuring people are trained (all front facing staff) and reasonable adjustments are made, etc. Adult Social Care Services plan to bring together a new vision/plan for integrated care and support pathways/networks including good information and advice, Early Intervention and Prevention (EIP) services will support individuals as well as diagnosis and pathways into adult social care/ housing/ disability employment advisors, etc.

The prevalence data contained in the 2019 Public Health report, LEARNING DISABILITY AND AUTISM IN BRADFORD - A Health Needs Assessment will be used to help understand potential demand for adult diagnosis services and will contextualise something of the challenge faced by commissioners and providers of services to support adults with needs linked to ASD.
https://jsna.bradford.gov.uk/documents/Mental%20wellbeing/05%20Learning%20Disability%20Health%20Needs%20Assessment/Learning%20Disability%20and%20Autism%20in%20Bradford%20-%20April%202019.pdf

The NHS Bradford District and Craven Health and Care Partnership Board (BDC HCP) also commissions services to support adults with autism with social, education and

employment needs through Specialist Autism Services and Sacar, through an annual budget of £61,000

3. **Report issues**

Update on progress, challenges and revisions made to plans since March 2022

Vision
The Bradford and Airedale Neurodevelopment Service (BANDS) aims and objectives are to deliver a clinically led, resilient Adult Autism pathway providing clinical triage, assessment, diagnosis and support. We will provide a service that has capacity to meet demand and can respond to new referrals within the NICE recommended timeline of 12 weeks. We will offer both clinical and social care services that support adults with ASD to have information and access training, employment and leisure across Bradford district and Craven (BdC).

Planning and implementation
The Bradford District and Craven ND project group meets monthly to design and manage improvements to adult autism and ADHD pathways (**Appendix 5**, Project Plan)
Faced with setbacks around workforce and recruitment to plans to expand the BDCFT BANDS service, the project team took a resilient approach to develop an innovative plan for partnership between BANDS and SWYPFT, putting the principles of our newly formed Integrated commissioning System (ICS) into action. The new plan builds on SWYPFTS proven pathway and ability to recruit. The plan is ambitious in scope to create a sustainable model that can meet increased demand. The new model also takes advantage of BANDS existing networks with BdC referrers and the wider system. We have also worked to increase integration between health, social care and VCS services, ensuring that people can have information about, and be signposted to, the organisations that can help them.

Resources (actual)
- £374,000 non-recurring NHSE Transformation Fund Allocation, over 2 years. Will part fund the new model of service and expansion of options for support.
- £100,000 CCG and SWYPFT (joint funded) non-recurring funds to outsource 100 assessments to SWYFT
- £75,000 BDCFT/BANDS Adult Autism core funding (block contract)

Resources (proposed)
- £250,000 recurring funding is needed to fund a new, sustainable model for BANDS – a business case is to be presented to System Finance and Performance Committee in October 2022. Recurring funding will support the recruitment process, attracting more and better-quality applicants.

Challenges and Responses The challenges we face in realising this vision are not unique to BdC but are also being experienced regionally and nationally.
Capacity and demand - Referrals for assessments for autism assessment continue to rise across Bradford and West Yorkshire, substantially outstripping current capacity (see Table 1) New referrals are as many as 50 per month, whilst the core capacity of the current model is 3 to 5 assessments per month.
This will be addressed through a new model of service and an expanded pathway for adults with autism (see tables 2 & 3) which can process 50 referrals per month. The new

model includes a process of clinical triage to provide early identification of those referrals where the information provided is not consistent with a presentation of a person who has Autism as described by the diagnostic criteria such as DSM-5.

Table 1 - No of people waiting for first Appointment

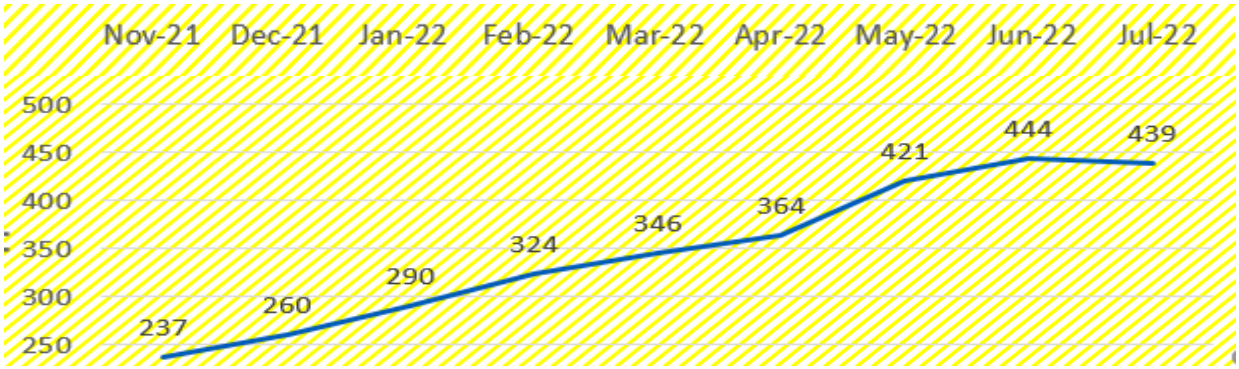


Table 2 – Capacity and demand gap

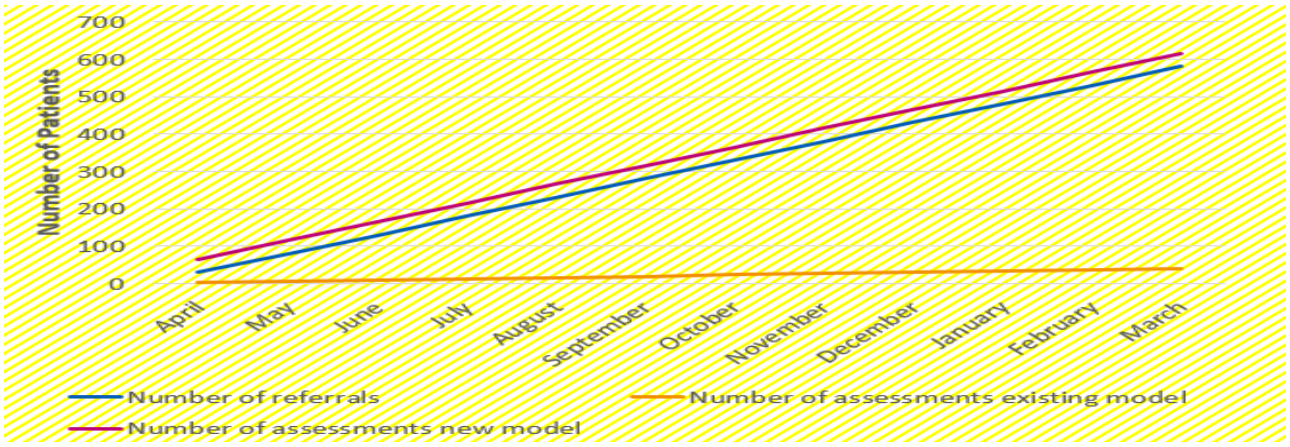
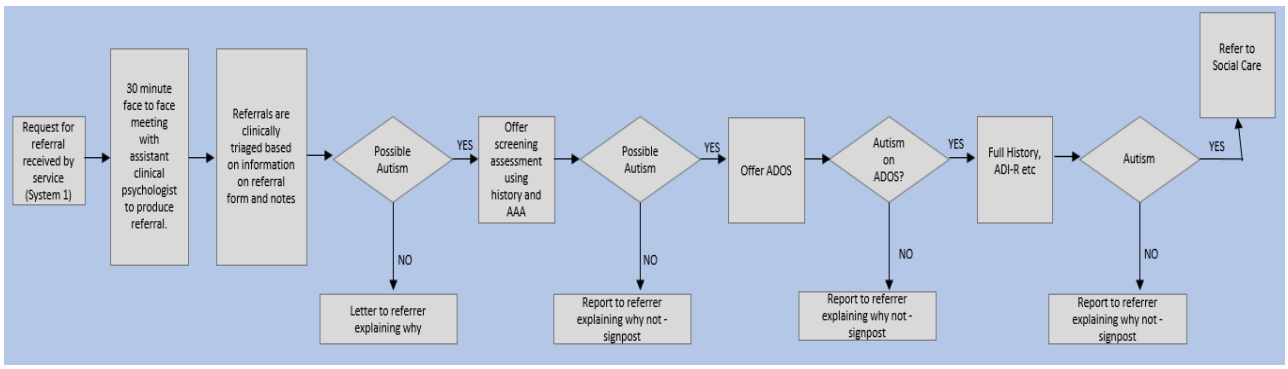


Table 3 – new Bands adult autism referral process



Workforce - Due to the small size of the BANDS team, BDCFT have been unable to recruit to new posts and, since May 2022, both existing staff have resigned.
This is being addressed by entering a partnership with SWYPFT, who have a proven record of recruitment to their multi-disciplinary staff team of 35 people, providing services across 3 CCGs.

Staff have already been recruited for the 100 assessments project and recruitment has started to replace core BANDS staff.

Referrals – in the existing model, clinical time has been used asking referrers for additional information and the quality of assessment has been affected by insufficient information being available. In the new model, an additional step is introduced to offer a 30 minute face to face meeting with the patient to gather all the information and evidence available for assessment.

Partnership

The new model is built on developing the partnership between BDCFT/BANDS and SWYPFT, putting the principles of the WY Integrated Care System into practice.
There is now joint recruitment to posts, building on SWYPFTs reputation and success, as well. The revised model of service will increase clinical capacity and end excessive waiting times. The expanded adult with ASC pathway will increase the quality of referrals which leads to better outcomes and improved options for support. There will be education for staff within social care and health to recognise, assess and meet the needs of adults with ASC around education, leisure, and employment
The 100 assessments project is ready to begin face to face assessments from Sept 2022 and the new model will commence from Feb/March 2023.
Through increased co-working with a Bradford based VCS organisation, Specialist Autism Services, we hope to increase the support for young people with ASC in transition from children's to adult services and into education and employment.

Outcomes

- Improve capacity of Adult Autism Pathway to meet demand
- Waiting times to access service to be reduced to NICE guideline levels
- Improved quality of referrals
- Improved experience of the Adult Autism Pathway

Revised Plan for the Assessment and Diagnosis of Autism in Adults in Bradford district and Craven

Action	Update
Outsourcing 100 assessments through SWYPFT	• Estate secured for local, face to face delivery of assessments at Hillside Bridge • Data sharing agreement in place • Clinical triage of 126 people from waiting list complete • Staff recruitment complete • Initial communication to patients complete • Additional step introduced to improve quality of referrals – pre-assessment meeting • Assessment activity to commence September 2022 • see **Appendix 1** for projected activity
Outsourcing 100 assessments through the independent sector	• Change of focus to more sustainable and quality improvement to BANDS through partnership working with SWYPFT • Resource diverted to support contracted outsourcing of 250 ADHD assessments from Clinical Partners • 250 people removed from adult ADHD waiting list of 887 • Activity begins Sept 2022

56 assessments through BANDS	• This has not progressed as planned
	• Recruitment issue: Despite support from internal and external HR specialists, BANDS unable to recruit to advertised roles.
	• Resignations: 2 existing staff left the service in May 22
	• Resilient approach and revised plan to deliver a sustainable and high quality service:
	  • Partnership with SWYPFT developed to include new service model, joint recruitment to posts and management support;
	  • Clinical lead support from Dr Sara Humphrey

New Service Model Phase 1	Phase 1 recruitment – beginning Sept 2022
	  • 1 x Band 8a Psychologist and
	  • 1 x Band 4 Psychology assistant
	
	• Joint recruitment to new posts from Sept 2022
	• on-going leadership, referral management and triage of 600 referrals for autism each year
	• Clear backlog of referrals
	• Reduce yearly waiting list increase from 560 to 50
	• total investment £166,752 per annum

New Service Model Phase 2	Phase 2 recruitment • 1 x Band 7 Psychology assistant • Revised Adult ASD Pathway, inc. improved quality of referrals, education, and non-clinical support

The BDCFT/Bands and SWYPFT Partnership

Provide emergency support to BANDS. May 22 – Dec 22	• Review the backlog of referrals. • Apply a Clinical Triage approach to referrals • Stabilise the waiting list
Support with the BANDS waiting list. May 22 – Mar 23	• SWYPFT contributed 50% towards assessing 100 patients from the BANDS waiting list. • Deliver a face to face SWYPFT service in Bradford, in collaboration with BANDS • Communication wit patients – 126 people from waiting list have received a letter explaining the process **(appendix 2)** • new step to pathway introduced – initial face to face meeting to gather in depth referral information • Initial steps commenced, assessments begin September 2022
Build up BANDS through partnership with SWYPFT Aug 22 – Dec 22	• Advertising to joint posts based on core funding and transformation funding • Agree an operational model • Clinical Lead, Dr Sara Humphrey • Revise GP ASSIST Pathway – pilot new referral process **(Appendix 3)** • Review and expand non-clinical support
Expand BANDS to create a sustainable model Dec 22 – March 23	• kick start the new service model through core and development funds • demonstrate a track record of success and develop a business case for sustainability • Apply to our Health and Care Partnership for recurring funding

BDMDC – Adult Social Care support and new developments in post-diagnosis and non-clinical support for adults with ASD

Bradford Local Offer	Information on current services and support available for both children and adults with Autism can be found on the **Bradford Local Offer**. https://localoffer.bradford.gov.uk/ General information for adults with care and support needs can be found at **Connect to Support**. https://bradford.connecttosupport.org/
Support for families and carers	Support for families and carers of children and young people (up to 25 years) with special educational needs and disabilities (SEND) is offered by the **Parents' Forum for Bradford and Airedale**. The **Carers' Resource** service provides support for carers who are defined as people who, without payment, provide help and support to a friend, neighbour or relative who could not manage otherwise because of frailty, illness or disability
Workforce training: (new)	• Introduction to Neurodiversity – all staff • Working with autistic people – social workers who work directly with people with autism; • Level 3 Certificate in understanding Autism (A level equivalent), which once complete will have trained 20 social workers – the course commences in September, • 48 places on a virtual Autism experience bus. This is an immersive training experience to allow participants to understand how autism affects people day to day and how to make adjustments to support autistic people. <u>Outcomes for training</u> • All staff are aware of autism and neurodiversity and how it might present in work, at home, in care settings and the community; Identify practical strategies to support neurodivergent individuals in a range of day to day situations; Understand how to support neurodiversity people and make reasonable adjustments • Staff who work directly with autistic people understand what Autism is and the varied presentation of autistic people understand the main characteristics which lead to a diagnosis of Autism; Understand the range of difficulties and challenges that autistic people can experience in everyday life; Have an understanding of policy and legislation that underpins good practice; Understand how to make practical adaptations and adjustments to make services accessible to autistic people
Supported Employment: (new)	• BDMDC has been awarded grant funding bid from DWP of £350k funding for a local supported employment initiative (LSE) for people with autism. • This new service will support 100 Autistic people into paid employment over the project which will commence next month and is funded until March 2025. <u>Supported Employment Initiative:</u> • Using a structured 5 stage supported employment model support 100

	autistic people into sustainable paid employment; provide a job coach to work with individuals through the entire process of gaining employment; to support employers with reasonable adjustments, understanding the needs of autistic people and how they can be an asset to their business; at the end of the project have a sustainable model and robust evidence base to extend the programme post 2025

Sacar/Specialist Autism Services, delivering post-diagnostic and non-clinical support for adults with ASD

Autism Engagement	• Increase opportunities for adults with an ASC across the district (social skills training) • Support social engagement • Support health and wellbeing • Increase awareness and understanding • Support to parents / carers of adults with an ASC by providing respite and encouraging independence / skills development
Autism Works	provides a tailored supported employment programme to increase confidence, employability and overall health and well-being • Includes peer support , passport to work , work orientation visits, volunteering, paid work opportunities etc • Supports health & wellbeing – person centred reviews, evaluate progression and development. • Increases the overall confidence of adults with an ASC through increased social skills, employability, social inclusion and independence.

This plan will be shared with a number of BDC HCP boards between August and November 2022

Board	Date	Outcome
Performance and Commissioning Forum	01/08/2022	Supported
System Quality Committee	23/08/2022 and 03/2023	Supported
Place Leadership Team	28/09/22 and 3 monthly	
HSCOSC Committee	06/10/2022 and 02/2023	
System Finance and Performance Committee	27/10/2022	

4. Options

Members may wish to comment on the revised plan for a sustainable BANDS adult autism service and to endorse the application for recurrent funding to the System Finance and Performance Committee.

5. Contribution to corporate priorities

This plan supports the BDC HCP priority; Parity of esteem for access and outcomes for people with Learning disability / neurodiversity

6. Recommendations

6.1 Members are asked to note the revised plan for a sustainable BANDS adult autism service which responds to issues of recruitment difficulties, referral issues and rapidly increasing demand

7. Background documents

- None

8. Not for publication documents

- None.

9. Appendices

Appendix 1 Projected activity for 100 assessments project
Appendix 2 Letter to patients re next steps
Appendix 3 BANDS adult autism assessment process
Appendix 4 Summary of Adult Autism monthly dataset report, Nov. 21 to July 22
Appendix 5 BdC ND Project Plan

Bradford Autism Project Outline Flow 2022

This plan is contingent on recruitment to posts:

Physician Associate recruited to post.	Complete
Assistant Psychologist interviews 11/07/2022	Complete

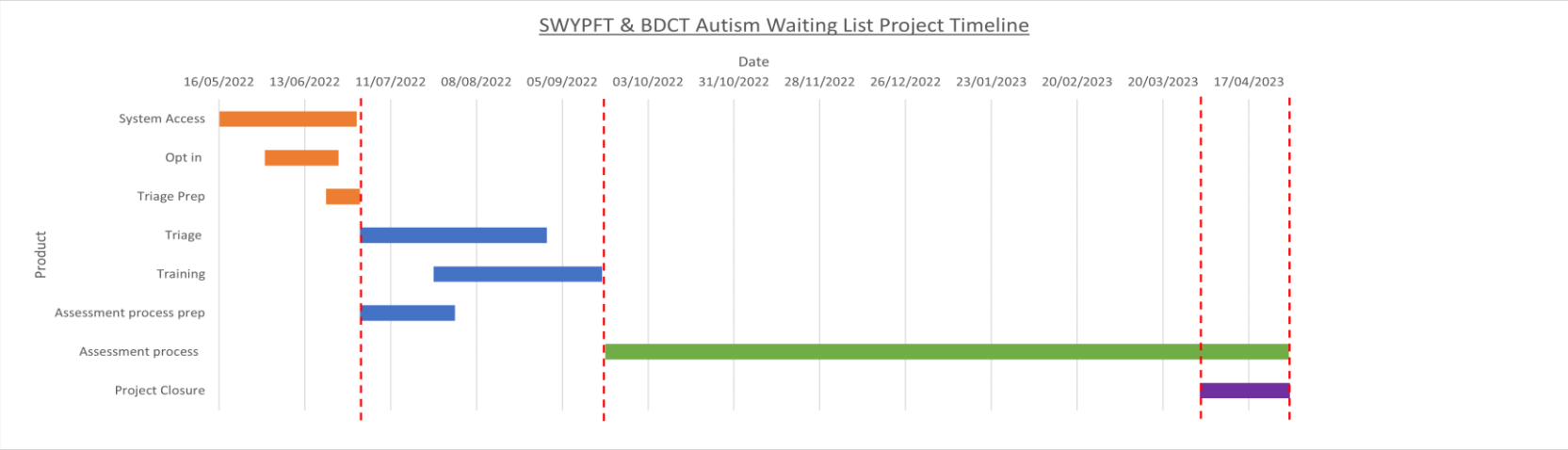
Assumptions:		51%	61%		
		Screening	ADOS	Further Ax	Clinic hours	Clinic days
		50	26	16	276	46
DNA	110%	55	29	18	306	51
Leave	120%	66	35	22	369	62

4 Week period	Screening	ADOS	Further Ax	Clinic hours	Clinic days	
1	8	0	0	24	4	Starting Phase
2	8	4	2	42	7	
3	8	4	2	42	7	Building Phase
4	8	4	2	42	7	
5	8	6	4	54	9	
6	8	6	4	54	9	
7	8	6	4	54	9	
8	8	6	4	54	9	Optimum Phase
	64	36	22	366	61	

Starting Phase	Week 1	Week 2	Week 3	Week 4
Physician Associate	2	2	2	2
Clinic days needed	2	2	2	2

Building Phase	Week 1	Week 2	Week 3	Week 4
Physician Associate	2	2	2	2
Assistant Psychologist	1	1	1	1
Diagnostician	1		1	
Clinic days needed	2	2	2	2

Optimum Phase	Week 1	Week 2	Week 3	Week 4
Physician Associate	2	2	2	2
Assistant Psychologist	1	2	1	2
Diagnostician	1	1	1	1
Clinic days needed	2.5	2.5	2.5	2.5



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What happens when I'm referred for an adult autism assessment

1. You have been referred for an adult autism assessment

2. You will be invited to a face-to-face appointment to gather more information for your referral. This will take about 30 minutes

3. The adult autism service check the referral to see if:
   a. You already have a diagnosis
   b. There is enough information from the GP or social worker
   c. The information suggests you MAY have autism

4. If it looks like you might have autism, you will be sent a pack with questions to answer and send back.

5. An autism specialist called a 'screening clinician' looks at your answers and invites you to have a chat with them. This may take place over a few appointments. This part is called information gathering.

6. The autism team look at all the information together and decide what the outcome is. The outcomes will be either:
   a. They're not sure and need to investigate a bit more
   b. Yes, you have autism
   c. No, you don't have autism (they might suggest you have a different condition)

7. The autism team will let you and your social worker or GP know the outcome. They will both tell you what support is available if you want it.

JOB NO 2731 AUG 22

In partnership with:
Bradford District Care NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust
Leaflet co-produced by Kirklees Autism Group

With **all of us** in mind.

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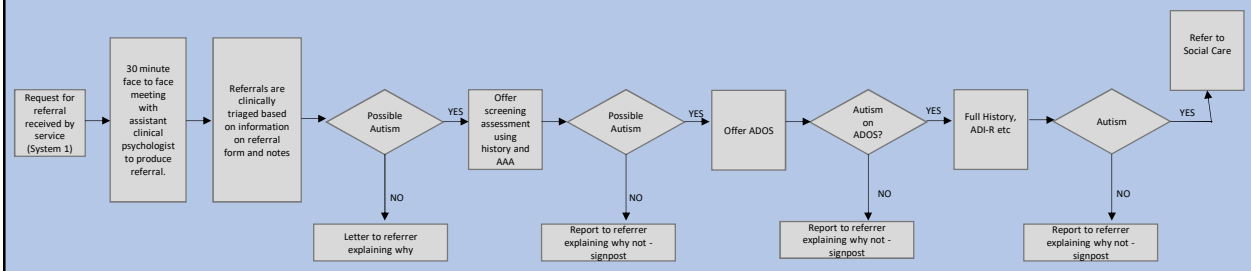
NHS South West Yorkshire Partnership NHS Foundation Trust

Bradford District Care NHS Foundation Trust

BANDS - Adult Autism assessment process:



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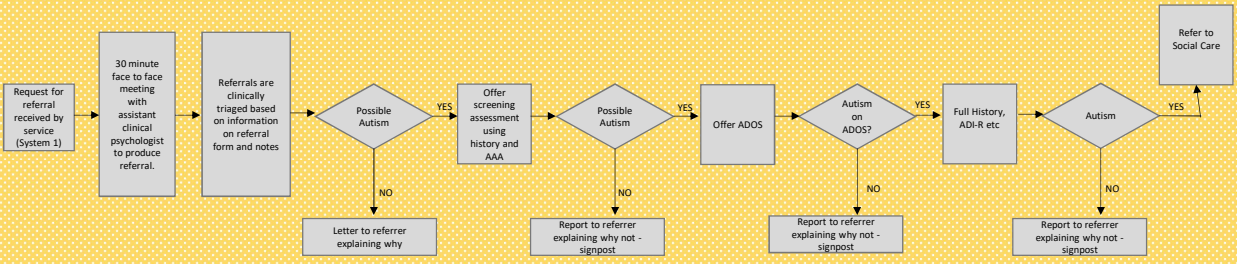

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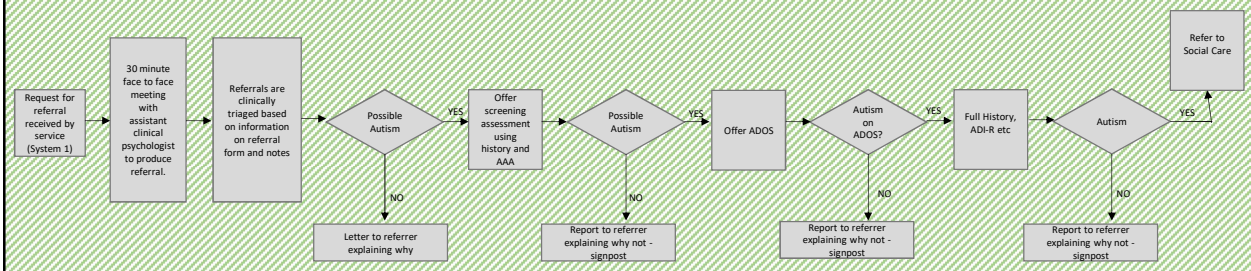

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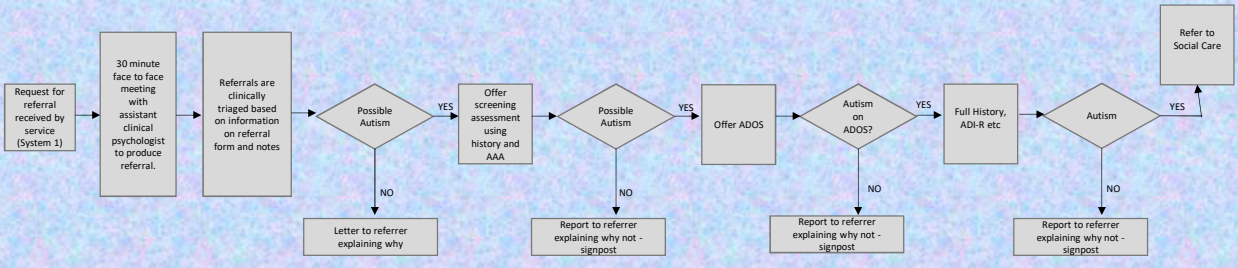

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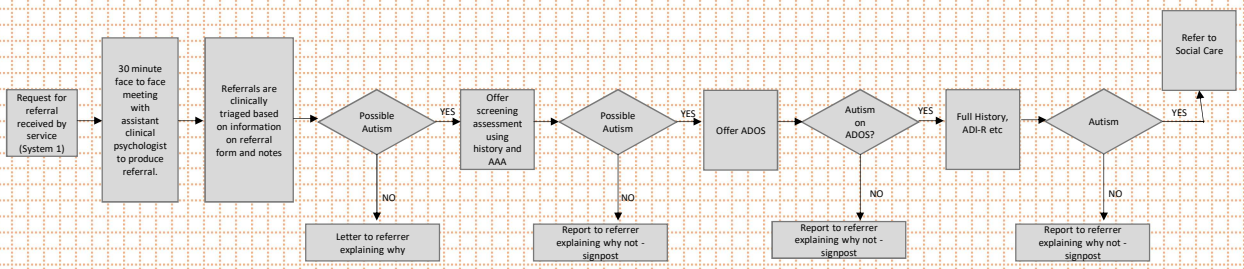

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Autism Diagnostic Assessment monthly totals

Metrics	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
No referrals received	41	35	48	40	57	43	59	33	26
No of referrals accepted	22	26	35	29	34	28	44	30	18
Referrals rejected (breakdown of reason)									
Refused By Service	16	8	12	9	21	10			2
Inappropriate Referral	1	1		2	1	2	8	1	1
No of people waiting for first Appointment	237	260	290	324	346	364	421	444	439
No of people receiving first appointment in period	3	5	2	1	8	3	-	1	
No of people waitiing for Diagnosis	243	267	297	332	357	366	421	445	440
Number of patients receiving confirmed diagnosis of autism	0	1	1	0	1	8	1	-	
Number of patients receiving a diagnosis of no autism spectrum disorder	3	4	2	2	0	4	0	-	
Average time waited from referral to diagnosis of autism spectrum disorder (days)	-	479	509	-	519	557	566	-	
Source of referrals (Breakdown)									
General Medical Practitioner	40	34	46	40	48	32	42	29	26
Internal Referral	1	1	2		2	3			
Patient/Parent					7	7	17	4	
self						1			

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ID	Activity	Responsible	Start Date	Planned Completion Date	Comments
Project Plan (Timeline) for Adult Autism					
1 - Adult Autism	**Partnership:** SWYPFT and BDCFT to work in partnership to a 4 point plan a. provide emergency support to BANDS. Review the backlog of referrals. b. Support with the BANDS waiting list. SWYPFT contributed 50% towards taking 100 patients off the BANDS waiting list. c. Build up BANDS; advertising to joint posts based on core funding already available to BANDS; agree an operational model d. Expand BANDS - demonstrate a track record of success in the first three steps and develop a business case for sustainability	WON/KB/MA	13/12/21	30/09/22	**16/02/22;** WON updated re SYFT **23/02/22;** CCG have discussion booked with SWYFT DOF to discuss plan KF has updated plan for use of Transforming Care funds **16/03/22;** Agreement made for 100 assessments, including triage Initial plan shared to implement SWYT service **25/04/22** WON shared update - Action: WON to invite SWYT to future meeting to share plan for delivery of 100 assessments. **22/06/2022** Wanting to see progress now on the 100 assessments. Marios to be added to this group from next week. Mel Pickup wants numbers regarding SWYFT.S1 and assist referrals, only referrals can be done on S1. **29/06/2022 Action:** Kelly to email Bernard/Marios to create a timeline around activity/progress. **17/08/2022** Ellen from SWYFT shared costings with Walter around model of service and take 600 referrals per annum. Phase 1 is recruit 2 staff and have a waiting list of 50 pa, 2nd phase appoint a B7 also and this will remove need for patients to go on a waiting list. **Action: Walter/Kelly/Finance to arrange meeting to look at and review figures.** Additional step to process introduced - short face to face meeting to improve quality of referral. Deliver service from Hillside Bridge.
1a - Adult Autism	Partnership: a. provide emergency support to BANDS. Review the backlog of referrals.	WON/KB/MA	01/06/22	30/09/22	**10/06/2022;** 70 referrals shared to be looked at. **13/06/2022;** Marios checked the first 30 Autism referrals from BANDS and the referral management process is working fine. Marios will ask our Consultant Clinical Psychologist to take over this so we will be catching up quickly with backlog. Otherwise, the referrals are of extremely poor clinical quality The interphase between the BANDS pathways needs improving; there are letters of BANDS ADHD asking GP to make a referral to BANDS Autism. **15/06/22:** 50 referrals now checked **17/08/2022:** providing leadership cover for BANDS and referral management cover. Work to improve processes and have meetings with local stakeholders.
1b - Adult Autism	Partnership: b. Support with the BANDS waiting list. SWYPFT contributed 50% towards taking 100 patients off the BANDS waiting list.	WON/KB/MA	01/06/22	30/09/22	**08/06/2022** Bernard updated SWYFT have S1 access but need access to where waiting list is should be sorted this week. SWYFT writing to 100 people on the list and to see if they still want an assessment, giving them 2 weeks to respond. (SWYFT believe only 50 will respond if this is the case they will take another 50 and do the same. **15/06/2022** SWYFT waiting list S1 access has been resolved. Marios made a start, Referral form wants changing, shouldn't take long to change the template. Marios made clear point that our referral process was poor. Kelly talked about the contractual position, may need MOU agreement in place as its just moving the same money around but in a new way not new money. MOU between CCG and SWYFT.Marios is triage new patients now as well, 70 on waiting list he has taken 30 of them already, checking and then passing onto his psychologist for handover, will just continue to do this going forward. Regular admin meetings are ongoing. 20/06/20; contract finalised **28/06/22;** update from 100 letters sent from the waiting list. 74/100 people have opted in to triage. 23/100 did not respond so will be discharged. 3/100 were discharged due to being OOA or an inpatient. **Next Step**; BANDS admin to send another batch of letters from the waiting list until we hit the number 100. Then we can start our Triage. **4/7/22:** Project Activity Plan shared (see Tab 4, Capacity Plan 100) **08/07/2022** Group reviewed and approved a leaflet SWYPFT will send to patients referred for appt **17/08/2022 :** on track and recruitment for this has been completed. From this 126 people were removed from the BANDS waiting list and 100 are waiting triage before we end up with 50 appointments. Option to introduce a new step to our pathway to ensure better quality referrals. Service ready to begin Sept 2022, from Hillside Bridge
1c - Adult Autism	Partnership: c. Build up BANDS; advertising to joint posts based on core funding already available to BANDS; agree an operational model **Recruitment:** From June 2022, plan agreed to recruit to posts in partnership between BDCFT and SWYPFT - Phase 1 1 x Band 8a Psychologist and 1 x Band 4 Psychology assistant	WON/KB/MA	13/12/21		**19/05/22:** Discussed with WON and Ali Jan, can confirm to Kelly and Bernard they can recruit with SWYFT for the BANDS roles - KF to notify - initial plan involves recruit only to roles to replace core roles, BDCFT need to give SWYPFT written confirmation of funding for those roles. **25/05/2022** Discussed the above. **Action:** Bernard to send SWYFT written confirmation regarding joint recruitment to posts. **08/06/2022 -** Bernard working with SWYFT to sort out the logistics and contractual arrangements of doing this jointly. This will include the 187k for 2 years. **24/06/2022** - Meeting to discuss joint recruitment of BANDS posts of 1 x Band 8a Psychologist and Band 4 Psychology **20/07/2022** - Marios update, Finishing draft job description, but on with it **17/08/2022** - Costings received from SWYPFT. total investment £166,752 per annum for Phase 1 recruitment and £77k per annum for Phase 2 recruitment
1d - Adult Autism	Partnership: d. Expand BANDS - demonstrate a track record of success in the first three steps and develop a business case for sustainability	WON/KB/MA	01/06/22	30/09/22	**17/08/2022** - Costings received from SWYPFT. total investment £166,752 per annum for Phase 1 recruitment and £77k per annum for Phase 2 recruitment
2 - Adult Autism	**Performance;** Monthly BANDS dataset report	WON/KB	13/10/21	On-going	**25/05/2022** GK to receive dataset and then share with group on monthly basis. **29/06/2022** Set-up Meeting with both BI teams (Walter/Bernard/Darren/Raj) to discuss requirements **06/07/2022** Won requests the dataset start to include the work SWYFT are doing - Triage/Letters going out and numbers dropping off due to no replies. **18/07/2022** Meeting held with both BI data teams, to discuss existing datasets and new requirements. Raj to amend dataset and to include agreed amendments. **Action: GK to set-up follow up meeting - Won/Kris/Bernard/Darren/Raj.** **20/07/2022 - BH/Marios -** Discussed how to include the work done by SWYT into the dataset, used to be done manually but want it doing automatically. **Action Bernard to meet and see how this can be progressed. Need to show how many people, month by month, will come off the waiting list.** **06/09/2022: Won/Gareth/Darren/Ellen met to discuss including SWYFT data into the monthly data reports.**

3 - Adult Autism	**Governance:** T&FG continue to meet weekly to plan, manage and review service development	WON/GK	22/11/21		**26/01/22**; capacity issues impacting on consistent BDCFT attendance A Taylor, CBMDC joined group S Leonard, CBMDC to be invited to attend group **9/2/22**: additional BDCFT and CBMDC reps have joined group **20/07/22:** Angela added Carine Baker (Commissioning manager Autism/ND) to join T&FG.
4 - Adult Autism	**Governance:** Senior overview and support to be provided by T Patten, D Sims and AJ Haider	AJH	13/12/21		**First meeting Jan 2022** **3/8/22** - suggest meeting to plan for HOSC **17/08/2022** Meeting is going ahead later today
5 - Adult Autism	**Referral Pathway** Adult ASD referral Pathway and GP Assist Pathway clarification update from WON. Support referrers with ASD awareness training	WON/BH	23/02/22	31/03/22	**16/03/22** Top Tips has been sent to Val ? (GP) There is a recorded session on website and training material has been produced. Action: Bernard will identify key materials and WON will circulate to GP practices through links **27/4/22** Discussions started to place referral on GP Assist - KF leading **22/06/2022** Info circulated by WON via email after meeting **29/06/2022** Won update meeting with JP last week, discussed BDCfT not using GP Assist but reasons unclear why not. Action: Kelly to check with Tom Rycroft. **20/07/2022** Update from JP about GP assist and S1, can help with the new form to auto-populate and make it easier for GPs when referring. Sara Humphrey now involved in discussions to help and link with GPs. MA/WON/S Humphrey met to plan and develop GP Assist pathway and support for referrers **3/8/22;** New referral form to be placed on System1 Follow up meeting booked for 28/09 to build Adult Autism Pathway on ASSIST. WON has requested J Parkinson to raise a ticket for development work on GP ASSIST
6 - Adult Autism	**Complaints**	KF/KB	12/01/22	On-going	**27/4/22 Action:** WON has responded to a recent complaint and will share narrative with KB. BDCFT and CCG Complaints teams to be copied in and request to liaise for any future complaints.
12 - Adult Autism	**ICS ND Deep Dive:** Engage with ICS work to explore system approaches to ASD assessment and diagnosis	T&FG	13/12/21	Ongoing	**23/02/22;** BDCFT and CCG reps attended ICS Adult Neurodiversity Planning Session **27/04/22**: BANDS and CCG reps will self nominate for ICS Deep Dive Steering and Operational Groups. Action: KF to share S Russell email re Deep Dive **3/8/22:** Programme Update **WY Violence Reduction Unit** - has received £5.8m funding https://www.westyorks-ca.gov.uk/media/8513/report-neurodiversity-and-violence.pdf Unit has been researching 4 key areas around young peoples with ND experience of violence - findings and recommendations shared - clarity of ND terms, further research and training **Initial WY data shared -** each place will have a meeting to confirm data **-** increase in all referrals accepted of 84% over 6 months - request for programme to address a consistent approach to reporting **Reciprocal Mentoring:** Nadia Hussain - learning partners, not mentor, mentee - **Dates for Workshops shared from Deep Dive for Right to choose – 13/10/2022 and Adult assessment pathway – 17/10/2022**
13 - Adult Autism	**Pre and Post Diagnosis support** Clarify pre and post-diagnostic support and resources Link with PCN Social Prescriber	BH/AT	13/12/21	Ongoing	**3/8/22 PPDS T&FG formed** - members Stacey Thomas, Carine Bake, W O'Neill - and workplan drafted 1. Map current support service – carine - add to the ND Pathway 2. Identify gaps 3. Draft proposal for VCS led support services or individual workers 4. Produce a local proposal QON met with C Brauns re Social Prescribers - need to raise awareness and provide training to SPs re needs of adults with ND **17/08/2022** WON/CB/SL visiting SAS/SACAR on 24/09/22 to gather information re services provided CBMDC have commissioned a range of training for our workforce: o 1. Introduction to Neurodiversity – all staff, o 2. Working with autistic people – social workers who work directly with people with autism; o 3. Level 3 Certificate in understanding Autism (A level equivalent), which once complete will have trained 20 social workers – the course commences in September, o 4. 48 places on a virtual Autism experience bus. This is an immersive training experience to allow participants to understand how autism affects people day to day and how to make adjustments to support autistic people. • In May we submitted a grant funding bid to DWP for £350k of funding for a local supported employment initiative (LSE) for people with autism. We were notified this week that our bid was successful. This new service will support 100 Autistic people into paid employment over the project which will commence next month and is funded until March 2025.
15 - Adult Autism	**Stakeholders - Update and present to:** A. Update Performance and Commissioning Forum - 01/08/2022 - Complete B. Update System Quality Committee - 25/08 C. HOSC Chair's briefing Weds at 1530 31/08 D. System Finance Deputies 14/09 D. Place Leadership Team - 28/09 and 3 monthly E. HOSC Committee 06/10 and Feb 2023 F. SF&P 27/10			Ongoing	**18/05/2022** - Walter and Kelly to meet and discuss. **25/05/2022** Ongoing still **22/06/2022** Plan changed so may need to update HOSC, wait until called back **29/06/2022** Action: Won to draft an updated document and share with KB. **06/07/2022** Won has created slide to present to HOSC **20/07/2022** Update HOSC in September meeting, will be a good time because we can show the early progress and numbers coming off the waiting lists. **17/08/2022** Will include user stories for Autism once we can get patient feedback from the new pathway.
20 - Adult Autism	**Finances**	All	29/06/22	Ongoing	**29/06/2022** - Create Finance schedule, All agreed use Transformation monies first, then use core funding to support other functions to help the service once they are identified. **20/07/2022 -** Meeting to arrange for Kris/Kelly/Walter/Marios **17/08/2022 -** SWYPFT have shared costings for new model - Kelly and WON to meet with BDCFT finance

22 - Adult Autism					
23 - Adult Autism					
24 - Adult Autism					
25 - Adult Autism					
26 - Adult Autism					
COMPLETED					
Adult Autism	**Outsourcing;** Engage with IS sector re outsourcing	WON/KB	13/12/21	COMPLETE	**WON to share outcomes from engagement** **28/01/22**; Engagement outcomes shared Some issues with use of available NR funding - Finance to discuss **9/2/22:** WON shared outcomes of engagement and finance discussions Action: BDCFT to engage with independent providers identified **25/04/22** WON shared update - **Action:** WON to invite SWYT to future meeting to share plan for delivery of 100 assessments. **18/05/2022** - SLAM offering a national referral for adults with ADHD / Autism, GK to arrange meeting GK emailed adhdasdadmin@slam.nhs.uk to set-up meeting. **25/05/2022 -** GK/WON meeting with SLAM on 27th May to discuss referral pathways - https://slam.nhs.uk/referrals-adhd-and-asd **27/05/2022 -** SLAM FT stopping their national referral due to local demands on their services, will keep us updated if this changes in the future. **20/07/2022** - project team decision to stand down outsourcing adult autism option to focus on partnership with SWYPFT- will move the 50 autism cases from Clinical partners and give them 50 more ADHD cases to work on. **08/07/2022; BH continues to meet monthly with CP. Agreed to increase to 250 patients. First step will be screening letter to people on waiting list. BANDS reviewing waiting list for complexity and co-morbidity - retain these within BANDS. CP cant access S1 - referral forms will be sent securely. Assessment process reviewed and approved . Mobilisation 1 Sept to 31 March.**
Adult Autism	**Estate** Provide suitable estate in Bradford for the SWYT team x 2 days weekly	WON		20/07/2022 COMPLETE	**18/03/22** Enquiries made to Bilton, Westbourne and Hillside 27/04/22: Hillside Bridge now preferred venue - Action: WON to book **25/05/2022** WON to book estate at Hillside Bridge
Adult Autism	Direct management support to be provided to service	DS/TP		20/07/2022 COMPLETE	**9/2/22**: Band 8b x 1 FTE to be introduced, at risk to BDCFT, to support BANDS **16/02/22**: some clinical leadership included in Psychology role - B7 operational manager role also to be introduced
Adult Autism	Self referral pathway to be introduced	KB	13/10/21	COMPLETE	**16/02/22;** has completed testing and link available to be added to BANDS website. Ready to go live from 1/3/22. WON will support sharing comms/Top Tips with GPs. Dr Val Wilson has been involved **16/03/22** Self referral is now live on BDCFT website **27/4/22** Discussions started to place referral on GP Assist - KF leading **18/05/22** SWYFT/IP's/SLAM don't offer self referrals, need to consider closing the self referral pathway and putting
Adult Autism	National Autistic Society	SL	25/05/22	Complete	**25/05/2022 -** Everyone was in agreement to ask NAS to help identify and map - Action: SL to set-up meeting with NAS **20/07/2022 -** Group agreed meeting no long required with NAS.
Adult Autism	Set-up Adult Autism Action Plan/log, with a new operational/strategic group. (Doing similar action for Adult ADHD)	WON/KF	22/06/22	Complete	**22/6/2022** Adult Autism action plan and adult ADHD action plans required, task and finish group to continue, but also set-up an operational/strategic group. Mel Pickup and Mark Hindmarsh to report issues to PLE because neurodiversity is now on the list of our priority areas, want to assign a main contact to lead on this. MH LD and neurodiversity board mentioned but not sure if there is a group set-up. Comms keeping in touch with people whilst they are waiting to be seen. **29/06/2022 -** Discussed above, may appoint VCS company to help people with daily life whilst on waiting list. discussed Healthy Minds website and updating this. **Action: Angela to follow up with Stacey about new Local Offer Officer (Nigel Hammon).**
Adult Autism	Bi-weekly meetings to be set-up for 1 hour, incl. Marios and his team to meetings.	GK	29/06/22	Complete	**29/06/2022** - Action: GK to arrange new 1 hour meeting slot every 2 weeks on Teams, Marios and his team to be included. **08/07/2022** - New bi-weekly meeting set up, Wednesday 2pm from 20th July onwards - Teams invite sent out to everyone.
	Prescribing				**08/07/2022 -** Issue re number of people requiring prescribing and may need to start a waiting list. Dr Makunden requests support from GPs in prescribing - WON to discuss with Dr S Humphrey

Project Plan (Timeline) for Adult ADHD

ID	Activity	Start Date	Planned Completion Date	RAG	Comments
1 - ADHD	Identify non recurrent funding to support short-term improvement to waiting times				£250k released from 2021/22 BDCFT underspend Potential additional £130k from same source Enquire if NHSE development funds can be used to support both ASD and ADHD.
2 - ADHD	Engage with independent sector re outsourcing – capacity and cost				BDCFT subcontracting with Clinical Partners for 200 ADHD assessments - To be completed September 2022 to March 2023 Engagement with IS and NHS providers is ongoing BH updated about Clinical Partners, data sharing agreement in place, working on getting referrals to them and other processes, beginning of the process to be confirmed in next meeting with BH/CP. **22/06/2022** BH Update ADHD meeting fortnightly with clinical partners to look at process, contractual agreement drawn up and processes in place, different approaches, starting 1st September and sorting pathway and how passed back, yearly review. Clinical partners unease about GPs accepting returned, shared agreement may go in place so they sit with BANDS still under the yearly review. Clinical partners have got worded document from previous work with other NHS Org. Bernard to share with Walter once he gets this communication letter. referral form revised and then onto assist would be great. **29/06/2022 -** Invite Diane Daley to future BANDS meeting - **Action:** Kelly to ask Diane. **17/08/2022 -** Bernard met with clinical partners, opt in letters sent out, 100 and further 150 to follow shortly (250), finalising the contract and costs. Hoping to start in September with patients been seen.
2 - ADHD	Identify recurrent funding to support short-term improvement to waiting times				Develop a business case for better use of Right to Choose costs - approx. 100k p.a.
4 - ADHD	Recruitment to increase BANDS, ADHD, capacity				level of funds available to be confirmed 08/07/2022 BH shared proposal to recruit a Junior Dr to support the ANP it initiate and titrate meds, and 1 year review, up to 31/03/2023
5 - ADHD	New BANDS, ADHD dataset and monthly report to be implemented				New dataset and monthly report now in place . Review and improve dataset. 20/07/2022 Meeting with performance reps, to understand and improve ADHD dataset
6 - ADHD	Build on partnership with SWYPFT ADHD Service				Identify and implement best practice
7 - ADHD	Engage and input to WY ICS Neuro Diversity Deep Dive				Learn from best practice and implement a long term, sustainable and consistent service model across West Yorkshire
9 - ADHD	Senior overview and support to be provided by D Sims, AJ Haider and PLT				First meeting Jan 2022
10 - ADHD	Patients Right to Choose				Guidance to be shared with GPs regarding patients right to choose referral to IS providers 16/03/2022 Guidance regarding right to choose with ADHD shared with GP Practices
11 - ADHD	Prescribing				Clarify responsibilities between referrers and BANDS, inc. Shared Care Agreements **03/08/22;** Issue flagged of capacity/demand re prescribing - request for support from GPs to continue prescribing until slot available for titration. **Action** WON to facilitate engagement with GPs. **17/08/2022**: Won updated about others in the area, Leeds waiting list then another list for prescribing. Look at the shared care agreement and see how we manage the pressures from a system wide position, along with Sarah Humpreys.
12 - ADHD	Post- diagnostic support				Clarify patient wants and needs . Identify community based support.
13 - ADHD	Set-up a new ADHD operational/strategic group. (Doing similar action for Adult Autism)	WON/KF	22/06/22		Initial workshop, with clinical engagement, held 13/05/2022 Joint ASD/ADHD project group commenced 22/6/2022 Adult Autism action plan/logs and adult ADHD action plan/logs required, task and finish group to continue, but also set-up an operational/strategic group. Mel Pickup and Mark Hindmarsh to report issues to PLE because neurodiversity is now on the list of our priority areas, want to assign a main contact to lead on this. MH LD and neurodiversity board mentioned but not sure if there is a group set-up. 20/07/2022 Group set-up from 20th July, bi-weekly meetings
14 - ADHD	ADHD Dataset to be reviewed with BI teams and amend - Similar with ASD dataset.	WON/BH		Mid August	**29/06/2022 -** ADHD data confusing wasn't clear. clearer data to show increase and demand going forward to meet that demand - inputs/outputs. nonclinical support discussed create support pathway incl. role of LA. **20/07/2022** Meeting held 18th July with both BI data teams, to look at and amend data for future datasets. Follow up meeting planned early August.
15 - ADHD	Complaints	KF/KB			27/07/2022 Complaint received to Baildon MC and ICB, RTC David D'Arcy and Walter to investigate
16 - ADHD					
17 - ADHD					
18 - ADHD					
19 - ADHD					
20 - ADHD					
21 - ADHD					
22 - ADHD					
23 - ADHD					
24 - ADHD					
25 - ADHD					
26 - ADHD					
27 - ADHD					
28 - ADHD					
29 - ADHD					

Adult Autism Action Log

ID	Activity	Action Description	Status	Date Identified	Action Author	Action Owner	Priority Rating	Anticipated Delivery Date	Actual Delivery Date	Comments / Updates
a.1		National Autistic Society - Meeting to be set-up	Complete	25/05/22	Stacey	Stacey	Medium			on hold, public engagement linked thru WT deep dive. Group agreed meeting no longer required with NAS
a.2		WON to book 25/05/2022 WON to book estate at Hillside	Complete	25/05/22	Walter	Walter	Medium			Booked Hillside Bridge 23rd August to 31st March 2023, LGF33 Tues/Wed 9-5pm and Fridays 9-1pm
a.3		Set-up new Adult Autism operational/strategic group	Complete	22/06/22	Walter	Task & Finish group	High			Wednesday 2pm from 20th July - Bi-weekly meeting, GK sent Teams invite sent out ot everyone.
a.4		Clarify reasons for non-usage of GP ASSIST to support BANDS adult ASD referrals	Complete	22/06/22	Walter/Gareth	T&F group	High			James Parkinson to set-up meeting/training, attended meeting on 20th July to update.
a.5		BANDS Adult ASD referral form to be revised by BANDS/SWYPFT	Complete	22/06/22	Bernard/Marios	T&F group	High			New referral form done, need to replace the old form with the new one. Testing ongoing, once complete will remove old and replace with new form
a.6		Methods to improve quality of referrals from GPs to be explored and implemented	Pending	22/06/22	T&F group	T&F group	High			Sarah Humpreys to help and support with this
a.7		Mel Pickup/PLT want to see numbers regarding SWYFT	Pending	22/06/22	T&F group	T&F group	High			To see current levels and projected future demand on this service. 29/6 Kelly to email Bernard/Marios to create. Marios shared action plan
a.8		Funds for CICONIARECOVERY assessments	On-going	22/06/22	Angela/Kris	Angela/Kris	High			Was transformation funding for ADHD only? Or can we use it for Autism. Also check if funds are held with LA or CCG.
a.9		Dataset requirements - BI teams to meet up	On-going	29/06/22	WON/BH	Gareth	Medium			Monday 18th 11-12pm, GK sent teams invite sent out. Raj to change dataset and make agreed changes from meeting.
a.10	Recruitment	Complete agreement for roles and responsibilities	On-going	29/06/22	WON/BH	WON/BH				draft SLA shared by Walter, still on-going
a.11	Recruitment	Agree costs for posts	On-going	29/06/22	WON/BH	WON/BH				waiting on costs from SWYFT
a.12	Recruitment	Advertise and recruit	On-going	29/06/22	WON/BH	WON/BH				
a.13	Finance	Identify and track all available finances for ASD projects	Complete	06/07/22	WON/Kelly/KF/	Walter	High			set-up meeting for Won/KF/Kelly 4th Aug
a.14		Expand Pathway - signpost to difference VCS organisations to help people manage.	Pending	06/07/22	Corine/Stacey/V	GK	Medium			Carine/Stacey/Won meeting Friday 15th July to discuss
a.15		Presentation Slide created by Walter to present to HOSC	Pending	06/07/22	WON	Walter	Medium			WON has created a slide to present to HOSC

ADHD Action Log

ID	Action Description	Status	Date Identified	Action Author	Action Owner	Priority Rating	Anticipated Delivery Date	Actual Delivery Date	Comments / Updates
a.1	Set-up new Adult ADHD operational/strategic group	Complete	22/06/22	WON	WON	High	20/07/22	20/07/22	Neuro Diversity Group - Bi weekly from 20th July onwards
a.2	Enquire if NHSE development funds can be used to support both ASD and ADHD.	Complete	22/06/22	KR/AT	KR/AT	High			Funds cannot be shared
a.3		On-going							
a.4		On-going							
a.5									
a.6									
a.7									
a.8									
a.9									
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a.25									

Bradford Autism Project Outline Flow 2022

This plan is contingent on recruitment to posts:
Physician Associate recruited to post.
Assistant Psychologist interviews 11/07/2022

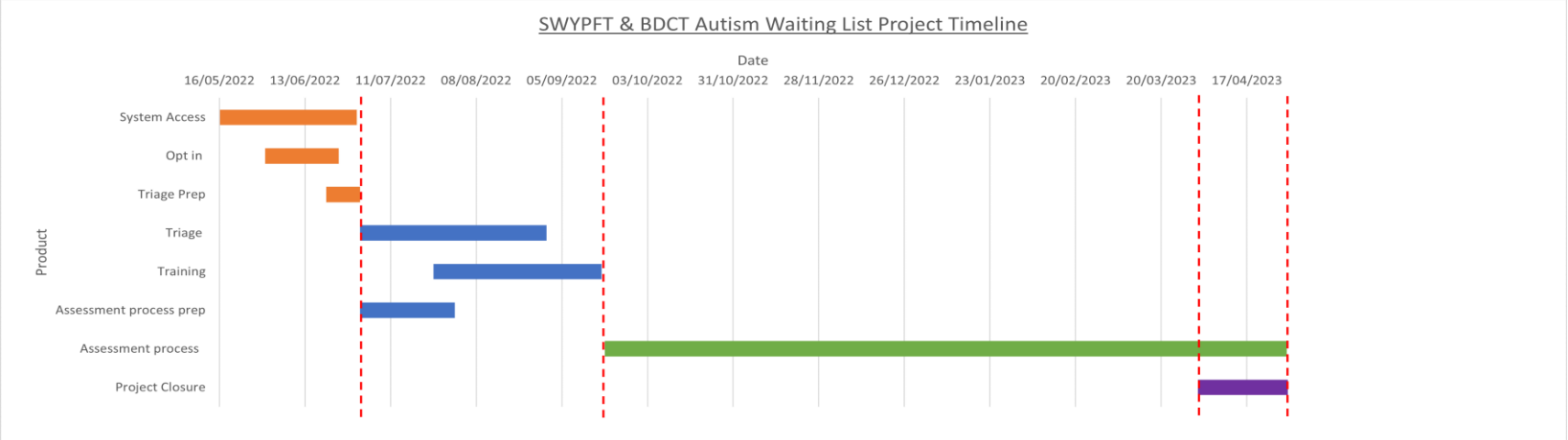
Assumptions:		51%	61%			
		Screening	ADOS	Further Ax	Clinic hours	Clinic days
		50	26	16	276	46
DNA	110%	55	29	18	306	51
Leave	120%	66	35	22	369	62

4 Week period	Screening	ADOS	Further Ax	Clinic hours	Clinic days	
1	8	0	0	24	4	Starting Phase
2	8	4	2	42	7	
3	8	4	2	42	7	Building Phase
4	8	4	2	42	7	
5	8	6	4	54	9	
6	8	6	4	54	9	
7	8	6	4	54	9	
8	8	6	4	54	9	Optimum Phase
	64	36	22	366	61	

Starting Phase	Week 1	Week 2	Week 3	Week 4
Physician Associate	2	2	2	2
Clinic days needed	2	2	2	2

Building Phase	Week 1	Week 2	Week 3	Week 4
Physician Associate	2	2	2	2
Assistant Psychologist	1	1	1	1
Diagnostician	1		1	
Clinic days needed	2	2	2	2

Optimum Phase	Week 1	Week 2	Week 3	Week 4
Physician Associate	2	2	2	2
Assistant Psychologist	1	2	1	2
Diagnostician	1	1	1	1
Clinic days needed	2.5	2.5	2.5	2.5



City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Strategic Director of Health and Wellbeing - Adult Services to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 6th October 2022

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Subject:

Home Support Review: Update and Commissioning Intentions

Summary statement:

This document provides an update on the Home Support Review, and an overview of the department's intentions to commissioning intentions

Iain MacBeath
Strategic Director of Health and Wellbeing

Alex Lorrison – Joint Commissioning Manager – OP PD SI
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Portfolio:

Overview & Scrutiny Area:

Health and Wellbeing

1. SUMMARY

This report provides an update of the Home Support Sector, the sector review and intended next steps.

2. BACKGROUND

Home support is the delivery of a range of personal care and domestic/community support services to individuals in their own homes. The support provided can range from a check to ensure that the individual has taken prescribed medication, for example, through to an extensive care package to meet their assessed needs including personal care i.e. support to get in/out of bed, bathing/toileting and meal preparation.

A report to the meeting of the Health and Social Care Overview and Scrutiny committee on Thursday 23rd September 2021 updated members on the current position for Home Support, including implementation of the Locality approach, the market landscape and national and local issues. It also referenced that a full system-wide review of Home Support was being undertaken with a view to developing creative solutions to delivering good quality, effective and affordable home support with the District.

Members requested an update on this review and a workshop.

3. REPORT ISSUES

3.1 Current landscape

The Home Support Sector remains challenging and remains a priority for the department. The following sections detail the additional measures that have been put in place to support the market over the last year and until the new contracts are in place.

3.1.1 Capacity Meetings

Weekly Home Support Capacity meetings continue to take place with key colleagues to assist with the flow of home support packages to the external market. This includes, Bradford Enablement Support Team (BEST), Support Options Team, Home Support Reviewing Team, Independent Advice Hub and Multi Agency Integrated Discharge Team (MAIDT), Operational Services and Commissioning and Contracts Team. More recently, membership has been extended to include Provider representatives from Bradford Care Association (BCA). Each meeting focuses on incoming and outgoing home support packages, key issues/analysis and support/possible solutions, along with key provider updates. Some specific work has included:

- Using available data differently so it is now possible to predict impending pressures on the system. For example, when the length of time people were being supported by BEST in Bradford South started to increase, this was identified early and resources targeted at that area.
- Improving the independent sector's access to equipment which means smoother, quicker and more successful discharges from hospital.
- Using funding from covid grants to pay enhanced rates over the winter and where there are additional costs incurred by the provider, to make the patch more attractive

- Giving grants to providers for innovative “quick wins” that would help them solve a specific problem they were having, enabling them to pick up more packages in localities where there were particular pressures, such as in Wharfedale (see Winter pressures at 3.1.6).
- Linking providers with local community groups to help them recruit people local to the area where the care is being delivered.
- Creating ‘rounds’ of care packages, rather than just passing on individual cases, which are easier for providers to fit within their current delivery and easier to staff as can be picked up by staff who do not drive. New use of mapping tools was developed to help with this.
- Working with providers to understand the specific issues in their area, for example when home care staff raised concerns about safety in an area, members of the group worked with Neighbourhoods to help manage some of those concerns.
- BEST sharing details of how they recruit staff with providers

3.1.2 Workforce

There are a number of approaches being taken to improve recruitment and retention into the sector; these are across the department, the BCA and the wider council.

- The BCA are working with the Council to develop a more strategic approach to recruitment. Initiatives to support recruitment and retention are being planned ahead of autumn and winter when service pressures are expected to increase.
- A new portal ‘Bradford Cares’ has been developed which encompasses both council and independent sector vacancies as well as providing wider information.
- Our links to colleges and universities have been strengthened, and we are targeting students (the next generation of workforce) about the benefits and rewards of working in social care.
- We have developed promotional videos featuring colleagues across the service, discussing their work and the opportunities available. There have been a number of recruitment events across the district, enabling potential candidates to talk to professionals about careers in social care.
- All of the BEST fleet cars are displaying magnetic advert plates promoting the service and to join our team.
- There are apprenticeship opportunities and casual contracts for flexibility.

3.1.3 Cost of Living

To support with the increase in cost of living, we have offered workers in the sector two different grants

- In March 2022, following a sharp rise in petrol and diesel costs, the Home Support Fuel Grant (HSFG) was launched utilising unused funding from the early NLW grants (through offsetting underspend from the Workforce Recruitment and Retention Fund and funding not claimed by providers). Providers received an additional 28p per hour to pass on to staff to help with fuel costs. A total of £269,534 has been awarded so far through this grant.

- In June 2022, the Council partnered with the Care Workers' Charity to provide funding small crisis grants to care workers living and working within the Bradford District area. The grants can help people working in the care sector who've experienced an unexpected cost with paying bills, rent, car repairs, replacing washing machines and other white goods as well as help for other costs. The purpose of the grants is to help people experiencing these unexpected costs to remain in the care sector. Further information is available here: https://www.thecareworkerscharity.org.uk/crisis-grant/

3.1.4 Fair Cost of Care

As part of the government's adult social care reform agenda, all local authorities are required to complete a fair cost of care exercise to arrive at a shared understanding with providers of the local cost of providing care. In addition, each Council is required to publish a Market Sustainability Plan detailing how they plan to move towards a fair cost of care over the next three years. As a Council, we have responsibility for understanding the costs providers incur in delivering care in a local area and this will be considered within any future fee setting approach and process.

Over recent months we have therefore undertaken a significant piece of work with Home Support providers completing a detailed financial position questionnaire for their individual services. Although this was not mandatory for providers to participate, we have had an extremely good return rate and is one of the highest for local authorities in the Yorkshire and Humber region. We are now in the process of developing our local Market Sustainability Plan for submission to the Department of Health and Social Care (DHSC) in October this year.

3.1.4 Bradford Council Enablement Support Team (BEST) and Home Support Reviewing Team (HSRT)

The BEST and HSRT teams are Council services and use a strength based approach to review and assessment, building on the person's own abilities and minimising the need for a commissioned home carer package. The team also oversee external cases and are working to ensure these are managed in a timely manner and that no one is over-supported. Work is also being done to identify where a person has a non-skilled care need and how to meet this, as well as development work to manage increases in a person's need and accurate, stream-lined billing. This should also support providers to be paid for additional work in a timelier manner.

3.1.6 Hospital Admissions and Discharge

Bradford is ranked highly for Delayed Transfers of Care (see section 3.2.3) and work by the Council Trusted Assessors team strives for continuous improvement. Working out of Airedale Hospital and Bradford Royal Infirmary, the team have put in new processes regarding hospital admissions of individuals who have a package of care with external providers. The Trusted Assessor teams at will be notified of the date of the hospital admission by the providers so they can support with timely discharge planning. This process will also support with some of the capacity issues all providers are currently experiencing due to recruitment issues and increased referrals.

3.1.7 Winter Pressures

In order to support the alleviation of Winter Pressures, a strategic, system-wide meeting with representatives from Home Support and Care Homes providers, the VCS CCG and Council Commissioning and Operations took place in November 2021. Here, proposals were discussed that focussed on improving in-hospital discharge into the Independent Sector through increasing capacity within services or improving workflow.

In order to increase resilience over Winter, additional funding was made available to

- Increase the hourly rate that Locality or ISF providers were paid so that they were on par with STEP, in order to encourage them to pick up short-term packages
- Increase the hourly around the Wharfedale area where were having difficulties moving packages on
- Pilot a new approach around Ilkley, using to cars and employing drivers to transport non-driving staff to and around the area.

This was funded from central Discharge to Assess (DTA) money provided by the DHSC, which stopped on 31st March 2022, but can be stepped again should the need arise and funding available.

Planning meetings to build resilience for winter started in the summer this year.

3.1.8 'Quick Wins'

Members of the Service Improvement Board for the Home Support Services alongside internal colleagues, to discuss any 'quick wins' that might be available via the council. There were a number of suggestions brought forward, and successes included, parking passes for Home Support staff (on par with District Nurses), access to volunteer–driven 4X4 vehicles for emergencies and sharing of staff benefits

3.2 Future Commissioning

3.2.1 Home Support Sector Review

Going forward, a complete rethink needs to be considered in order to address the long-term issues in the market. The starting point for this is to ensure that these are understood fully. Therefore, the department has been conducting a review of the Home Support Sector and which has recently concluded. The full details of this are available in a separate paper but covers the following areas:

- Current Provision and Performance - The current contracting arrangements, spend and commissioned hours (see report for full description)
- Current Demand and Trends – this is for both trajectories of demand and hours delivered but also workforce projections. (see report for full description)
- Consultation results - This involved extensive consultation with key system leads across Health and Social Care, providers and service users. This was used to pull together a rich picture of the issues and good practice in Bradford.
- Issues – national and local
- Good practice – local – which will be retained in the new model and we will continue to build on these in the run up to the new contract.

3.2.2 New Ways of working

The review also encompassed desktop research looking at new national models of care as well as speaking to other Councils both nationally and regionally.

The four areas below summarise the key new areas of working

Self- Governed Teams

- These are teams of care workers, based in a locality that focus on more person-centred care and with more continuous staff who can build up a relationship with the service user.
- The staff can work more flexibly to meet someone's needs, with the support they want or need able to change as they fluctuate, rather than sticking to a rigid schedule/ set amount of time each day or week. It is a move away from time and task, to more of a focus on outcomes for the individuals, and what is important to them.
- It will also incorporate a Community Led Support (CLS) approach and look to support people in their communities, including through non-paid for care and should further reduce travel time.
- This approach will also look at time-banking, permanent contracts, the removal of split-shifts.
- It offers more autonomy for both the service user and the care giver.

Integrated Teams

- These would be based in the community for which they provide support and be integrated Health and Social Care Team.
- These Locality boundaries are (for the most part) running close to Area Team boundaries.
- The level of joint working could differ from co-location to fuller integration.
- It will further strengthen the CLS approach and offer a more holistic, joined-up approach to the individual's health and care needs.

Skilled workforce/ career of choice

- This is reimagining the workforce so that the Home Support staff can be skilled–up/specialise in different areas. This may include some delegated nursing tasks that could command a higher hourly rate.
- It is hoped that this will help make social care a more attractive career, with clearer routes for progression and support other roles in the district where there is a shortage.

Technology

- This is either increasing the use of technology in the sector, freeing up staff time. It will complement the current workforce, it will not replace it.
- Electronic Call Monitoring (ECM), online training for staff, online access to care records to support service users
- It can offer the individual more autonomy, for example medication prompts, support at access telecare

Together it is likely that these will help us fully meet the requirements of the Ethical Care Charter.

3.3 Commissioning Intentions

Two workshops have been held with senior managers to discuss the findings of the review, what was felt to be the priorities for Home Support and tested the appetite for change. The four themes above are felt to be the future direction of travel for Home Support and works to Home First principles, Community Led Support and a strength-based approach. It was agreed that the new model had to be ambitious, but that the stability of the market was paramount in both the short as well as the long-term.

It was therefore agreed that a transformational contract approach be taken, with the current Locality approach broadly being retained, and a steady approach taken to build in pilots which will provide proof of concept, learn and refine before rolling out further in the district. This will be via a longer, transformational approach which will allow us to work together with providers to make changes incrementally without destabilising the market.

3.3.2 Proof of concept

It is proposed 3 pilots in the first years of the new contract to provide proof of concept which can then be rolled out to the wider district, reducing risk of large-scale change.

1) Time Banking of Hours and Outcome Focussed Plans
Providing flexibility to home support recipients to choose how and when their hours are used in line with the agreed care plan.
This will provide learning for self-managed teams

2) Shift System/ Established Contracts
Providers staff have permanent contracts and guaranteed minimum hours. Any 5 in 7 working is introduced to increase flexibility.
This will provide the foundation for self- governing teams and evidence for staff recruitment and retention.

3) Social Care Hub
Fully integrated teams, co-located in a specific geographic area comprising, health colleagues, DN's, PCN footprint, Physio, OT, SW. Local Single Point of Contact.
This will provide learning for integrated teams, self-governing teams and career of choice.

3.4 Engagement and Consultation

3.4.1 Service Users
We have randomly selected a sample of 400 service users and sent a service user feedback survey to them to gather their feedback on what they feel works well and what they feel could work better. The survey has been designed to try to capture the qualitative data we would usually obtain through service user led workshops. It is anticipated, based on usual survey responses, that there will be a 10-15% return rate which will give a representation approximately equal to the number who would attend a workshop discussion. The survey is currently open and responses are being collated ready for analysis which is due at the end of October 2022.

Going forward, we will involve Service Users in the design of the new ways of working, notably during the pilot phase where feedback from all parties will be critical.

3.4.2 Market Engagement

An Expression of Interest (EOI) has been published – this alerts the market to our intentions and allows us to discuss future commissioning. An engagement event has been scheduled for 27th September so that we can share information with providers as early in the process as possible and lay the ground for partnership working. It is essential that we work together throughout the process, and at this date we will set out full opportunities to shape the model.

3.4.3 Workshop with HSCOSC members add dates and future plans

A workshop has been proposed for the 27th October, following the update to HSCOSC, to share more detail on the new model of working and allow for a more in-depth discussion.

4. FINANCIAL & RESOURCE APPRAISAL

The Council continues to see a significant increase in spend in home support provision linked to increased demand as previously described. The review will consider the necessary finance and resource needs in detail and make recommendations for future provision.

It will take into consideration the outcome of the Fair Cost of Care ' People at the Heart of Care: Adult Social Care Reform White Paper'

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

The sustainability of the home support market is a concern at both a local and national level. There is a large focus on supporting the market to be able to meet the support needs of people in the district in the work of the Commissioning & Integration section in the Department of Health & Wellbeing.

The review and subsequent remodel will take into account the whole system around home support including Locality, ISF, DTA and reablement pathways.

6. LEGAL APPRAISAL

The procurement and implementation of Home Support services is to ensure the Council is meeting its statutory duties under the Care Act 2014, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Mental Capacity Act 2005, and to cater for future demand.

The Local Authority must also have regard to its public sector equality duties under section 149 of the Equality Act 2010 when exercising its functions and making any decisions.

7.1 EQUALITY & DIVERSITY

The Department will undertake an Equality Impact Assessment as part of the re-commission of Home Support where requirements necessitate and is incorporated into the specific work/procurement plan. All work undertaken will address issues of equality and diversity as they apply to protected characteristics groups.

7.2 SUSTAINABILITY IMPLICATIONS

The re-commissioning of home support services in contributing to sustainability strategies will be considered as part of the tender process to ensure that the Departments functions and services maintain their capability and quality through the transition process and beyond.

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

The proposal to retain specific small geographical localities will enable provider staff visiting people to reduce the organisations carbon footprint and emissions from a reduction in the use of vehicles. In some instances, staff are able and encouraged to walk between visits.

7.4 COMMUNITY SAFETY IMPLICATIONS

There are no community safety implications arising from this report.

7.5 HUMAN RIGHTS ACT

The Human Rights Act 1998 provides a legal basis for concepts fundamental to the well-being of older people and others who are in need of home support. The Act provides a legal framework for service providers to abide by and to empower service users to demand that they be treated with respect for their dignity.

7.6 TRADE UNION

Officers have liaised with the Trade Union (Unison) in respect of the implementation of Unison Ethical Care Charter which forms part of the new contract arrangements.

7.7 WARD IMPLICATIONS

There are no direct implications in respect of any specific Ward.

7.8 IMPLICATIONS FOR CORPORATE PARENTING

There are no Corporate Parenting issues arising from the implementation of the Home Support Locality Contracts.

7.9 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

Specific areas of GDPR and information security will form part of the tender and evaluation process. It is recognised that the transfer of personal data is significant.

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

None

10. RECOMMENDATIONS

We would welcome the view of members and their constituents either at the meeting or the following workshop in late October.

11. APPENDICES

Home Support Sector Review

12. BACKGROUND DOCUMENTS

Previous report -
https://bradford.moderngov.co.uk/ieListDocuments.aspx?CId=145&MId=7628&Ver=4

Dept. of Health & Wellbeing

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Service Review Report

Name of Service: Home Support

1. Introduction

Home support is the delivery of a wide range of personal care and domestic/community support services to people in their own homes. Support may range from a short visit to ensure that a person has taken prescribed medication through to a significant care package meeting assessed needs for personal care such as support to get in and out of bed, bathing/toileting and meal preparation.

People identified with an assessed need for home support provision will be eligible for the service. This includes older and those with a physical disability, sensory impairment, mental health or learning disability.

The majority of this support is delivered by the independent market, the exception being reablement. The contracts for these are due to end on 31 March 2023, therefore the department needs to now undertake a service review. The review will take into consideration the full range of home support currently available in the District, and will co-produced with partners, providers, people who use services, their families and carers.

2. Current Provision and Performance

Current Provision- Overall

Market

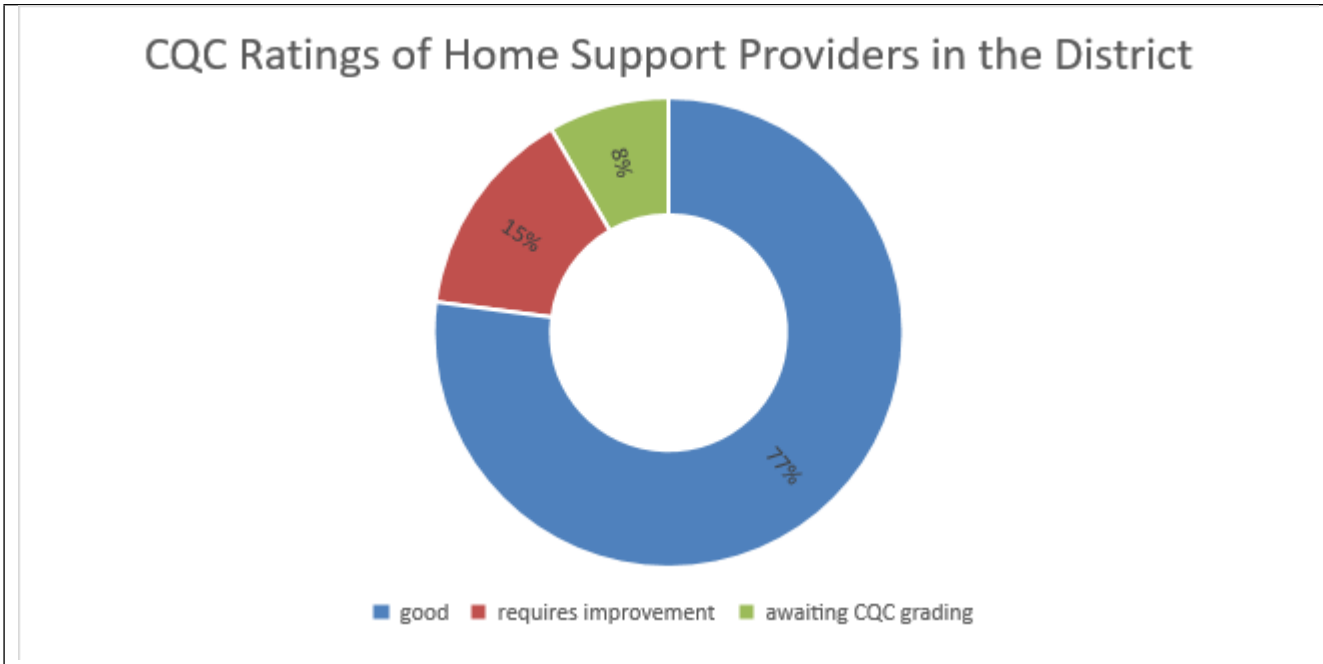
At present the contracts database shows 218 contracts/arrangements including locality are in place with 82 providers delivering against these. More detail of the different arrangements can be found below.

Spend and Hours

The total home support hours commissioned externally are: 28,364.75 (not including CCG, MH or LD). The total weekly spend is £549,000 (not including CCG, MH or LD) and estimated annual spend is projected at £28.6 million for 2022/2023.

Quality

The quality of services in Bradford District shows above the average for England for Good and Outstanding CQC ratings by 2%, with Bradford at 89.7% (England average is 87.7%). However, only a small number of providers in Bradford District have been subject to inspection in recent years, with five services being inspected and rated in 2021, and two services being inspected and rated in 2022 to date. The COVID-19 pandemic impacted on the regulator method of inspection, and which reduced the overall number of inspections taking place nationally- therefore the England average for Good and Outstanding homes may also change.



Data as of August 2022

Locality Contracts

In April 2019, home support locality contracts were introduced, which comprises of 35 geographical areas according to ward, population size and demographic data. These are currently delivered by 16 providers. The locality contract providers do not cover all support packages within their designated areas, for a host of different reasons, such as early contract implementation issues due to lack of TUPE transfers, existing service users not transferring across when provided with option to 'leave or remain', through providers already in place based on individual spot contracts, pre-existing framework call-offs or option to choose an Individual Service Fund 1.

Since the commencement of the locality contracts ten retenders have taken place. The majority of these retenders have been due to poor performance attributed to staffing difficulties, and with a small portion of providers leaving the market due to personal reasons or change in business strategy. All care packages have been transferred successfully without provider market failure but the challenges presented due to staffing i.e. leavers/sickness, has meant prompt timescales for undertaking tender and contract transfer.

STEP Contract

The council introduced Short Tern Enhanced Provision (STEP) contracts in January 2020, on a 2-year short term contract basis, to support the short term needs of people requiring early intervention and immediate home support assistance. Five geographical areas were created with five individual organisations delivering against each of these. At present, four out of the five areas have a provider which is due to one organisation failing to meet CQC regulatory requirements and the Council subsequently ceasing the placement of new packages/ withdrawal of existing packages.

STEP services have been consistently overstretched due to the high number of enablement cases and limited workforce numbers. This is applicable to all four areas with a STEP provider in situ. In addition, the commissioned services have operated on a task and time basis which has meant reliance upon a consistent volume of work however it has always been subject to frequent changes due to its pattern of increase/decrease by needs.

Alongside the introduction of the above STEP services, support with hospital discharge was also commissioned. This came in the form of two separate geographical areas delivered by two individual organisations, with each main hospital (Bradford Royal Infirmary and Airedale General Hospital) assigned a STEP provider. The utilisation of these services has been mixed as the Council's BEST/hospital team have been able to refer directly to the provider delivering support to people from BRI, whilst the provider delivering support to people from AGH only except referrals from health professionals based at the hospital.

IPSAC Spot Contracts* and ISF Framework*

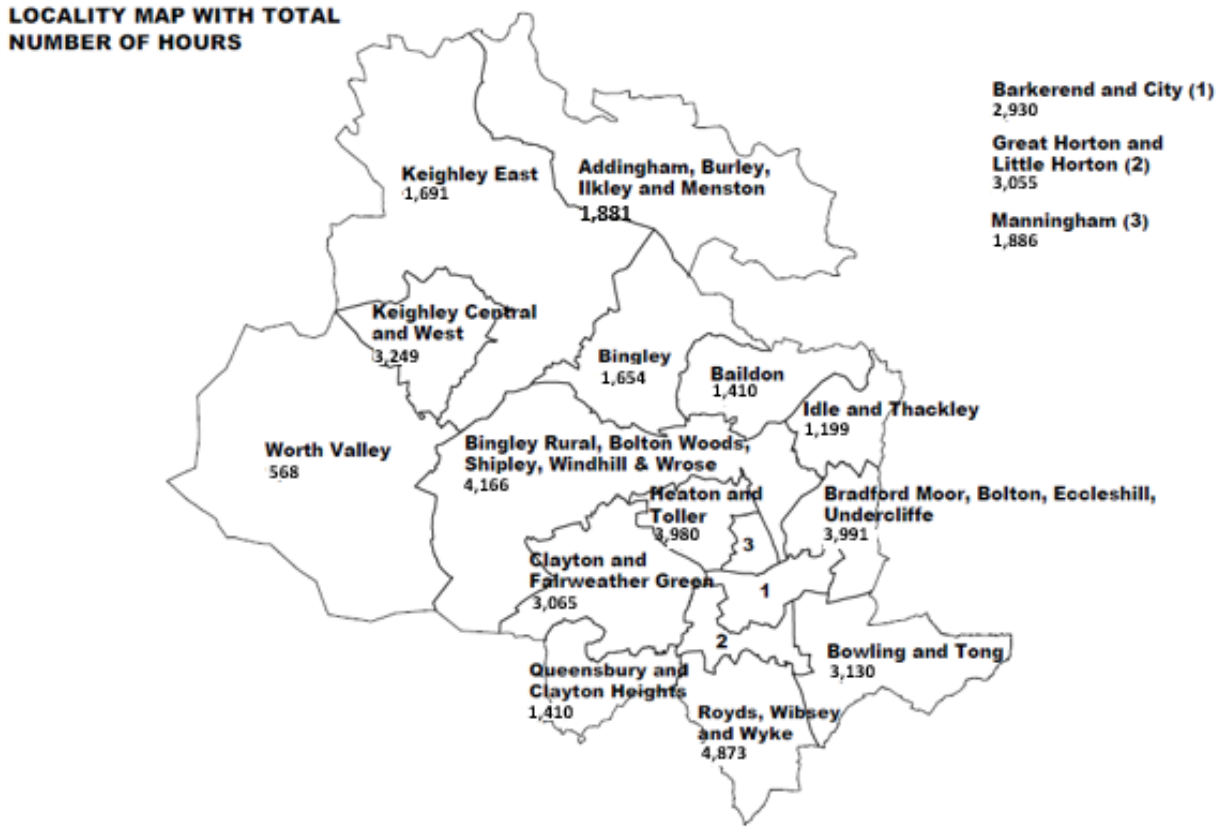
At the same time as introducing the Locality model, the Commissioning Team introduced Individual Service Fund 1. This was to enable individual choice allowing individuals to stay with their current provider) and also to make in-roads to full Individual Service Funds e.g. full choice and control for service users about their support arrangements whilst not facing the challenge of making payment arrangements. This enabled people to remain with their Provider who had been commissioned via the previous IPSAC framework, but is increasingly used by people who wish their long-term care to be provided by the STEP provider or SPOT provider.

Cross- reference with section 3.1 below to see the relative increase in ISFs.

Health

Colleagues from the Personalised Commissioning Team at the ICB (formally CCG) also make placements using BMDC commissioned services when seeking support provision for people with complex healthcare requirements, including split funded packages. In the event BMDC commissioned services are unable to meet the needs of a particular package, then SPOT purchases will be made with Health's own list of Providers. These placements are with organisations that have not been through a Council accreditation, however are on the Council's system for payment purposes. This can present issues when individuals' packages change from fully funded to split funded or ICB funding is no longer required (see Issues, section 4). Currently data shows five organisations funded by ICB only.

Locality map – current hours



Bradford Enablement Support team (BEST)*

The Bradford Enablement and Support Team (BEST) are in-house team that provide short term personal care and support to people at home. Whilst BEST are not commissioned, it is important to understand their role within the system.

BEST provide support to individuals under the following client group categories; Older People, Physical Disabilities, Sensory Impairment, Mental Health and Learning Disability. BEST may deliver a service when the

individual has been discharged from hospital, the individual's health has deteriorated, family are no longer able to provide the required support, or in response to a social care crisis.

BEST works with the individual in creating a person-centred service that maximises their independence. This is usually provided for about 4 weeks, up to a maximum of 6 weeks, without being charged. Once the individual has progressed sufficiently an/d or met their outcomes, the service will become chargeable unless the individual's review has not taken place. After this time, if there are still needs, this is usually provided by a commissioned service.

Currently, there are 158 care package line items for re-ablement services from BEST. On average, 82% of care package line items at BEST are re-enablement services.

3. Current Demand and Future Projections- Older People and Physical Disabilities

3.1 Overall picture of the district

Picture of the District

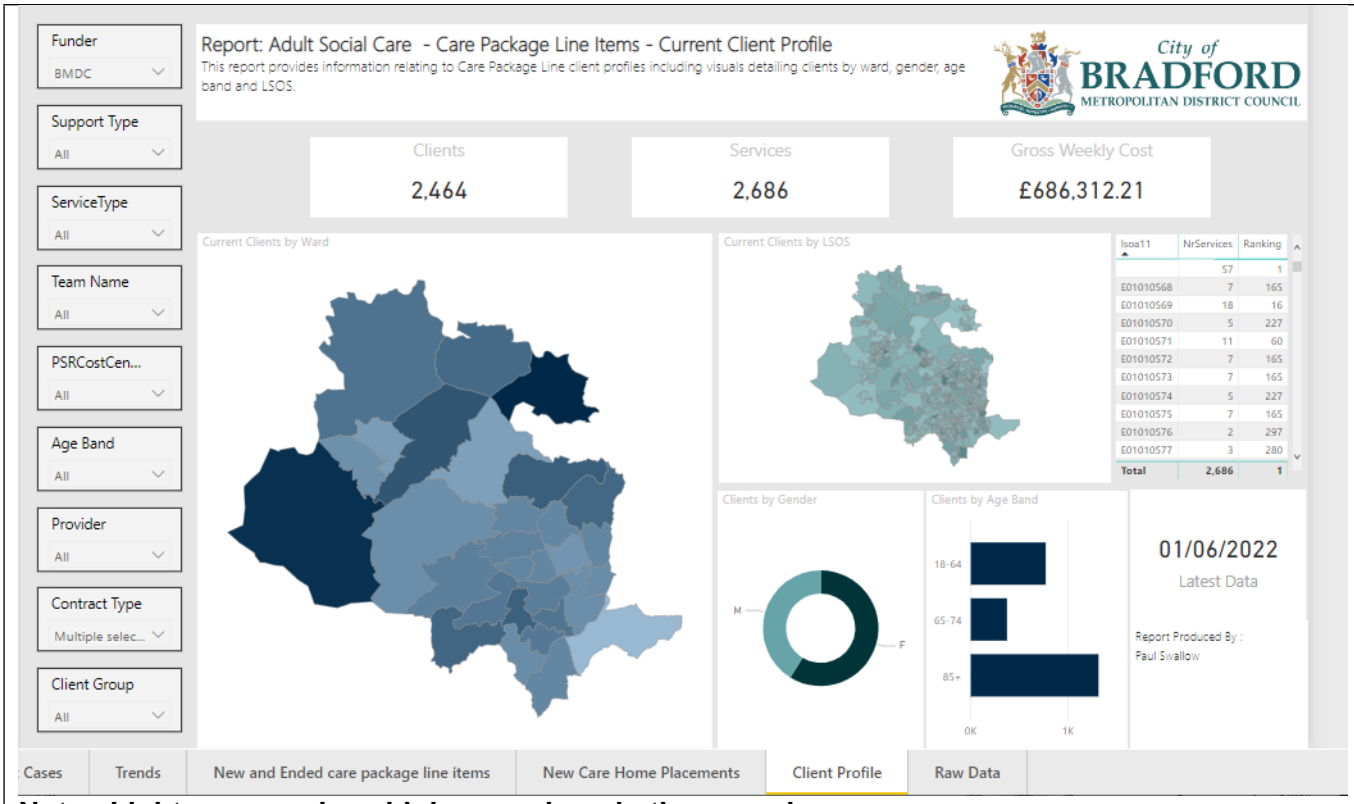
There are 30 wards in Bradford District, which range from the more rural, less densely populated wards like Wharfedale and Worth Valley in the north and west of the District to the more urban densely populated wards like City and Little Horton in the inner city. For the purpose of this tender and accessible service provision some areas differ from the recognised electoral wards.

- City ward has the highest population total with 24,260 people and Wharfedale has the lowest population total with 11,850 people
- Bradford District has 1.9% of empty homes and 6.2% of homes which are overcrowded. City ward has the highest percentage of empty homes (4.2%) and Baildon ward has the lowest percentage (0.7%). Manningham ward has the highest percentage of overcrowded homes (17.8%) and Wharfedale ward has the lowest percentage (1.2%)
- Life expectancy in Bradford District is 81.5 years for females and 77.5 years for males. Keighley Central ward has the lowest life expectancy for females (76.8 years) and Wharfedale ward has the highest life expectancy for females 85.3 years). Manningham has the lowest life expectancy for males (72.3 years) and Wharfedale has the highest life expectancy for males (84.7 years)
- Bradford District has 12 wards which were identified as being within the 10% deprived in England, according to the Index of Multiple Deprivation 2015 - Manningham, Bowling & Barkerend, Little Horton, Bradford Moor, Tong, Keighley Central, Toller, City, Great Horton, Eccleshill, Bolton & Undercliffe and Royds. Ilkley ward and Wharfedale ward are within the 10% least deprived wards in England.

Homecare Packages of Support

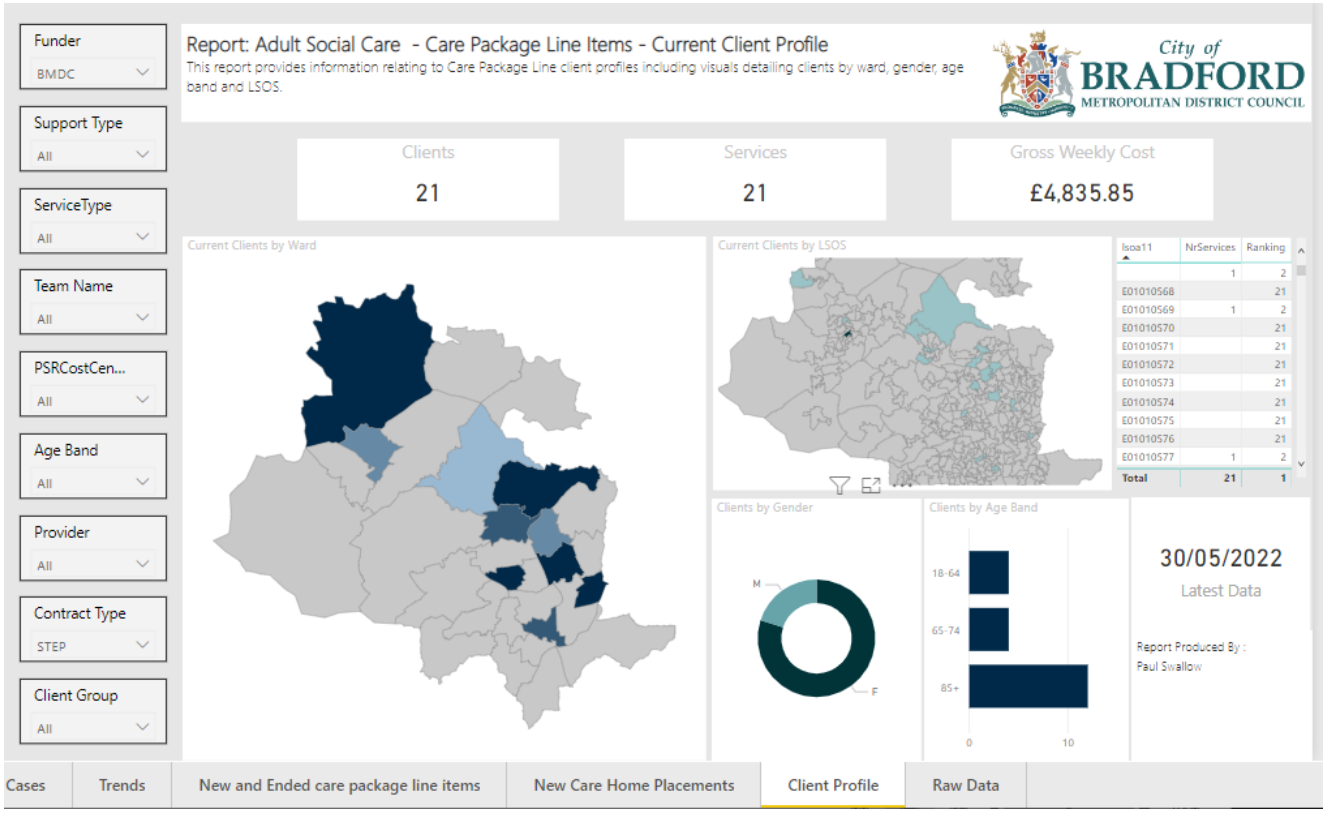
Demand for services are high across the Bradford district. The graph below shows that as of June 2022 currently 2,464 people are receiving 2,686 services through homecare or ISF homecare within the Bradford District.

1,315 of the individuals receiving a package of support are those who are in the 85+ age bracket.

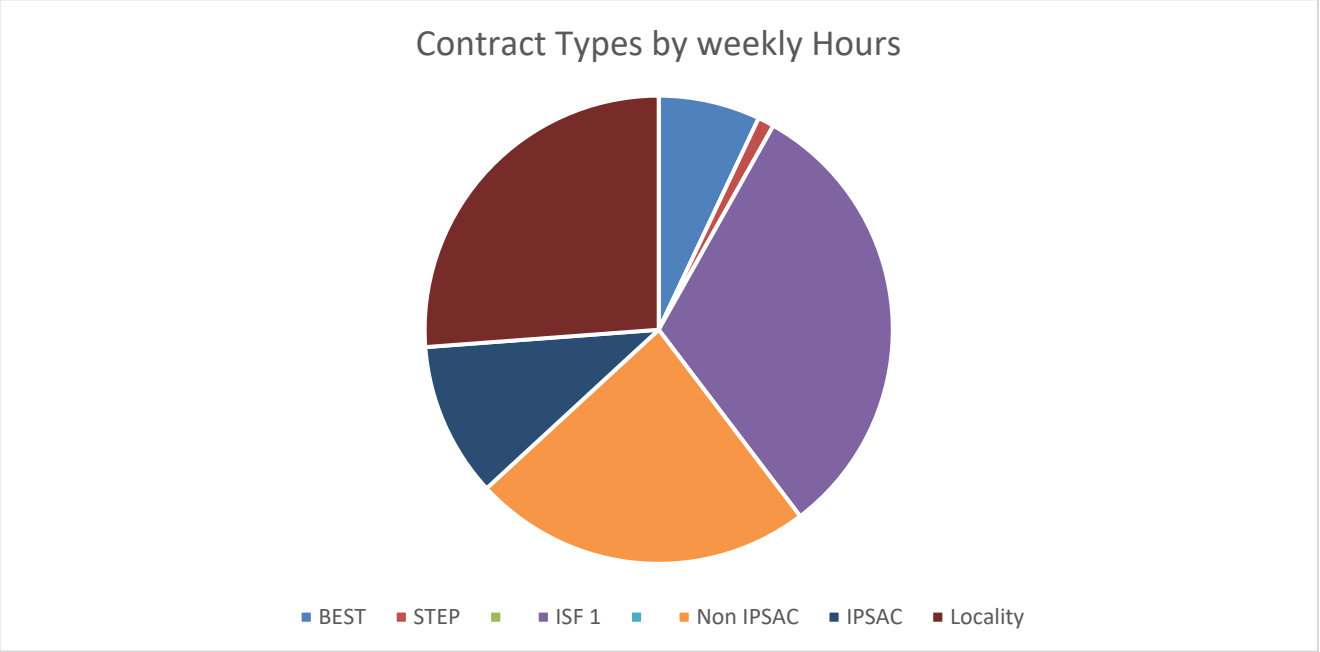


Note - Lighter areas show higher numbers in the map above

The STEP contracts are delivered in limited areas and not district wide due to capacity issues within the providers. This results in the locality providers addressing the gaps, in particular the gaps in the areas of highest demand



Note - Lighter areas show higher numbers in the map above



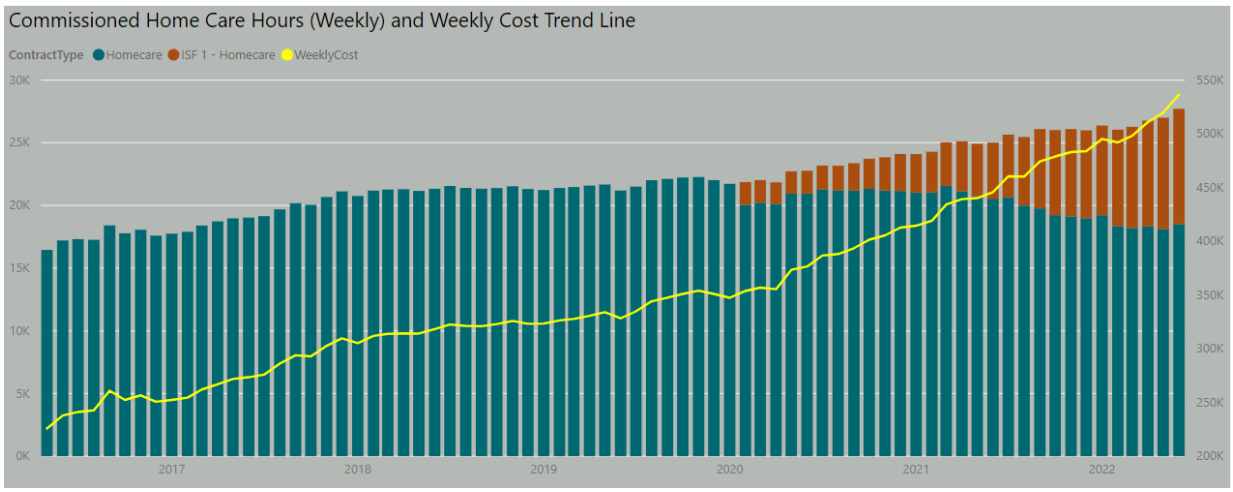
Snapshot taken July 2022

3.2 Demand and trends*

There has been a year on year increase in the total number of home support hours commissioned. This is reflected in the weekly cost of home support to the Council.

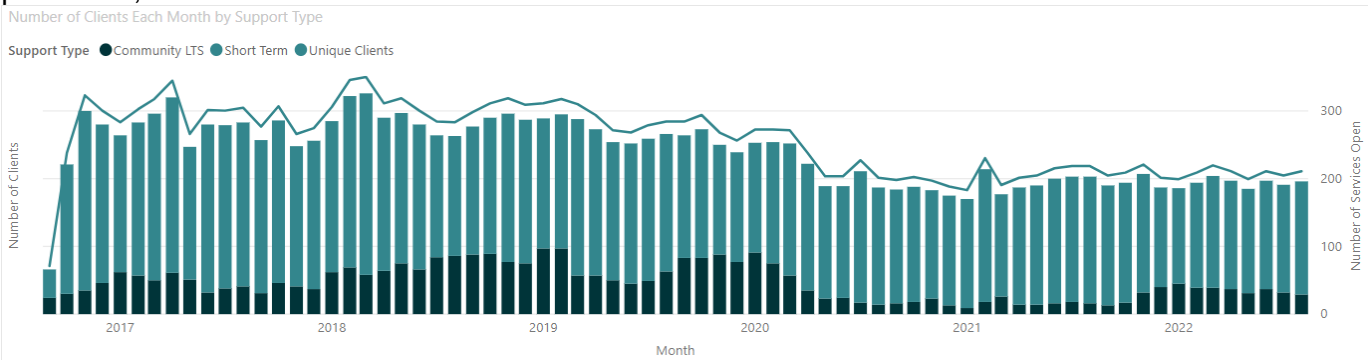
Approximately 2,100 hours (July 2022) of home support is commissioned from externally commissioned providers a week. 29% of the hours are supported through the Locality Contracts. The percentage of hours being picked up by locality contracts is decreasing over time which is balanced through the increase in ISF contracts which has now increased to 34%. During the same time Direct Payments have been increasing over time to now 11% of the market share

Individual choice and demand is increasing as evidence by the number of requests from people to choose a specific provider increasing, this is largely where people have been placed with a Short Term Enhanced Provision provider (or 'STEP' provision) rather than move onto a Locality Provider for their area of residence.



BEST has continued to place packages externally over the last two years. A consistent trend has been the continuous week on week placements to the external provider market. Discharge to Assess pathways have increased the requirement upon Bradford Enablement Support Team to utilise external providers. It is anticipated that service demand will significantly increase based on historic trends of more demand for support at home.

The graph below provides a trend line relating to the number of clients who have received support from BEST per month, from 2017 - 2022.



Approximately 45% of all home support provision requires 2 carers per visit (known as 'double handed' visits)

The data will be analysed to establish the trajectory and trends of double handed visits in terms of how many are temporary due to enablement and how many go on to become single handed and if there are any trends to this.

PowerBI data reports that on average each person receives 14 hours of support per week. The average size of packages has been increasing since the start on 2020, but are still below 2018 levels. The graph and table below maps the average weekly home care hours per client, from 2017 – 2022.

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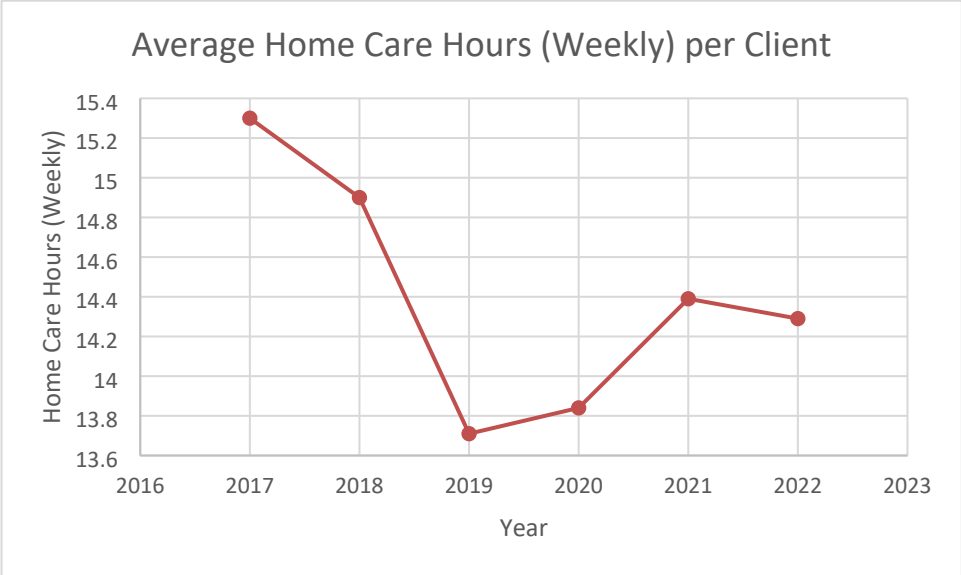


Table of Commissioned Home Care Hours (Weekly) per Client, per Calendar Year

Year	Average Home Care hours (weekly) per client
2017	15.3
2018	14.9

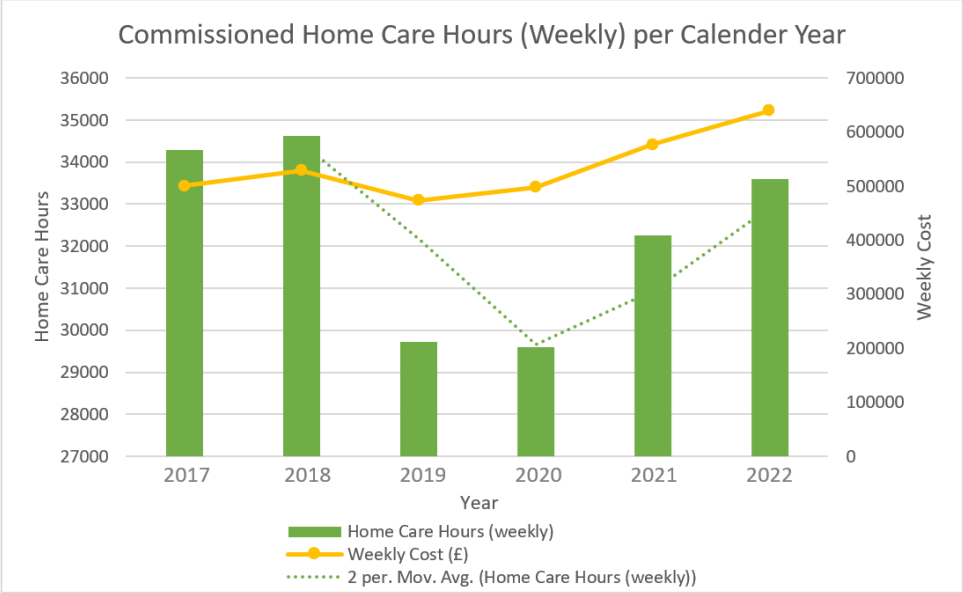
2019	13.71
2020	13.84
2021	14.39
2022	14.29

The table below shows the number of hours commissioned annually, which is increasing year on year.

Table of Commissioned Home Care Hours (Weekly) per Calendar Year

Year	Home Care Hours (weekly)
2017	34277.08
2018	34625.76
2019	29730.09
2020	29600.08
2021	32251.76
2022	33588.52

However, whilst the hours may not be back to 2018 level, the cost has surpassed this and continues its upwards trajectory.



[1]

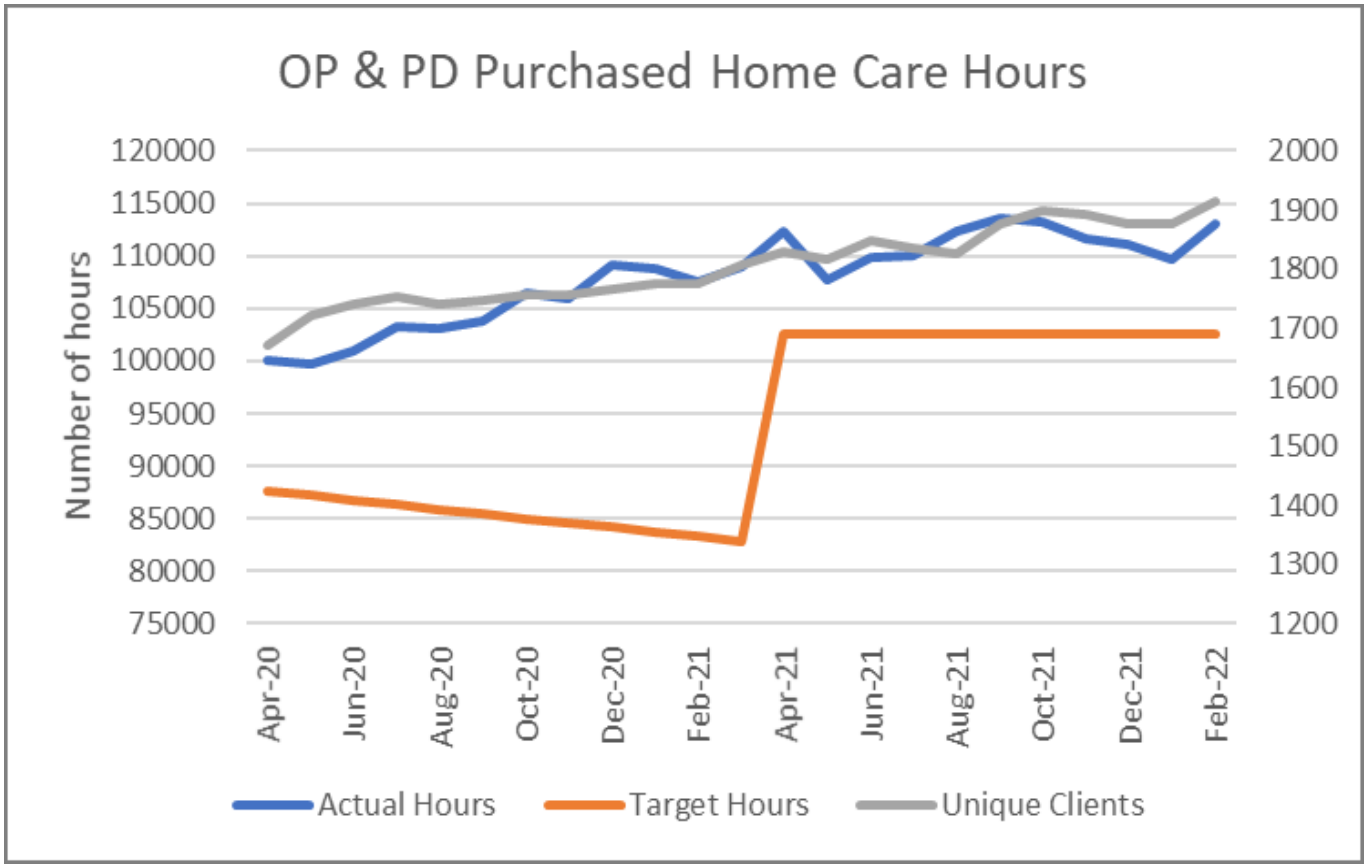
[2]

[1] The average commissioned home care hours and weekly cost for 2022 is based on data collected from 1 January 2022 to 1 August 2022.
[2] The average commissioned home care hours per client and weekly cost per client for 2022 is based on data collected from 1 January 2022 to 1 August 2022.

[3]At June 2022, the trajectory for the annual cost of Long Term Care Homecare predicts an overspend of £3.3m. The number of commissioned hours for Home Care dropped significantly during 2019/20 and is gradually rising again against a backdrop of significantly increasing costs to provide the service.

	Annual Net Budget £m	Annual Forecast £m	Forecast Variance £m
Homecare (including ISF1)	9.2	12.5	3.3

Data from PowerBI reports that commissioned home care hours have increased by 3,461 hours between May and June 2022. Current levels are 113,075 versus a target of 102,603 for the end of the year 2021/22.



Workforce and Provision

The ONS estimate that in 2034 there will be 344 people of pensionable age for every 1,000 of working age, rising from 310 in 2014.[4] This may make it harder to recruit the paid carers needed to meet the growing demand for care. These projections are sensitive to long term assumptions about net migration. As inward migrants are generally young, lower net migration means an older population.

Deloitte Insights[5] have published a paper on transforming social care outlining that being more efficient or cost effective measures will no longer be sufficient to produce meaningful change in social care. The focus must move to early intervention and create paths to greater self-sufficiency and resilience.

[4] This assumes disability rates remain constant and current patterns of care are maintained. However, recent trends suggest that the prevalence of disability in older groups may be increasing

[5] Future of social care | Deloitte Insights

The fragility of the home support market has been raised as a concern by the CQC, which has highlighted large churn among providers registering and deregistering (many of which have not been inspected). Home support providers employ around 147,000 people in Yorkshire and the Humber and there are around 6,800 vacancies across social care at any one time. More than half of care workers are employed on a zero-hours contract and turnover for domiciliary care staff is at 33.8 per cent. [6]

In Bradford there are 11,500 jobs in the independent sector and an additional 950 jobs working for direct payment recipients. It is reasonable to extrapolate that the Bradford district carries approximately 5% vacancies (575) in line with the Yorkshire and Humber statistics.

Forecasts show that if the adult social care workforce grows proportionally to the projected number of people aged 65 and over in the population between 2020 and 2035, an increase of 28% (3,220 extra jobs) would be required by 2035.

Employers with favourable workforce metrics (such as high levels of learning and development), on average, had better outcomes (lower staff turnover and/or high CQC ratings).

4. Consultation

Consultation has been undertaken and is continuing with Service Users, Independent Providers and Departmental Staff. A summary of the consultations undertaken to date or planned is listed below.

Due to the large amount of data, 'themes' from this have been pulled together and can be found in section Appendices 1 and 2, and have been used to partly inform the 'Issues' section at 5.2 and 'Good practice' at 6.5.

4.1 Service Users

Provider Feedback

The provider 121 discussion included a question about any themes or trends that providers are aware of around service delivery and Home Support.

Service User Feedback

We are developing and trialling an electronic workshop format to ascertain the views of service users. This will be completed via an electronic and paper based survey to a sample a cohort of 300 - 400 users with an anticipated 10 - 15% response rate.

*Review of the Commissioning Team Customer Care Log (CCL)**

Year (April-April)	Number of Concerns	Number of Safeguarding Referrals	Numbers of Complaints
2022-present	103	174	17
2021-2022	326	309	48
2020-2021	351	157	31
2019-2020	284	169	36
2018-2019	226	143	80

[6] https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/regional-information/Yorkshire-Humber/Yorkshire-Humber.aspx

Upon review of the Customer Care Log, the key issues identified in relation to concerns or complaints raised against providers are about the length of visits, specifically, calls are not delivered within call times, such as 30 minutes, due to carers rushing; calls are not delivered at set times, i.e. 8am morning call and medication errors. Themes show that providers that are the most responsive to the requests of the Council Brokerage Teams package uptake often incur higher frequencies of referrals. The trend reflects that the more packages being picked up by a provider the higher the chance of a referral being made.

4.2 Independent Providers

121 discussions
Six providers have been approached to take part in 121 meetings to discuss in more depth the challenges and positives in their area in context of Home Support. Key areas we are looking to understand more fully are

- What contract types they currently deliver and what are the advantages and challenges with each of them?
- What are the areas that cause a disproportionate amount of work to complete?
- The impact that the lack of capacity (or anything else) has on their work area
- What are the messages/themes they are hearing from service users about the challenges and positives?

Shadowing
Shadowing both on rounds and in office, covering in particular rota planning is in the early planning stage and will be looked in to further in line with current COVID restrictions and limitations in place.

Snap Survey
A Snap Survey has been circulated to all providers who have contracts for Locality Areas, IPSAC, Non IPSAC, ISF and STEP to understand the priorities, challenges and positives they experience within contract delivery across the various contracts. The Bradford Care Association also circulated the email to provider encouraging them to respond to the survey. Of the 82 providers who currently deliver services for Home Support and we had 25 responses, giving a 30% response rate. The analysis is in Appendix 2.

The feedback supported the information already collated internally, however with additional detail around cost of living, recruitment and relationship with the department.

Provider Contract Meetings
A review of the home support provider monitoring reports carried out over the last 12 months was undertaken in order to capture provider's future plans and developments.

The vast majority of service providers are feeding back difficulties with identifying new staff and retaining existing staff due to market pressures. Specifically, it's becoming increasingly challenging to compete alongside the supermarkets, health and beauty and courier sectors which are offering better pay and terms and conditions. Also, for people who want to work in health and social care, providers have given feedback to say it is becoming unaffordable for their staff. The greatest challenge is workforce for providers to be able to provide a level of service that meets existing demand levels, which reflects the fragility of the local market place.

BCA staffing discussions
Discussion take place frequently with the BCA which is informing our workforce strategy. See section 6.5 'Good practice'

Service Improvement Board/ Provider meetings
Providers have identified a need for work to be done to improve communication streams between provider, social worker and service user to avoid cancellation of packages. The Support Options Team are currently in talks with care home managers to discuss capacity, communication breakdown and call times to try see how things could improve.

Lessons Learnt meeting
On 16 May 2022, Commissioning Managers and Contract and Quality managers held a meeting to discuss the current home support contracts and identify lessons learnt. Items that were identified for review include

workforce pressures, contract layering, collecting information on providers' performance and market engagement. These are reflected in the issues section below.

Winter Pressures*

In order to increase resilience over Winter, additional funding was made available to

- increase the hourly rate that Locality or ISF providers were paid so that they were on par with STEP, in order to encourage them to pick up short-term packages
- Increase the hourly around the Wharfedale area where were having difficulties moving packages on
- Pilot a new approach around Ilkley, using to cars and employing drivers to transport non-driving staff to and around the area.

This was funded from DTA money and stopped on 31st March. The initiatives are still being evaluated: on the surface they successful in terms of increase in packages in that area, however more work is needed to be done to unpick any ripple effect on other areas (e.g. a corresponding decrease in another part of the district) and the full cost of the pilot; this was expensive and may not be viable for full-time delivery.

4.3 Departmental Staff

Qualitative research with Health and Social Care Staff

Throughout May and June, a series of discussions were held with 15 staff across areas that intersected with the delivery of Home Support. These focussed on building a picture of the role that Home Support plays within the different elements of the system and capturing both the positives and challenges their team were experiencing, as well as any suggestions for improvement. All the meetings were transcribed and themes were pulled in to a document Themes from Home Support Feedback are in Appendix 1

Capacity meetings

A weekly meeting is held with departmental staff, identifying difficulties in placing packages with providers due to issues with capacity. From these, trends are identified and system pressures discussed.

Workshop with DMT/ Key System Partners/ Providers

A workshop with DMT is scheduled for 29th June

Further workshops with Key System Partners and Providers will follow - dates TBC

A workshop with HOSC members is pencilled in for August, with a follow up report in September.

5. Current issues

5.1 National Issues

5.1.1 Home Support nationally

It is recognised nationally that Home Support it is critical to the longstanding strategic intention to enable people to 'age in place' and to deliver care as close as possible to people's homes, however for many years the home support market across England has been fragile with both large national providers and smaller local providers struggling to maintain business. The 'churn' seen in the Bradford market is reflected nationally, with pre-pandemic 39% of local authorities having had experience of home support providers ceasing to trade.

Key issues seen nationally are[7]:

- Difficulties recruiting and retaining staff
- Difficulties delivering in rural, diverse or deprived areas
- Insufficient funding
- Extensive growth in the need for home support (the DHSC have predicted a 57% increase in people needing support between 2018 and 2038)

[7] https://www.kingsfund.org.uk/sites/default/files/2018-12/Home-care-in-England-report.pdf; https://www.homecare.co.uk/news/article.cfm/id/1653300/More-home-care-staff-quitting; https://www.homecare.co.uk/advice/home-care-facts-and-stats-number-of-providers-service-users-workforce

- The lack of a long-term vision for social care

5.1.2 Workforce recruitment and retention

Recruitment and retention has become increasingly challenging than before the pandemic[8]. Locally home support providers are reporting more competition with other sectors, with recruitment/retention generally against supermarkets, health/beauty, and the hospitality sectors.

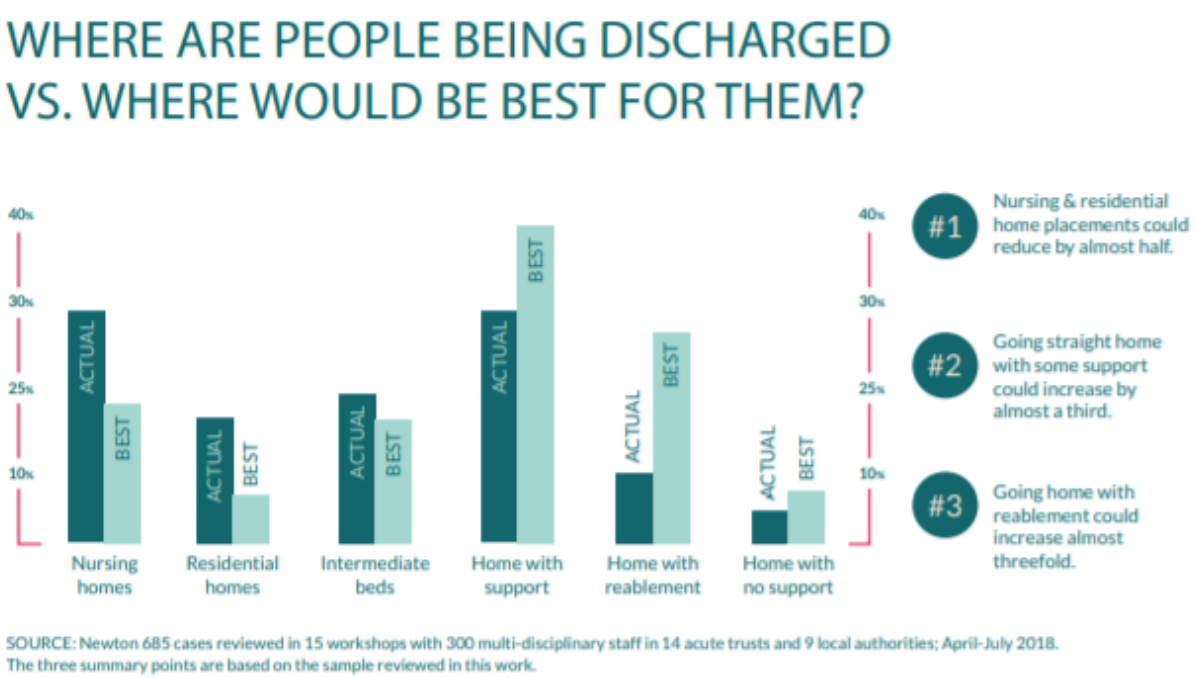
High staff turnover and workforce instability impacts negatively on the experiences of people receiving home support; increases changes in support provision; causes delay in support pick up; reduces the quality of care and increases provider's costs Skills for Care estimate that the cost of recruiting each care worker is over £3.5k. Replacing half the frontline workforce each year, around 950 care workers, would costs commissioned providers around £3.5m per annum [9]

5.1.3 Discharge to Assess

Once people no longer need acute hospital care, being at home or in a community setting (such as a care home) is generally considered the best place for them to continue recovery. However, unnecessary delays in being discharged from hospital are a problem that too many people experience. NHS figures suggested that on 13 March 2022, 12.9% of all available acute hospital beds were occupied by patients who no longer needed to be there

NHS North East and Yorkshire Region have identified discharge and flow issues, and the greatest pressure is home with reablement where demand is outstripping capacity in a significant way

Below shows where people are being discharged to and where would be best for them[10]



5.1.4 Changes to the way we arrange and pay for support

The recent white paper People at the Heart of Care sets out funded initiatives to implement proposals put forward in the Care Act. These include a 'cap' on care costs i.e. the maximum amount a person can be expected to pay for social care costs in their lifetime. It also presents that the Local Authority will play much

[8] Home care worker recruitment and retention 'harder than ever before', UKHCA finds (homecareinsight.co.uk)
[9] Calculating the cost of recruitment (skillsforcare.org.uk)
[10] Produced by NHS England and NHS Improvement for NHSEI North East Yorks Regional Webinar August 2021

more of a role in arranging people's care when they are self-funded, and addressing the gap in costs between them and those who are eligible for LA funding and access care at LA negotiated rates.

In preparation for this, we need to conduct and consider the findings from Market sustainability and fair cost of care exercise, ensuring the end result is a stable, diverse market with sufficient supply.

5.2 Local issues

From consultation detailed in section 4 above, the following issues with the market and current model have been pulled together into themes.

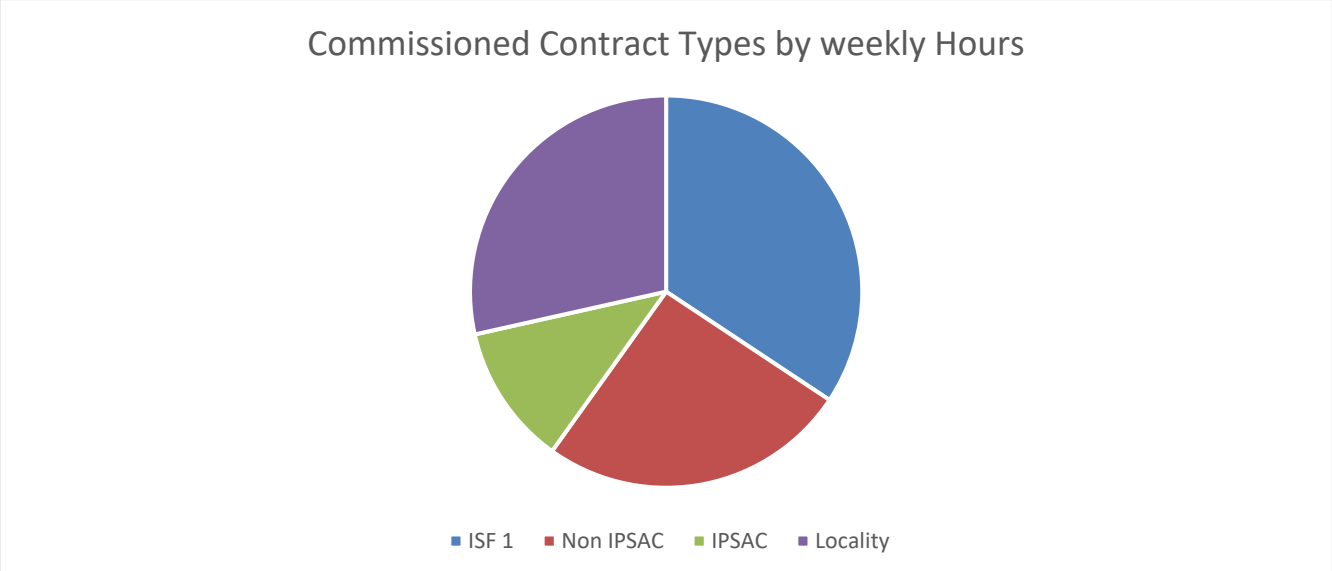
Provider/ Market Issues

5.2.1 Fragmented Market

The current Home Support market is fragmented, with 82 organisations with 218 number of contracts between them who have been accredited at various points over the last decade or longer. This large number of different types of providers has often been the result of offering choice to Service Users however has meant that contracts are layered over each other as an increasing number of frameworks/ contract types are introduced. Section 2 above provides the detail of these.

To date, the Council operates four different types of contracts for long term support, which were all introduced at different periods over the last nine years and continue to be utilised. With the Council's brokerage teams taking a tapered approach to selecting organisations from current to old contract type based on their capacity to accept the support package/s.

This has resulted in the ISF 1 contract having the largest share of the market at 34% of available hours and the locality contract taking just 29% of the available package hours



Data taken as a snapshot on 27 July 2022

Further work will be undertaken to map commissioned contract types by hours across the localities

5.2.2 Disparate locations

- Providers may not be able to create economies of scale
- There is less 'concentration' of service users so that the effectiveness of the localities is diminished
- The previous evaluation process meant that some local providers had to move from the area where they were established, to a new location they were less familiar with.

5.2.3 Market failure

- When setting up the Locality contracts previously, a far larger number of Service users stayed with their current provider than anticipated, so that the 'indicative numbers' in the tender were much lower than expected. Many providers were slow to start up and ten defaulted on their contract, meaning that the area had to be re-tendered immediately.
- In the last 24 months, five service providers have withdrawn from the delivery of home support provision for OP/PD/SI. This has been largely attributed to staffing difficulties, with one provider leaving the market due to their own personal circumstances.
- In the last 12 months, three providers have defaulted on their contracts. This was due to poor levels of performance, with recovery plans being introduced.
- Conversely, there are some Providers who now have such a large number of packages/ hours that we could become too reliant on them which poses risk- it becomes difficult to manage under-performance - Providers can go in to default with few or no consequences- and we cannot afford for them to fail if there is likely no alternative when we retender.

5.2.4 Throughput between providers

- The introduction of STEP has impacted on the flow of packages to Locality with the individual staying with the STEP provider for long-term support via an ISF. The levels of long term support picked up by Locality providers has been much reduced since 2019.
- There is currently no incentive for Providers to enable people quickly or pass packages on to other providers.
- When Locality Providers do not pick up the package in the area, this is then advertised on Connect To Support. Other providers can then pick this work up but there is only a general onus of them to do this, and difficult/ complex/ night packages which are less attractive may take weeks to be picked up.
- Providers are sometimes competing against each other in one area as they have had to step in to different locations.

5.2.5 Discharge to Assess

The pandemic accelerated the direction of travel for people to be assessed outside of an acute setting. This approach was implemented quickly as a necessity, but now needs to be built into the business as usual.

- Due to the earlier discharge we are seeing people requiring Home Support (Pathway 1) but who are likely to have higher, complex needs resulting in an increase in package size and often double-ups. DTA processes have put significant pressure on Providers due to issues around the quality of discharge information, the quick response time needed, their ability to access service such as Occupational Therapy and larger packages of support decreasing in size suddenly after DTA funding is ended.
- Short-term packages often involve the same amount of back-office time to set up as a long-term package, which makes them financially less attractive and can act as a disincentive.
- Where BEST are unable to meet demand, STEP and Locality (or others) may potentially pick up. Both contracts require Providers to meet all new 'demand' for service within 4 hours and 2 hours respectively (the latter being where this includes people being discharged from hospital with on-going support needs) but rarely meet these short timescales.
- Providers do not have the capacity to be agile and responsive to rapid response packages or taking packages out of hours. This is generally due to rotas developed one week in advance, and workforce issues which means they are unable to pivot quickly.
- Discharges from hospital for end of life care are sent to providers who are not able to navigate the fast track pathway resulting in additional assessments and poorer care for the individual

The impact of this is a back- up in hospital discharges, ideally there would be a steady, manageable stream rather than ebb and flow.

5.2.6 Reablement

The STEP service that was introduced to supplement BEST has worked well to support the flow out of hospital, however has caused an impact on the wider system

- STEP were commissioned as an intermediate service, with time and task clauses within their contract
- The specification does not require them to work to the same standards as BEST, nor do they have access to the same level of resources.
- This can result in a second rate service to the individual (compared to BEST). Statistical analysis across BEST, STEP and the wider homecare market show that there is a small difference in the amount of positive outcomes across each areas, but when the positive outcomes are analysed it is notable that BEST have

the largest percentage (67%) who are able to self-manage without a package of care.
- STEP services have had issues with recruitment resulting in the wider Home Support market being asked to fill the gap in service
- Data analysis is not robust enough to draw definitive conclusion due to the small cohort of people within the BEST service as opposed to BEST and the wider homecare
- Reablement support on DTA can cover a range of tasks from visits to ensure medication is taken through to enabling an individual to undertake tasks independently

5.2.7 ***Service lines***

Often people leaving hospital require a temporary increase in hours over their normal package. If this is classified as reablement, it is funded by the Council for up to 6 weeks. On discharge BEST will take on the whole package as enablement even if they had an existing package before

- This means the entire package is free to the individual as the council is unable to claim a client contribution.
- BEST are delivering previously assessed support needs (rather than just reablement) to the individual. This situation is being considered internally to understand the most appropriate way to ensure the individual is supported by their original provider, so that BEST can deliver just the reablement aspect of a package.
- Home support service lines are not being ended in a timely manner by the social worker, this is causing issues for BEST when a package is referred to them. This is also causing a discrepancy between the hours we commission and the hours we deliver as commissioned hours are inflated due to the line not being ended.

5.2.8 Parity of Costs

There is a discrepancy in the market between different providers for intermediate care. STEP providers are currently paid £20.60 p/h as a reflection of the increased monitoring of the changes during the initial period of support to people identified as requiring assessment and package adjustments, as well as more frequent communication with the Council's Reviewing Teams. However, STEP cannot meet the demand, so not all packages were being picked up within timescales, increasing pressure on the hospitals/ BEST. As part of Winter Resilience, all providers were given an interim uplift for this work, paid from DTA funding. This has now stopped and the different rates have recommenced.

5.2.9 Hospital Retainers

There is a hospital retainer scheme where by Providers are paid at the hourly rate for up to four (4) weeks to keep the package open whilst a person is in hospital. This has been previously praised by the CQC peer review that took place in 2018/19, however Providers are often not taking back the original package, due to the increased size of package. (see also DTA at 5.2.6)

5.2.10 Non-social care activity

There are packages of care that include non- regulated activity such as domestic support, shopping and social inclusion. These are funded at the same price as personal care. They can also be included as part of a reablement package without any charge to the individual for 6 weeks. During consultation it raised that locally these are partly responsible for the increasing home support hours however is difficult to monitor due to lack of discrete service line.

5.2.11 Brokerage Systems

We currently have 2 Brokerage Teams: For general reablement and DTA support, the BEST Duty Team can place with STEP Providers but also use the rest of the market to pick up the work as needed. Support Options Team broker for long-term work on Connect to Support. If Locality providers do not pick up for their area, Support Options will follow up and/ or use the rest of the market to support.

- BEST team work 7 days a week and contact the providers directly to place enablement packages and push the packages towards them. This is resource intensive but due to the urgency is often faster.
- Support Options place packages on Connect to Support for providers to pick up packages., however Providers do not always check CTS frequently. Support Options then use a lot of resource following this up having to then constantly phone and email Providers, and check/ update CTS.
- This has created somewhat of a competing situation where the general market may be approached by BEST and feel they have no need to check CTS.

- Connect to Support – placement system is used for the placement of OP and PD/SI support packages. It also includes LD/MH when the existing placement methods have been exhausted or providers cannot be identified to meet the requirements of the support package. The local CCG have adopted the same platform recently but the level of implementation/utilisation and impact on Providers needs to be understood further with the CCG.

5.2.12 Working Hours

There is a disconnect between staffing hours for the Provider market (including back- office) the BEST Team, hospital teams and the needs of Service Users. Provider back office and Support Options generally work office hours Mon-Fri, where BEST work longer shifts with some availability through evening (and overnight). Hospitals are 24/7 as are Service User needs.

- When hospitals discharge late in the day (especially Fri pm to Monday) it is often difficult to put support in place.
- New packages often do not start until Monday
- It is difficult to put in quickly a short-term intervention to react to a temporary situation eg urine infection
- This is likely more of an issue regarding short-term work: when Support Options have trialled working weekends and bank holidays – the results were 95-99% down time for Support Options as no or very few referrals were coming through – so staff were paid, but with no work to do

5.2.13 Locality Boundaries and 'Challenging' Areas*

In the last tender, smaller service delivery areas were created to align the provision with internal operational localities. This aimed to expand the potential work pool by allowing for the recruitment of staff that may not drive. Generally, the move to smaller areas has had a lot of positives (see section 4.1) however the effectiveness of this has been diluted by the market fragmentation and they do not fully utilise a CLS approach and link to Area teams/ hubs.

Future commissioning will review the boundaries, in particular around Health areas to ascertain if any adjustments need to be made to existing locality areas.

5.2.13.1 Ilkley/ Burley/ Menston

These areas continue to be challenging. They cover a significant geographical area that is not walkable across the whole locality, and as much of the area is rural or very rural there are poor public transport links. Whilst some other locality providers have been successful in recruiting carers who live locally, this has not been so successful in the Ilkley locality, probably due to the demographics in that area, which in most parts is far more affluent than most other areas of the district, and possibly with an older demographic

Data suggests the vast majority of providers operate around Bradford City Centre, whilst fewer numbers appear in the centre and towards the boundaries of the district. This indicates that providers are seeking to operate in the urban areas of Bradford District where we see a higher population of people but not necessarily older age adults. Over the winter periods, it has become increasingly apparent that we experience a shortage of supply in more rural parts of the district, e.g. In Addingham, Ilkley, Menston and Burley and Wharfdale, provider options were so low that a grant had to be introduced towards the end of 2021, with only one organisation coming forward for this. The MoonBoots pilot (paying for people and fuel so that walkers could be driven to around rural areas) was successful but came at a high cost.

5.2.13.2 South

South Constituency providers on the whole have been new to the District and have taken a long time to establish, or have not fully established – this has started to impact on BEST in 2020 with long term placements taking longer than normal to place, meaning that people were staying with BEST longer in this area compared to other areas (Ilkley aside)

Non- personal care Home Support Hours

5.2.14 Sitting Service

During Covid-19 the Timeout sitting service has only been able to offer a limited service. In most cases this has meant that people who have a current home support service have not been receiving their usual Timeout

service (priority has been given to people who are receiving no other home support services) or new services have not been offered if home support is in place.

BEST colleagues have identified that this has led to an increased demand for home support providers to deliver 'sitting services' to support carer breaks. This has an impact on the budget but also has an impact on service capacity and hospital discharge.

5.2.15 Domestic/ Social Hours

Home support contract Providers are delivering for social inclusion, shopping, cleaning etc. and we are unable to establish how much of the contract is delivering this type of work – packages that include these types of tasks mask the true picture of positive outcomes for enablement

5.2.16 Nights

Night Roaming/task and time visits are included in the existing agreements for the locality providers. The volume of work is inconsistent and deemed as unviable because demand is very low for night support across the whole district and providers cannot attract staff to work on a night call basis paid for on task and time. When packages are placed on CTS they are generally not picked up.

5.2.17 New Provider Requests*

When new packages of care are sent to the provider market to be picked up the providers are sometimes unable to accommodate the times that an individual wish to receive their care which can cause difficulties with the relationship between individual and provider company. There is often a mismatch in expectations between providers and individuals about what constitutes a late call which can result in the individual in expressing a wish to change providers.

Consideration needs to be given to how we communicate with social workers, individuals and providers to ensure that expectations are managed to be realistic with a focus towards conflict resolution and not an immediate move towards a change of providers.

The change to package form is used to both amend packages and end packages and requires the same level of detail for both. The amount of detail required is contributing to the forms not being completed in a timely manner which then causes financial and time challenges to backdate changes. This process has been reviewed and a pilots for a new approach are in place.

5.2.18 Staffing

In addition to the general pressures that are being faced nationally as described in section 5.1 above, some of the specific issues noted in Bradford are:

- As a result of the workforce challenges, Providers are more likely to pick up packages that are more straight-forward to deliver, so more complex packages are not always picked up in a timely manner
- Some staff are moving from one sector to another as the opportunities for career progression are limited by the current time and task model
- Staff are moving out the sector into Health as there is no clear pathway/ opportunities within Bradford sector. When people are recruited to more senior roles e.g. care coordinator, care manager and RM but not sufficient people entering the system
- Having staff who can drive is often essential to delivering services and maintaining capacity within provision. Due to the pandemic there is increase demand driving tests meaning availability is limited with dates being offered three to six months from booking. Bradford Providers regularly raise this as an issue, particularly in more rural areas with poorer transport links.
- Providers report a lack of integration on the frontline between health and social care. Staff continue to feel under-valued and second class to NHS. Costs of internal recruitment and no accommodation available.

Further detail and the Workforce Strategy is in 6.5.6 below

5.2.19 Sector recruitment

Social Care is not the only sector struggling to recruit and retain staff (including Nursing Home staff). Initial discussion with BDCT colleagues highlighted a shortage of district nurses- there is the potential here for opportunities to work together to address overall capacity issues.

5.2.20 Ethical Care Charter

The Ethical Care Charter highlights how poor terms and conditions for workers can help contribute towards lower standards of care for people in receipt of homecare services. The charter includes a number of practical recommendations to ensure that carers travel time is funded, that they do not have to rush from one client to the next, and that residents should keep the same carer as far as possible.

The new contracts set out to address the issue of very short call provision (15 minute visits) by phasing these out, in line with the Unison Ethical Care Charter. In 2021/22 a 7.2% uplift was applied to contract home support rates in recognition of the need to improve the terms and conditions of staff in the sector. In a recent survey 97% of providers reported increasing staff wages as a result of this uplift.

In August 2021, a survey was carried out which included key questions about the Ethical Care Charter. 35 providers responded to the survey. 63% of the providers that responded to the survey stated that they were meeting stage one of the Ethical Care Charter. The barrier considered for not meeting stage one was put forward as being unable to meet mileage cost (23p per mile). 43% of providers that responded to the survey stated that they were meeting stage two of the Ethical Care Charter, with barriers put forward for those not meeting stage two as being the uncertainty of work and the Council's uplift not sufficiently allowing for this. 29% of the providers that responded believed they were meeting stage three of the criteria. The barriers put forward for not being able to meet stage three were a lack of funds within the organisation to be able to pay the real living wage, an unsustainable hourly rate payed by the local authority when compared to the UKHSA and insufficient care fees paid to them for staff to be able to work full shifts and offer improved terms and conditions.

5.2.21 Cost of living

The sharp increase in cost of living has exacerbated difficulties in the workforce. Feedback from the Provider Snap Survey and BCA express concerns regarding the rising cost of fuel, general cost of living and competing with other markets eg retail and hospitality, and supports the national issues detailed in section 5.1.2). In addition to this, providers reported,

- Neighbouring Authority Leeds has committed to have specified a minimum payment to staff of £10.50. Some staff have left to work over the border and a Provider who works in both reports that this has created a divide in the team as Bradford staff are paid less.
- Some staff are worried about using their cars for work due to the rise in petrol costs. This will have a high impact in the more rural areas where we already struggle.
- Lack of car drivers is further exacerbated by the cost of learning to drive, car, insurance and petrol (see also 5.2.17)
- No payment for Covid19 absences
- The cap on universal credit and hours that people can work.

5.2.22 Procurement and Accreditation

- The financial limits places on providers as part of the previous due diligence meant that some new-start-ups to the area were awarded, where already established providers where not awarded business. Observations by the Contract team have noted that local providers will 'see out' rough patches, possible due to a commitment to the area. They are also more engaged in Service Improvement and forums.
- The evaluation process meant that some current providers/ local providers had to move from the area where they were already established, and a new entrant to the market took over. It generally acknowledged that Providers and their staff perform better in areas they are familiar with, as well as facilitating better outcomes for service users due to their knowledge of community links.
- There is currently no mechanism for new Providers to be added strategically (although this could increase market fragmentation)
- Some providers are on more than once framework e.g. Locality Contracts and ISF Framework and some providers who we still place with have not had been through any recent accreditation e.g. the previous IPSAC framework. This means that we have carried out different due diligence on some Providers, some of whom will not have undergone any recent assurance.
- There is also a 'backdoor' approval process whereby Providers who have been accredited by Health are added to the Council's payment system and may deliver jointly funded packages.

- Some of the recent tenders for Localities where there has been market failure, have been awarded to Providers who are already struggling. They have been slow to start up and in some cases still under-performing.
- Each time there is a new tender/ a provider fails, there is a risk ok staff being lost to the Social Care sector. In addition, staff do not always TUPE to the new provider which makes it difficult for providers to pick up the full packages needed as there is no guarantee of workforce.

6. Evidence and best practice – what others are doing, alternative service models etc.

6.1 Policies and Direction of travel

National

- Hospital Discharge and Community Support[11]
- The Health and Social Care Approach to Winter Pressures[12]
- Health and Care Act 2022[13]
- People at the Heart of Care: Adult Social Care Reform White Paper[14]
- Market Sustainability and Fair cost of Care Fund 2022 to 2023[15]
- Levelling Up the United Kingdom[16]
- Home First/Discharge to Assess[17]
- Unison's Ethical Care Charter[18]
- Social Care Reform and Independent Review by Baroness Cavendish[19]
- The Health Foundation How ageing affects health and care need in England[20]
- Future of an Ageing population[21]
- REAL Centre Making Health and Care Services More Sustainable[22]
- Think Local Act Personal – The Asset Based Area[23]

Internal

- Home First
- Commissioning strategy
- The Joint Health and Wellbeing Strategy[24] outlines the key priorities for implementing the 'Better Health, Better Lives' priority of the Bradford District Plan.

6.2 Alternative Models

Policy-makers have outlined their ambitions to provide joined-up care closer to home and enable people to remain independent and in their own homes. Home Support/ Care is a central component of meeting these ambitions. Against a backdrop of varying quality of care and rising demand, some innovative models and approaches to commissioning[25] and delivering home support are emerging.

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[11] https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance
[12] https://www.gov.uk/government/publications/the-health-and-social-care-approach-to-winter
[13] https://bills.parliament.uk/bills/3022
[14] https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper
[15] https://www.gov.uk/government/publications/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023-guidance
[16] https://www.gov.uk/government/publications/levelling-up-the-united-kingdom
[17] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/overall-approach/discharge-to-assess
[18] https://www.unison.org.uk/content/uploads/2013/11/On-line-Catalogue220142.pdf
[19] https://www.gov.uk/government/publications/social-care-reform-an-independent-review-by-baroness-cavendish
[20] https://www.health.org.uk/publications/our-ageing-population
[21] https://assets.publishing.service.gov.uk/future-of-an-ageing-population.pdf
[22] https://www.health.org.uk/what-we-do/real-centre
[23] https://www.thinklocalactpersonal.org.uk/Latest/The-Asset-Based-Area-/
[24] Joint Health and Wellbeing Strategy 2018-23.pdf (bradford.gov.uk)
[25] New-models-of-home-care.pdf

The extent to which these approaches have been adopted and are widely used varies in lots of ways and for a number of reasons. Despite some being long established in policy rhetoric, such as outcomes-based commissioning, the extent to which finding examples of them in practice is limited. Traditional approaches to commissioning are commonly cited as a barrier to spreading innovative models of care.

Some alternative models of providing care at home – for example, Shared Lives and the US Capable programme – have robust evidence to demonstrate improved quality and/or impact. Others show great promise and the following direct extracts from the Kings Fund New Models for home are provided for reference below.

6.2.1 Wellbeing Teams
Self-managed teams that focus on person-centred care and supporting people in their communities, inspired by the Buurtzorg approach. Care is based on a support sequence co-designed with the person to deliver their priorities. This sequence is repeated every six months to ensure that people are able to live well at home and are connected to their community. It involves moving through the following steps:

- self-care – a health coaching approach focused on what can be done to make the individual feel more confident in how they are managing their care at home
- digital or assistive technology – this may include remote sensors or facilitating video calls with family members who do not live nearby
- community – this may include lunch clubs or falls clinics
- wellbeing teams are the final step in the sequence.

Wellbeing teams are small, self-managed and neighbourhood-based. Individuals choose their own team using video introductions and one-page profiles, with a guarantee of no more than four people. They design an ideal week for the person, where visits have an indicative time related to what they are trying to achieve in that visit. Reduced travel time and lack of hierarchy provides low back-office costs. Wellbeing teams work closely with Community Circles to provide support beyond formal services. Wellbeing teams are being developed in a range of formats, including with local authorities incorporating reablement teams, or teams that are based in GP surgeries

Locally this model could be aligned with a community led support with Area teams or a wider integrated approach, but which will be a significant culture shift and require a collaborative agreement to move towards that new way of working

6.2.2 Outcome Based Commissioning
Moving to outcomes-based commissioning requires investment and time to realise benefits as well as new ways of working. The onus is on providers to take financial risk and this may be less attractive for some providers. One of the barriers to implementing outcomes-based commissioning is that outcomes are difficult to measure, which means that providing assurance for commissioners is more complex. Technology and digital approaches to care management may enable a more outcomes-focused approach to care – for example, with programmes that enable capturing of data about individuals (see ‘Co-ordinated care planning’). Conversely, existing technical approaches such as electronic call monitoring, which may be used to provide assurance based on time, can often act as a barrier to adopting new cultures of trust and relationships that enable outcomes-based approaches. Outcomes should be measured against progress towards personal goals.

One potential challenge with outcomes-based approaches is that they could lead providers to cherry-pick individuals who will provide good outcomes. This is linked to complexities of measuring outcomes and linking payment to results. Outcomes-based contracts themselves will not hold providers to account for achieving improved outcomes for service users, and ongoing constructive relationships between providers and commissioners will be required.

Locally we need to consider how to build in incentives or requirements to address potential issues about packages not being picked up but also an incentive to reduce the package, e.g. through informal or community support or re-able the person where possible. Care will need to be taken to ensure that this does not create perverse incentives or destabilise the market through unintended consequences.

6.2.3 Integrated health and social care community-based teams
Working with services beyond social care such as district nursing, occupational therapy, housing and other public services offers an opportunity to maximise assets and ensure that people's experiences of care are co-ordinated and person-centred

Integrated community teams bring together community health, social care and other professionals. They exist in many forms: some use stratification and case management approaches aimed at specific populations, others are based on principles of placed-based teams such as the Buurtzorg example of Autonomous team working, while others still are aligned with GP practices. Key elements include shared assessments and care planning, which have the potential to reduce duplication and improve co-ordination of care. There is potential for alternative approaches to workforce and traditional roles – for example, having more generalist or flexible roles. Some approaches are commissioned jointly by the local authority and the CCG. The important elements are that working together enables care that is focused on meeting all of a person's needs

Locally, an integrated approach could open up the possibilities for a career pathway for workers within the organisation that they work for and putting in place suitable packages of remuneration to acknowledge differing skills and workloads within the career pathway, providing better parity with Health.

'The effectiveness of new care models is very dependent on whether those implementing them really understand that they are about new models and not about organisational re-structuring.'

6.2.4 Assistive Technology
While some new models, such as technological adaptation, may be considered to have potential to reduce demand or usage of formal care services, there is little evidence to date that this is happening. Cost saving may be an unrealistic aim of some or all new models of home support, particularly if home support budgets are considered in isolation and in the short term.

While there are multiple examples of technologies and tools that may be very effective at promoting independence, preventing falls and helping to manage risks, the impact these have on changing the approach to statutory home support services is limited and there is a question about the extent of demand for them. These technologies do not remove the need for care services. They should be viewed as an enabling tool for care workers and service users where new ways of working have been developed, as a preventive tool and in supporting informal carers.

Issues with assistive technology include a lack of ongoing support for the use of the technology, inappropriate choice of equipment for personal capabilities and circumstances at the assessment stage, and a failure to keep its use under constant review.

Home automation and advanced telecare: A home automation package, including a light path that comes on when someone steps out of bed, gas and smoke sensors, fall alert devices, alarms, and 24/7 remote telecare call centre assistance. An evaluation found that it contributed to a reduction in falls, reduction in hospitalisation, reduction in depression, and carer productivity (Carretero 2014).'

Locally this will need a two pronged approach and would be dependent upon the robustness of the existing digital infrastructure. A locality based approach could facilitate implementation to address differing infrastructure requirements.

Carer marketplaces
Examples such as SuperCarers and Care.com aim to reduce cost and promote consumer choice by linking self-funders directly to individual care workers. Care.com is in part funded by Google Capital and also operates across childcare, petcare and cleaning, among other sectors. They may offer greater choice and cheaper service provision. However, these are introductory platforms that do not provide services directly and are not CQC registered.

To facilitate development within the district time and support would need to be put in to developing the PA market and existing micro providers and supporting self-funders to access that market with confidence. This is out of scope of the re-tender but could work alongside it.

6.3 National Good Practice/ Examples

Wellbeing teams in Calderdale and London. Equal Care Co-op[26] is an example of a company who is working to set up wellbeing teams working in circles of support. Equal Care first established in London and have been placed on the Home Support Approved Provider List in Calderdale where they now have established an office base and presence

Outcomes-based commissioning in Wiltshire: Wiltshire is an example of a large-scale change in commissioning approach, which involved reducing 90 individual contracts worth £14 million to eight outcomes-based contracts with four providers worth £11 million. Wiltshire's **Help to Live at Home service**[27] is an outcomes-based model for commissioning domiciliary care with payment-by-results on rehabilitation. Since its launch, it has enabled the council to place fewer people every year in long-term care and to make significant financial savings

Systems thinking in Gwynedd Council
Systems thinking considers systems as whole entities, rather than looking at their individual components. This enables complex relationships and their effects to be examined. Applying systems thinking approaches requires a fundamental shift from thinking in a step-by step, linear way to a circular, more holistic way that views complex problems as interrelated. Gwynedd Council[28] introduced systems thinking to develop a new way of working in 2022 with a 5 + 4 year contract. It has taken up to 6 years to develop and change prior to implementation and were supported by Vanguard Systems Thinking

Carer Marketplace in Devon
Devon have developed Humans of the Peninsula[29] which aims to connect people to join their dedicated network for both paid and unpaid opportunities to support people throughout the Peninsula to make life a bit better for everyone. Tasks advertised are such as clearing the fridge, shopping, looking after the home such as cleaning and laundry, paying bills, cooking, giving people prompts to take meds, making appointments and providing companionship, all to ensure a person's wellbeing needs are met, so they can remain well in the community. This project has been built up during the pandemic capitalising on the interest in volunteering opportunities during that time.

Helen Sanderson in Leeds
Leeds are implementing the Helen Sanderson teams model and also moving away from a finance model to try and have a flexible service – they will be piloting something soon. Leeds are looking at annualised hours, so people can have flexibility through a month. Also integrating with district nursing so may take on some preventative visits. May also pay provider as a team rather than hours. Leeds has taken 2 years of planning and pilots to reach this stage in implementation whilst having support from the Helen Sanderson organisation.

Isle of Wight Personal Assistant Initiative
Personal assistants (PAs) can enable people to be more independent and in control of their lives. The Isle of Wight Council has worked with partners to establish a personal assistant market that is well placed to support residents in their own homes and reduce avoidable admissions to care homes.

The council has used PAs[30] to avoid and reduce care home admissions by increasing the number of PAs across the island, focusing on rural localities whereby historically home support capacity was limited and resulted in care home admission. Providing training to PAs to support complex needs, for example, manual handling training, meds training etc Implementing a specific PA scheme related to support hospital discharge

[26] https://www.equalcare.coop/
[27] https://www.local.gov.uk/adult-social-care-Wiltshire's Help to Live at Home service.
[28] https://www.gwynedd.llyw.cymru/Adults-and-older-people/Home-Care-Project.aspx
[29] https://www.humansofthepeninsula.co.uk/
[30] https://local.gov.uk/isle-wight-personal-assistant-hospital-discharge-initiative-and-pa-hub.

to home and in addition utilised PAs to support crisis situations in the community whereby care home admission was often the default position.

6.4 Regional overview

Yorkshire & Humber Region
The Yorkshire and Humber [31] meeting in March 2022 captured the regional position for local authorities and where each of them are in the commissioning process with regards to their immediate area. At the time, 8 out of 15 Local Authorities in the Yorkshire and Humber are recommissioning their Home Support in the next year. Some discussion was held about the differences across each area and the number of providers that work across different local authorities.

Barnsley are looking to do a joint cost modelling for a flat rate or bandwith

North Lincolnshire have a base rate with rural and complex additions but welcome consideration of a regional contract. They are also looking to increase technology usage

Leeds are moving away from a finance model to try to have a more flexible services with consideration of annualised hours and integrating with district nursing to take on some preventative visits. Also considering paying providers as teams not hours.

Rotherham are looking to undertake a joint contract with Health. Looking at a flexible model, particularly around a trusted assessor model to increase capacity and the ability to decommission care packages

East Riding looking at a large open framework with an ambition to move from task and finish to outcomes based that supports the market

North Yorkshire are moving from an approved provider list linking in PAMMS work and outcome based approaches

Sheffield looking towards a locality based model and piloting neighbourhood and outcome based work

York have an outcome based specification and rapid service in place that is not able to expand with providers who are stretched and some leaving the market

Kirklees have moved to a principal provider per neighbourhood with that one having 70% of the market

Wakefield
The local authority Commissioners proposed a transformational contract over several years which would allow flexibility to adapt to a culture shift within the Council and Providers. Their Procurement team were positive; however, the legal team would not endorse the proposal which resulted in the team running out of time to deliver a step change. Two contracts were then put in place over short timescales to facilitate change every couple of years to get to the culture change envisaged.

Y&H ADASS Homecare Group
Suggestions have been made by the participants of the Y&H ADASS Home Care group about moving towards universal terms and conditions with basic standard clauses that are region wide to support providers whilst still enabling a tailored package that would work for individual authorities. This is being considered by the Y&H ADASS Homecare Group as a positive suggestion.

6.5 Internal Good Practice

[31] Yorkshire and Humber ADASS Homecare Group 22-23.docx"

6.5.1 Delayed Transfers of Care (DTOC)
Bradford stats are top in the country. Historically, Bradford Districts and Craven have low levels of delayed transfers of care (DTOCs). Bradford is ranked 7 nationally and 3 compared with statistical neighbours, with current performance at 3.6 per 100,000 population. The NHS England target is for Bradford to perform better than 3.8 per 100,000 for all delays. This has only been achievable by all parts of the system pulling together, but notably

- Pre-pandemic Bradford already had in place a discharge model that included Enablement Coordinators and Trusted Assessors which help facilitate a faster discharge.
- Bradford has the Bradford Enablement Support Team (BEST) an Outstanding in-house reablement team (BEST), and the Home Support Reviewing Team (HRST) which can both work with people effectively and then reducing packages quickly.

6.5.2 Localities
In the last tender, smaller service delivery areas were created to align the provision with internal operational localities. This aimed to expand the potential work pool by allowing for the recruitment of staff that may not drive from the local area and reduce journey time. Generally, the move to smaller areas has been welcomed.

6.5.3 Partnership working
There are generally good relationships across the system. The introduction of the Capacity meeting has helped bridge understanding across the system and Service Improvement Board and provider forums offer opportunity for dialogue with Providers. There have been a couple of 'Quick Wins' meetings where Providers have shared ideas which Commissioning has been able to develop, or their own good practice and innovations, in order to build resilience across the sector and BEST and Support Options have worked to 'group' packages together for Providers.

Some of the comments from the Qualitative Interviews include
- Change is already happening and there is appetite for improving further
- Co-production, partnership working and increased communication are the key areas teams are working on
- We have good foundations to build upon and expand on
- There is recognition that change will not happen in isolation and teams are ready to take further steps into co production
- Co-location has been very positive for understanding other team pressures

6.5.4 Community Led Support in Bradford
Community Led Support seeks to change the culture and practice of community health and social work delivery so that it becomes more clearly values-driven, community focused in achieving outcomes, empowering of staff and a true partnership with local people. It has a person-centred flexible support service which supports people to take control of their lives, and do the things they want to do. Ideally working closely with the people they support, their families and carers to deliver a wide range of supported leisure, learning, and employment opportunities.

6.5.5 Providers' response to Covid and DTA
Providers have been tested significantly since the start of the pandemic, taking on short term support packages and supporting discharge to assess model.

6.5.6 Recruitment and retention
The Bradford Workforce Strategy
Skills for Care is a workforce development body that the Council has commissioned to undertake the Bradford Workforce Social Care Strategy. The aims, key priorities, and objectives of the Bradford Workforce Strategy are detailed in the pdf document below.

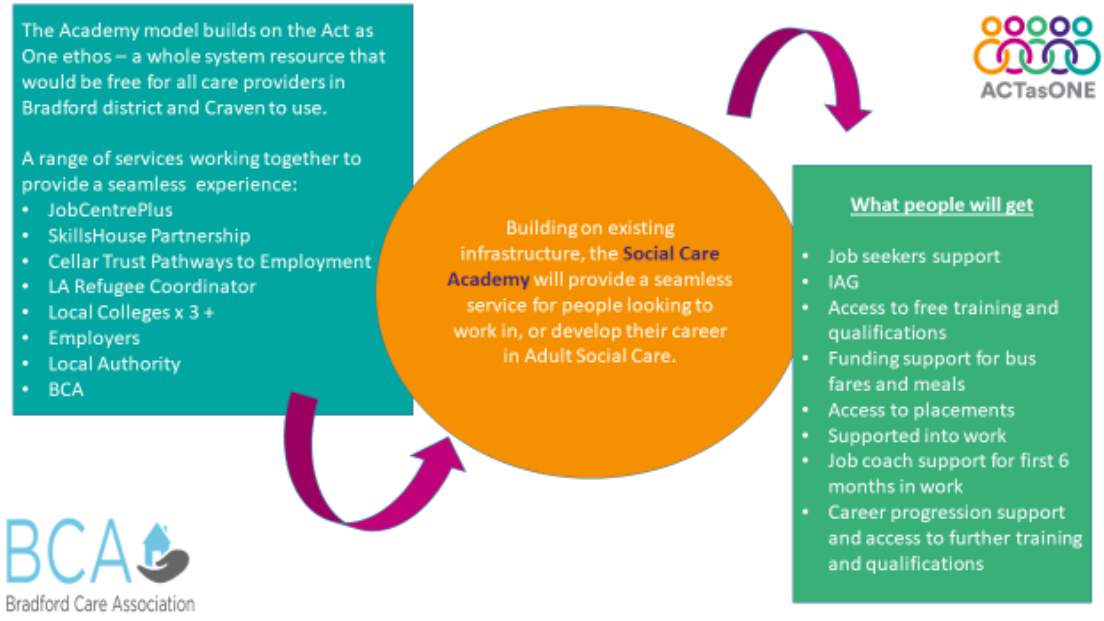
Bradford Workforce Strategy .pdf

Advertising Strategy
The Council have employed various methods of advertising to support recruitment in the adult social care sector.

- The Council have distributed leaflets and posters encouraging people to join the adult social care sector to local units across the Bradford District to support recruitment in local areas.
- The Marketing and Communications Team, for the Health and Wellbeing department, are making magnetic car signs that will signpost individuals to job vacancies, i.e., the Bradford Cares Website. The magnetic car signs will be attached to Council vehicles used for social care.
- The Council are using master adverts to advertise vacancies in adult social care. Previously, managers were responsible for advertising vacancies for their own service area. Master adverts filter vacancies by job role, rather than service area. For example, the Council may advertise a vacancy for an Enablement Assistant. The advert will list the service areas that are recruiting for an Enablement Assistant, as opposed to each service area advertising for an Enablement Assistant. Master adverts are being used to streamline the job hunting and recruitment process.
- The Council are arranging for ambassadors to visit schools and speak to students about career pathways in social care. Students will have the opportunity to learn about the benefits of working in social care.

Social Care Academy Model
Initiatives to support recruitment and retention are being planned ahead of autumn and winter when service pressures are expected to increase. The BCA are working with the Council to develop a more strategic approach to recruitment.

The Social Care Academy model was built on existing projects and infrastructure. The flowchart below lists the range of services working together to support recruitment and the ways people are being supported with job hunting and career progression opportunities. The model intends to encourage students and young people to join the adult social care sector by making access to training, qualifications and work placements more convenient. There is opportunity for more funding into the Social Care Academy as a result of the Prince's Trust £40,000 grant.



The Bradford Cares Recruitment Portal
The Bradford Cares Recruitment Portal was developed by the BCA and the Council to allow the Council and independent care providers to advertise their job vacancies and inform individuals interested in working in the adult social care sector of the variety of jobs available.

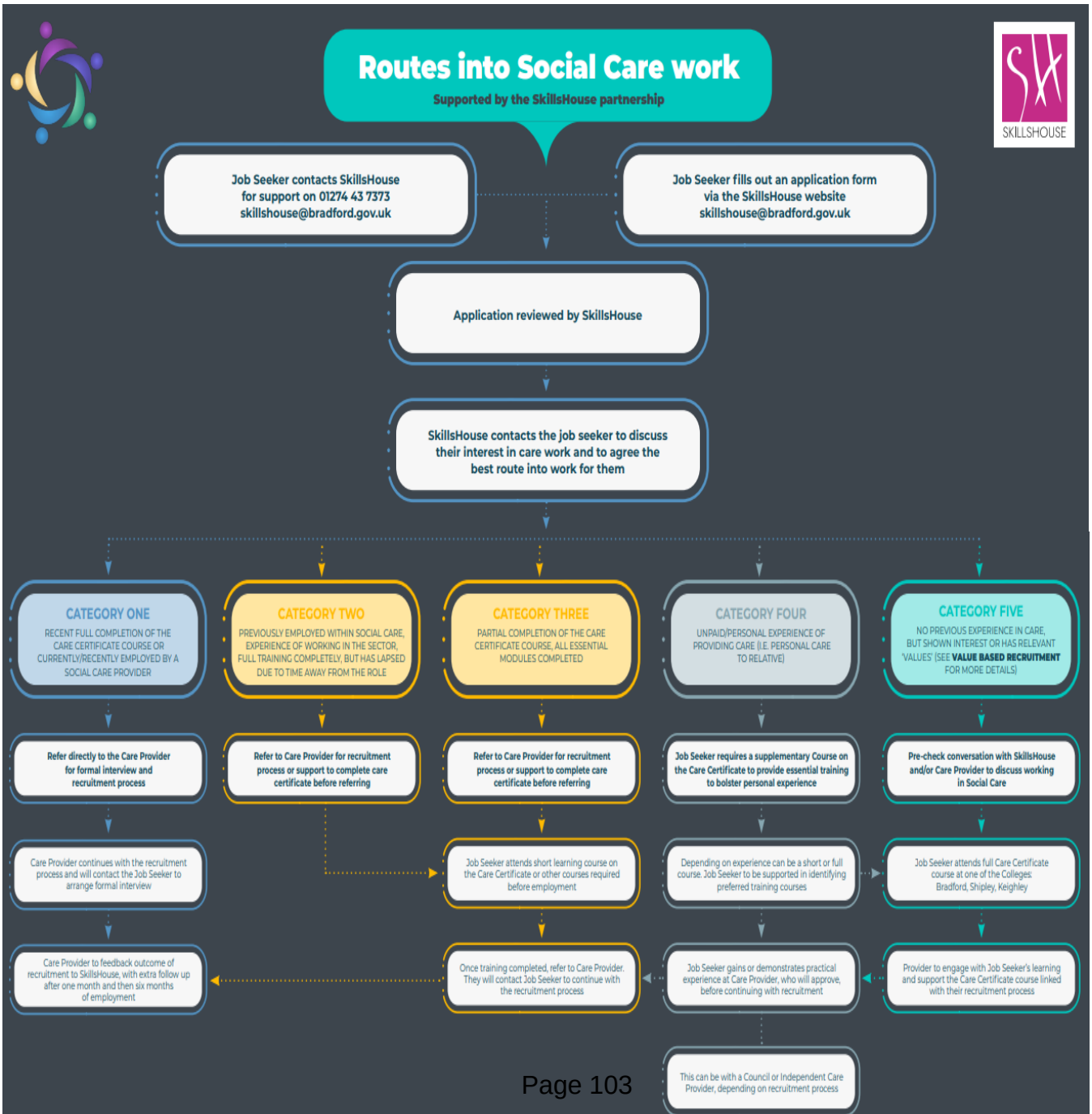
Independent care providers, who are BCA members, can contact the BCA admin and request a job vacancy form. The provider will complete the vacancy form and return to the BCA admin. The BCA will add the vacancy to the job portal and update the provider if they have success with recruiting using the Bradford Cares Portal.

Bradford Cares offers a streamlined approach to recruitment and job seeking as it helps match job seekers with care providers who have job vacancies.

The Bradford Cares Recruitment Portal can be accessed using this link: https://bradfordcares.co.uk/

SkillsHouse Jobseeker Pathway
Jobseekers are encouraged to contact SkillsHouse. SkillsHouse will provide the job seeker with an application form and support them with completion. SkillsHouse use value based recruitment to assess job seekers and ensure only appropriate applicants are chosen. Jobseekers are directed to the relevant job seeker categories based on their experience and their interests in care work. Job seekers are expected to complete the recruitment pathway, by following whichever route into social care that is best for them. SkillsHouse will support job seekers with completing of the Care Certificate. SkillsHouse will ensure that applicants are fully understand what is expected of them as part of the recruitment pathway.

The different job seeker categories can be found in the flow chart below.



6.5.7 Quick Wins

We invited members of the Service Improvement Board for the Home Support Services alongside internal colleagues, to discuss ways the council can support providers over the winter period with packages coming out of hospitals, whilst recruitment and staffing is challenging.

There were a number of suggestions brought forward, and providers were asked to prioritise those which they felt would be the most beneficial and achievable. Successes included, parking passes for Home Support staff (on par with District Nurses), access to volunteer –driven 4X4 vehicles for emergencies and sharing of staff benefits

7. Proposals for New Ways of Working

Below are 4 new ways of working which draw on the research detailed in section 6. These are not mutually exclusive, for example self-governing teams will need to be community-based, utilising a strength-based approach to support.

We need to be brave, we need to think long-term, we need to trust

7.1 Self-Governing Teams

These are self-managed teams that focus on person-centred care and supporting people in their communities, inspired by the Buurtzorg and Helen Sanderson approaches as detailed in section 6.2.1.

It is a move away from time and task to more outcome – based results therefore also incorporate Outcome Based Commissioning detailed in 6.2.2. as well as a Community Led Support approach. It will involve a substantial culture change for Providers but also Social Workers with a view to working to outcome focussed care and support plans.

Potential Features	Potential benefits
Small, self-governing teams which are neighbourhood based	Increased staff retention- more valued/ trusted, guaranteed income, set hours
More emphasis on developing self-care, community links, unpaid support, AST before delivering personal care.	Reduction in budget Security of Hours
Consistent, recognisable staff.	Better outcomes for people.
Builds on CLS approach	More personal and person-centred
Move from time and task to outcome based	More flexible and able to respond to quickly

Move to permanent contracts/	Could everyone have some level of reablement?
Shift patterns (no split shifts)	Staff more valued/ trusted – staff retention
Utilise non-drivers.	Opens up recruitment pool.
	Job Security

Note – the benefits are not necessarily aligned to the features

7.2 Integrated Teams

- These would be based in the community and be more integrated with Heath and Social Care Teams as detailed in section 6.2.3
- This could range from working more closely with Social Workers and/ or co-location to fuller integration with Health colleagues
- These Locality boundaries are (for the most part) running close to Area Team boundaries and could be potentially mapped against Primary Care Networks.

Potential Features	Potential Benefits
Build on 5 Area team Localities and/ or 12 Bradford and District community partnerships	Better experience for Service Users/ continuity of care
Co-locations	Fewer complaints and requests for new provider.
Joined-up, holistic approach.	Reduced staff turnover
Better links in to VCS and informal networks	Reduction in commissioned support
Reduced travel time.	Bigger pool of potential workers
Utilise non-drivers.	
Established providers with a good knowledge and links to the local area	

Note– the benefits are not necessarily aligned to the features

7.3 Skilled workforce/ career of choice

This is reimagining the workforce so that the Home Support staff can be skilled – up/ specialise in different areas.

Potential Features	Potential benefits
Career progression/ opportunities within smaller teams	More attractive to potential staff
Specialities: range from domestic, personal care and healthcare*	Care priming market for Health

Apprenticeships	Better retention
Different rates of pay/ better remunerated	More esteemed career More Skilled Up workforce

Note– the benefits are not necessarily aligned to the features

7.4 Technology

This is the incorporating elements (or more) of that detailed in Assistive Technology at 7.4

Potential Features	Potential benefits
ECM	Greater independence for Service users
Info sharing	Reduced spend – fewer calls Don't have to keep telling the same story
Telecare	Prevention, early intervention when trends show intervention required and greater independence for the service user. Increased peace of mind for the family
Assistive Technology/ Technology Enabled Care (TEC)	May be less intrusive Free up staff time

Note – the benefits are not necessarily aligned to the features

8. What is our appetite for change? Feedback from DMT

A workshop was held with DMT. As part of this, an exercise discussing what was in scope/ out of scope took place, with some clear and some still to be explored.

There was also a lot of appetite for the above new ways of working, and a high-level prioritisation exercise was completed which indicates when different aspects of the models should be rolled out. This will be considered in the next stage.

9. Next Steps

Model Development

- Discussions to be held with other Commissioned Areas to develop a firmer picture of services in-scope (or in principle)
- Commissioning to bring back a firmer proposal to DMT to include:
    - Outline plan and model
    - Recommendations for contract type
    - Options Appraisal re procurement
    - Risk and Issue log
    - Decision logs
- Dependent on commitment and resource from all partners

10. Authors and Approvers

10.1 Author Alex Lorrison, Jacqui Turner, Rominder Dhothar
Date: 18/08/2022

Appendix 1
Consultation themes from 1 to 1 meetings with managers across the system

Key Positives

- Change is already happening and there is appetite for improving further
- Co-production, partnership working and increased communication are the key areas teams are working on
- We have good foundations to build upon and expand on
- There is recognition that change will not happen in isolation and teams are ready to take further steps into co production

Issues/theme	**Detail**	**How we can mitigate/solve/address**	**Issue Area – Hospital/ Procurement/ Commissioning**
Flow of patient journey	Challenges throughout the whole system Patients are being discharged from hospital to make way for those who are waiting to be admitted and can sometimes risk being readmitted Patients being discharged to BEST and they are struggling to then make space by discharging in to the provider market	Solution is system wide and will be impacted by all the measures put in place to address issues noted below	System wide
Locality Contracts	Providers are unable to take 100% of the individuals due to staff capacity Restricts choice for individuals about providers Challenges if there is a provider breakdown Been propping up with layers of additional contracts Providers given locality contracts where they do not usually have a presence Larger companies are finding it difficult to enter the market	Move from locality with only 1 provider and consider a shared option of 70/30 or other so providers can flex between each other in the locality areas or a provider in one area and neighbouring localities can provide for the 30% Ensure providers can demonstrate the positives of their local presence or an ability to be locally present and able to meet demand within a set timeframe – this becomes easier with a shared locality Move from legacy contracts to new provider contract – can only be done quickly and efficiently if we get the capacity and flow right Work closely with provider market to keep stability and	Commissioning – tender, tender questions and specification clauses Some input from Procurement and Legal Consultation input from providers Input from SW and BEST re assessments to transfer to the new providers

Issues/theme	Detail	How we can mitigate/solve/address	Issue Area – Hospital/ Procurement/ Commissioning
	Smaller companies are struggling to meet capacity demand Too much change causes instability in the provider market due to staff uncertainty Providers can go in to default with few to no consequences as the tender process is considered lengthy	capacity in place during any transitions - need to work within the legal and procurement framework when doing this Will all individuals need to be assessed to transfer? If staying with same provider no assessments and prioritise those who will be changing, BEST assessment will sufficient for transfer. Will need to consider procedure and SW message needs to be rigorous We need to take action when providers go in to contract default in a timely ways	
End of Life Pathway on Discharge from Hospital	Discharges from hospital for end of life care are sent to providers who are not able to navigate the fast track pathway resulting in additional assessments and poorer care for the individual BEST not always being able to pick up in the 4 hour guideline	Providers to liaise closely with BEST to work together to move the individual to the fast track service using the OT specialist within the BEST team Reviewing the discharge process and potential for co-producing internal standards to work too https://chshealthcare.co.uk/	Commissioning with specification clauses for working with BEST and developing knowledge and links to the Fast Track service
BEST – flow and capacity issues	struggling to be able take cases from the hospital and at the other end to move people on in to home care providers Receiving inappropriate referrals eg UCR for Mental Health support or for where enablement element not required which takes time to redirect	BEST to be fully staffed A flexible STEP contract or clause in specification to step up and step down for BEST peaks and troughs. Better flow would resolve this too Communication and training across the teams to raise awareness and understanding of appropriate referrals and pathways to ensure better patient care and support	Commissioning with Specification communication ??
Hospital Discharge and BEST	BEST not picking up packages quickly enough for the hospital BEST finding the hospital delays to be challenging for pick up	Co-location has been very positive for understanding other team pressures Trusted assessor model works well in Bradford and would be a solid base for co-producing internal standards for discharge	Hospital and BEST collaboration Can we do capacity modelling?

Issues/theme	Detail	How we can mitigate/solve/address	Issue Area – Hospital/ Procurement/ Commissioning
	Hospital teams not joined up which can cause pressures with clunky discharges Discharge on pathway one is the biggest challenge for hospital (now moved to home first model but old pathway one cohort still a challenge) Hospitals putting people where there are spaces and this results in poor care	pathways which could include discharge slots East Lancs have a set number of slots each day for discharge and patients get booked in and suggested as potential model to adapt	
BEST and Existing Packages	On discharge BEST will take on the whole package as enablement even if they had an existing package before Providers are not taking back the original package, particularly if they are unable to accommodate an increase	Consider split packages between BEST and provider during enablement process with option for BEST to step down and provider to step up where appropriate to maintain continued support for the individual	Commissioning through specification clauses Closer collaboration with BEST and Providers
STEP Contract	T&Cs do not have any enablement aspects and positive outcomes are not as high as BEST Links with flow – BEST had capacity issues so STEP introduced who had capacity issues and home care introduced	Assisted Lives do good partnership working with BEST – pull this in to future contracts Specific clauses around working in co-production with BEST, consider areas of co-location for specific points during the transfer of the individual to a STEP service Consider if STEP service should be additional step up step down service or built in to the main contract. How much is required if BEST is not carrying vacancies BEST OT assessor will facilitate a more timely ability to move person on to a chargeable service after enablement has finished	Commissioning and procurement – T&Cs and Specification, tender questions BEST, in particular OT assessors

Issues/theme	Detail	How we can mitigate/solve/address	Issue Area – Hospital/ Procurement/ Commissioning
S243 – changes to packages and cessation of packages	Currently no incentive to work out issues prior to provider breakdown Providers submitting S243 increases months after they have commenced and requesting backdated payments S243 increases in provision being paid for months without an assessment occurring Support Options spending a substantive amount of time to unpick issues each week and to check backdated payments which could be utilised more effectively to reduce other pressures within their team	Put in place processes that incentivise open communication and trust to resolve issues when first raised SW to work proactively to support individual and provider communication and manage expectations of call times BEST dedicated OTs to carry out rapid assessments to approve increases to packages Cease backdated payments for increases due to late submission of S243 by provider Having staff who are reflective of communities and who are culturally capable and supportive	Commissioning through specification clauses Procurement Communication with providers and SW to support resolving of issues at first instance Collaboration between BEST and providers
Communication and understanding of roles across teams	Teams along the whole system – know their area but not clear on what it available from other teams in the process Area highlighted - Inconsistent messages from SW and lack of understanding on their part about how their decisions impact on other teams	Co-location Co-production Work shadowing Central hub for information and sign posting available across the whole system	Hospital BEST Providers Commissioning Contracts Procurement
Providers	Hospital retainers being paid but not taking person back, especially if there is an increase Being able to step up and step down support to react to a temporary situation eg urine infection Recruitment and retention issues for provider staff	Suggestion of considering Time Out model of annualised hours to support step up and step down situations Look at fair cost of care and providers signing up to Ethical Care Charter Potential for exploring mix of contract types for provider staff to improve staff retention including shift work	Commissioning specification and T&Cs clauses Procurement Providers

Issues/theme	Detail	How we can mitigate/solve/address	Issue Area – Hospital/ Procurement/ Commissioning
	Providers do not have the capacity to be agile and responsive to rapid response packages or taking packages out of hours		
Providers and Home Care Tasks	Home care contract delivering for social inclusion, shopping, cleaning etc. and we are unable to establish how much of the contract is delivering this type of work – packages that include these types of tasks mask the true picture of positive outcomes for enablement Providers are cherry picking contracts that they have staff skills to deliver so more complex packages are not always picked up in a timely manner as providers do not always have the skill set available to deliver that support	Consider additional payment lines on ContrOCC to enable analysis of support types – will require SW to ensure they select the correct payment lines when inputting a package Split costs for differing levels of skills within the contract Enabling requires longer to carry out than doing for and will need to be addressed within call times Need to skill up providers to undertake more complex work or support health for enablement packages	Support Options Commissioning Providers
Staff recruitment across Providers BEST and Health	Some staff are moving from one sector to another as the opportunities for career progression are limited by the current time and task model	A more holistic view of career progression and training to undertake different types of tasks within sectors could increase the opportunities for individual staff within areas to flex up and down to roles that are a good fit with their ambitions and skill sets. Eg training workers to take bloods and increase pay in line with skills	Providers Commissioning Hospitals Health BEST
Support Options and BEST brokerage systems	Have 2 brokerage systems BEST contact the providers to place enablement packages and push the packages towards them Support Options place packages on Connect to	Review the two systems to work out how they can be streamlined to work in partnership and reduce potential for provider issues	BEST and Support Options

Issues/theme	Detail	How we can mitigate/solve/address	Issue Area – Hospital/ Procurement/ Commissioning
	Support for providers to pull packages		
Support Options	constantly first point of call for queries	Set up a central information portal for FAQs to reduce the amount of queries and recurring queries	Support Options Commissioning for sign posting

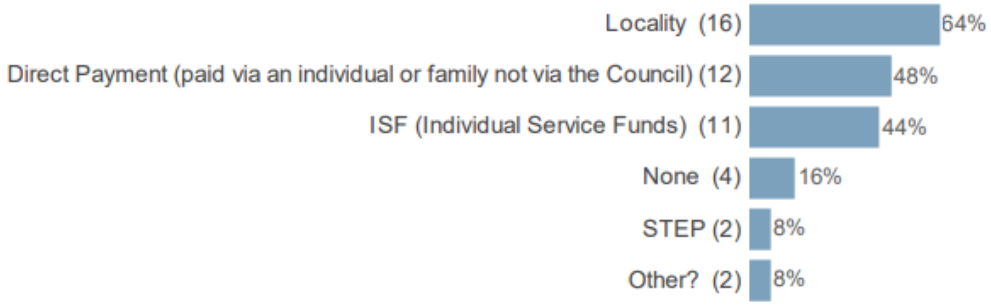
Appendix 2

Home Support Survey Summary - Providers

The survey was sent to all providers currently delivering Home Support for Bradford via the Commissioning Inbox on 10 June 2022. A reminder was sent on 17 and 20 June. The Bradford Care Association also circulated the email to provider encouraging them to respond to the survey. **The closing date for responses was 6pm Monday 20th June**

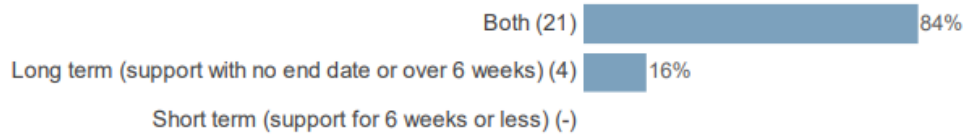
There are currently 82 providers who deliver services for Home Care and we had 25 responses giving a 30% response rate. The survey was designed so that it could be anonymous but allowed for details should anyone wish to put themselves forward to be contacted further and 16 providers left contact details.

What type of Home Care contract(s) do you hold or deliver in the Bradford District? (please tick all that apply)

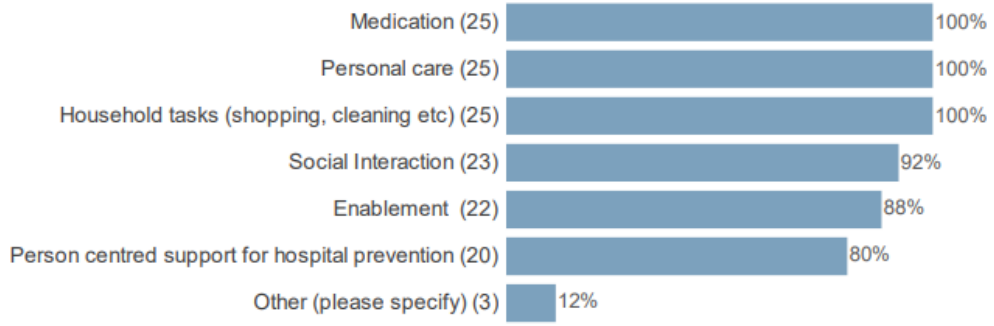


Please specify
CCG
isc's for individuals

What length of support do you deliver?



What types of support do you deliver? (please tick all that apply)



Companionship
Respite care, companionship
complex care

Outside of workforce, what are your biggest challenges?

Challenges	Biggest challenges	Top two
Organisational costs/overheads	**4**	3
Family intervention in care eg giving medication	**1**	
Staff pay	**1**	3
Compliance with red tape/recruitment	**4**	2
Recruitment	**5**	6
Digital Innovation	**1**	1
Location of calls	1	1
Fuel costs/ cost of living	7	6
Accurate information from Bradford colleagues	4	2
Consistency of SW	1	1

Specific areas that have been highlighted as issues around working practice are

- Family intervention, sometimes meds are given before care staff arrive so the Dossette box has an empty slot which we have to then chase to find out why which is time consuming
- Setting new employee quickly so they can join the team
- getting correct and accurate information regarding potential residents
- Chasing payments with Support Options
- poor hospital discharges
- dates for transfer not being passed on to the various agencies people who need to know
- Assessment with inaccurate or out of date information.
- not recognised by Bradford Council in comparison to the bigger companies
- having a regular social worker for people being supported if their needs change.

Specific areas that have been highlighted as issues around the contract are

- Travel and location of calls
- Voids in properties in areas that are not desirable to people looking at vacancies
- Not having a contract with Bradford Council
- lack of support from the council
- Processes of tendering for small businesses
- lack of information and direction provided to care providers who are not on the Bradford Council framework

What is working well?

Working Well	Biggest impact	Top two
Carer/service user relationships	4	3
Internal team working	6	4
Staff and staff retention	5	4
Investing in staff - training and career pathway	5	6
Digital solutions	4	4
The geographic placement of packages	3	1
Recruitment	2	2
Support from Bfd	3	1
Staff pay	1	

Specific areas that have been highlighted around supporting staff are

- Training programme - New in house programme specifically designed for our company
- We have invested in a career pathway that provides front line staff the opportunity to develop within the business
- Staff on line training

Specific areas that have been highlighted around digital solutions are

- Electronic systems e.g. real time care records and training platform.
- Care management app, electronic system is going well, as contributes towards making the service more effective
- Technology has made life easier using mobile Apps

Specific areas that have been highlighted around the Local Authority are

- The geographic placement of packages
- Communication with the local authority regarding adjustments and reassessments
- Working closely with Best and the professionals - sometimes they do understand our predicament

It is recognised that workforce is one of the most pressing issues generally for Home Support, what do you feel are the specific challenges you have encountered recently in this area?

Specific Challenges	
Recruitment	12
Pay	8
Cost of living	8
Non drivers	4

The biggest issue identified is the recruitment of staff and the barriers of unsocial hours, low pay and the rising costs of living that are affecting the ability of staff to use their own vehicles due to the rising fuel costs. One provider has mentioned they have been subsidising the cost of petrol for their employees

Specific areas that have been highlighted are

- People not wanting to join care and not being able to drive
- Petrol costs - staff threatening not to use their cars for work
- There is no integration on the frontline between health and social care
- Staff continue to feel undervalued and second class to NHS
- Recruitment in Bradford is the biggest challenge and there is little support from the Commissioning team, apart from pressure
- inability to recruit staff who can drive
- Non drivers applying for driver roles

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Director of Legal and Governance to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 6 October 2022

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Subject: Health and Social Care Overview and Scrutiny Committee Draft Work Programme 2022/23

Summary statement:
This report presents the Committee's work programme 2022/23

Portfolio:

Healthy People and Places

Report Contact: Caroline Coombes
Phone: (01274) 432313
E-mail:
caroline.coombes@bradford.gov.uk

1. Summary

1.1 This report presents the Committee's work programme 2022/23.

2. Background

2.1 Each Overview and Scrutiny Committee is required by the Constitution of the Council to prepare a work programme (Part 3E – Overview and Scrutiny Procedure Rules, Para 1.1).

3. Report issues

3.1 **Appendix A** of this report presents the work programme 2022/23. It lists issues and topics that have been identified for inclusion in the work programme and have been scheduled for consideration over coming year.

3.2. Best practice published by the Centre for Public Scrutiny suggests that 'work programming should be a continuous process'[1]. It is important to regularly review work programmes so that important or urgent issues that come up during the year are able to be scrutinised. In addition, at a time of limited resources, it should also be possible to remove projects which have become less relevant or timely. For this reason, it is proposed that the Committee's work programme be regularly reviewed by Members throughout the municipal year.

4. Options

4.1 Members may wish to amend and / or comment on the work programme at **Appendix A**.

5. Contribution to corporate priorities

5.1 The Health and Social Care Overview and Scrutiny Committee Work Programme 2022/23 reflects the priority outcomes of the Council Plan, in particular, 'Better Health, Better Lives' and 'Living with Covid-19'[2]. It also reflects the guiding principals of the Joint Health and Wellbeing Strategy for Bradford and Airedale 'Connecting people and place for better health and wellbeing'.

6. Recommendations

6.1 That the Committee notes the information in **Appendix A** and considers any amendments or additions it may wish to make.

6.2 That the Work Programme 2022/23 continues to be regularly reviewed during the year.

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[1] Hammond, E. (2011) *A cunning plan?* p. 8, London: Centre for Public Scrutiny
[2] Our Council Plan: Priorities and Principles 2021-25 https://www.bradford.gov.uk/councilplan

7. **Background documents**

None

8. **Not for publication documents**

None

9. **Appendices**

9.1 **Appendix A** – Health and Social Care Overview and Scrutiny Committee work programme 2022/23

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Appendix A

Democratic Services - Overview and Scrutiny

Health and Social Care O&S Committee

Scrutiny Lead: Caroline Coombes tel - 43 2313

Work Programme

Agenda	Description	Report	Comments
Thursday, 24th November 2022 at City Hall, Bradford			
Chair's briefing 09/11/22 Report deadline 14/11/22			
1) Shipley Hospital / Keighley Healthcare Estate	TBC This may be two separate reports / items	Helen Farmer / Robert Madden	Last update on Shipley Hospital received 5 March 2020
2) Implementation of 'host commissioner' arrangements	TBC	Iain Macbeath / Michelle Turner	Resolution of 21 October 2021
3) Covid-19 update	Update	Caroline Tomes	Resolution of 18 Nov 21
4) Community Diagnosis Hubs	Update on plans to deliver additional diagnostic capacity to deliver a faster service and require fewer visits for patients to access a range of diagnostic tests	Helen Farmer	
Thursday, 15th December 2022 at City Hall, Bradford			
Chair's briefing 29/11/22 Report deadline 05/12/22			
1) Mental wellbeing	To include information on the reviews of IAPT and older people	Sarah Exall / Kris Farnell	Resolution of 16 Dec 21
2) Re-imagining day services	To include information on the co-production partnership and people with lived experience be invited to attend	Gareth Flemyng	Resolution of 18 Nov 21
Thursday, 19th January 2023 at City Hall, Bradford			
Chair's briefing 05/01/23 Report deadline 09/01/23			
1) Cap on care costs / contributions policy	TBC	Jane Wood	Care Act 2014 allowed for a cap on care costs but implementation was postponed. Amended by the Health and Care Act 2022 and now expected to be implemented in 2023
2) Cancer	Outcomes of the lung cancer pilot programme and update on cancer waiting times target performance	Janet Hargreaves	Resolution of 13 June 2019 (postponed from April 2020)

Health and Social Care O&S Committee

Scrutiny Lead: Caroline Coombes tel - 43 2313

Work Programme

Agenda	Description	Report	Comments
Thursday, 16th February 2023 at City Hall, Bradford **Chair's briefing 01/02/23 Report deadline 06/02/23**			
1) Respiratory Health in Bradford District	Update	Public Health	Resolution of 22 November 2018 to have an update in 2 years
2) Safeguarding Adults Strategic Plan and Multi-Agency Safeguarding Hub	Update	TBC	Resolution of 6 September 2018
3) 0-19 Children's Public Health Services	Update on performance with Bradford District Care Trust	Contact: Liz Barry	Resolution of 23 June 2022
Thursday, 23rd March 2023 at City Hall, Bradford **Chair's briefing 08/03/23 Report deadline 13/03/23**			
1) Adult Autism	The Committee has resolved its expectation that 80% (256) of the projected number of assessments will have been delivered by March 2023. Report to also include a plan to ensure the sustainability and continued improvement of the service	TBC	Resolution of 17 March 22