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DATE: 26 June 2018

ADULT CARE AND HEALTH POLICY DEVELOPMENT AND SCRUTINY COMMITTEE

Meeting to be held on Wednesday 27 June 2018

Please see the attached reports marked "to follow" on the agenda.

9c **THE EVALUATION AND PROPOSAL TO EXTEND THE DISCHARGE TO ASSESS PROCESS** (Pages 3 - 20)

10e **NURSING CARE BEDS CONTRACT UPDATE** (Pages 21 - 24)

Copies of the documents referred to above can be obtained from http://cds.bromley.gov.uk/

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Report No.
CS18146

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**EXECUTIVE**
Date:	**For Pre-Decision Scrutiny by the Adult Care and Health Policy Development and Scrutiny Committee on Wednesday 27th June 2018**
Decision Type:	Non-Urgent Executive Non-Executive Non-Key
Title:	**THE EVALUATION AND PROPOSAL TO EXTEND THE DISCHARGE TO ASSESS PROCESS**
Contact Officer:	Jodie Adkin, Assistant Director: Urgent Care and Discharge Commissioning Tel: 07803 496492 E-mail: Jodie.Adkin@bromley.gov.uk
Chief Officer:	Stephen John, Director of Adult Social Care, ECHS Tel: 020 8313 4754 E-mail Stephen.John@bromley.gov.uk
Ward:	Borough-wide

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1. Reason for report

1.1 The report provides the evaluation of the Discharge to Assess pilot and recommendations for next steps.

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2. RECOMMENDATION

2.1 The Adult Care and Health PDS Committee is asked to note and comment on the contents of this report prior to Council's Executive being requested to:

i) Agree the drawdown of £304k from the Better Care Fund (BCF) underspend to support the extension of the Discharge to Assess pilot, as set out in Paragraph 3.5 to 3.7 of Report CS18146 which will deliver full year cashable savings of £419k from 2019/20 as set out in Paragraph 5.6; and,

ii) Agree that an update report to include any legal or procurement implications identified by the D2A Programme Board associated with mainstreaming the D2A activity be brought back to Council's Executive as required.

Impact on Vulnerable Adults and Children

1. Summary of Impact: The Discharge to Assess pilot supports vulnerable adults.

Corporate Policy

1. Policy Status: Not Applicable
2. BBB Priority: Supporting Independence Healthy Bromley:

Financial

1. Cost of proposal: £1.55m:
2. On-going costs: £1.45m:
3. Budget head/performance centre: Not Applicable
4. Total current budget for this head: £Not Applicable
5. Source of funding: BCF

Personnel

1. Number of staff (current and additional): 12
2. If from existing staff resources, number of staff hours: 0

Legal

1. Legal Requirement: Statutory Requirement:
2. Call-in: Applicable: Executive decision

Procurement

1. Summary of Procurement Implications: At this point in time all D2A activity is procured through the CCG on behalf of the LA. To mainstream the activity, LBB will be required to procure relevant activity associated with the delivery model. A detailed report outlining procurement implications and timescales will be taken through the relevant governance processes as required,

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Customer Impact

1. Estimated number of users/beneficiaries (current and projected): current 0, proposed 450

Ward Councillor Views

1. Have Ward Councillors been asked for comments? Not Applicable
2. Summary of Ward Councillors comments: Not Applicable

3. COMMENTARY

Background

3.1. The October 2017 Executive agreed 6 months funding of £819k from the Better Care Fund (BCF) underspend to pilot Discharge to Assess (D2A) in Bromley (see Annex A for D2A description).

3.2. The pilot sought to reduce delayed transfers of care (DToC) and the impact prolonged hospital stay has on frail and elderly individuals including reduction in muscle mass and physical ability as well as mental and emotional decline. Reducing DToC is a national priority with potential financial implications for local areas iBCF funding where the DToC target is not achieved. While the national data shows DToCs in Bromley have increased, the reported DToCs at the PRUH, where the pilot focused have reduced considerably with 1,208 bed days saved between September and April 2018 against the same period of the previous year.

3.3. The aim of the Pilot was to transform out of hospital assessment and support processes for people with on-going care and support needs. Discharge to Assess offers access to immediate wrap around care and support in the community, reducing length of hospital stay in order for the assessment of long term care and support needs to be undertaken in a more familiar setting, and critically, once individuals have recovered and are functioning at their likely baseline level. Evidence suggests assessing people in hospital results in an over prescribing of on-going care and support needs. Assessing at home, can result in significant reductions in levels of on-going care and support and improved independence. This was strongly echoed in the outcome of the local pilot.

3.4. Discharge to Assess was mobilised during the busiest winter in the history of the Bromley system however many successes were achieved and lessons learnt to be further built upon in order for the full benefits to be realised.

Proposals

3.5. Extend the pilot for 2018/19 to allow for full benefits to be realised and activity to be mainstreamed wherever possible.

3.6. Approve the use of £304k from BCF underspend to extend the pilot for a further 12 months.

3.7. Utilise the pilot extension to

- Provide sufficient time for the recently established Quality Assurance & Performance Monitoring Framework (QAPMF) to be fully embedded to understand the impacts, outcomes and long term benefits of D2A as well as achieving a more robust monitoring framework going forward.
- Continue to streamline assessment and planning processes to reducing duplication making the system more efficient wherever possible.
- Recruit a Project Manager to support the extension of the pilot and the programme of work associated with scoping and implementing any mainstreaming activity. The Project Manager will have a key role in ensuring robust monitoring and tracking processes are embedded and required governance processes are followed for all D2A pilot and mainstreaming activity.
- Allow the D2A Programme Board to scope, undertake a robust options appraisal and develop required Procurement and HR plans to be formally approved as required in line with the Councils Policy and Procedures for any potential mainstreaming activity.

Outcomes

Highlights and Achievements

3.8. The full service was successfully mobilised during the busiest winter in the history of the PRUH which included:

- The recruitment of an innovative multidisciplinary team consisting of GP Liaison, care management, Care Management Assistant and more recently Physio therapy and Occupational Therapy input.

- A dedicated domiciliary care provider was procured able to provide rapid, responsive care in all areas of the borough, starting 7 days per week. The provider plays a key role in the MDT and assessment process fully utilising all human resources across D2A.

- Full systems and processes were developed including discharge and referral processes, as well as more recently full adaptation of Carefirst which will enable more rigorous impact and outcome monitoring and tracking.

3.9. The pilot supported 226 people that met the Care Act threshold for assessment and support. 162 were supported on the home pathway, 23 in interim beds and 41 into permanent placements. Numbers have continued to rise as the pilot becomes more established.

3.10. Length of stay reduced from 32 days in the initial months of the pilot to 21 days with the some people transitioning off as close to 3 days post hospital discharge. As the team are becoming more experienced and established the length of stay will further reduce.

3.11. Contact is made to all D2A clients within 48 hours of leaving hospital with all assessments commenced within 1 week of someone leaving the PRUH. Some individuals are transitioned immediately onto permanent services and others receiving an active care plan to further increase independence before long term care and support is prescribed.

3.12. 100% of clients are seen in hospital by the liaison GP before they were discharged and screened by hospital based Transfer of Care bureau team to ensure they are being appropriately discharged. This element was seen as extremely beneficial by both hospital based clinicians and the discharge to assess team.

Outcomes

3.13. **Pathway 1: Home (161 individuals)**

121 individuals saw a reduction in on-going care and support needs with 40 of these no longer requiring any long-term care.

32 clients care remained the same as at the point of hospital discharge to ending D2A

8 clients saw an increase in levels of care, however all were able to remain at home

24 hour care was tested for 10 clients to prevent admission. 6 remained at home with a standard package of care while 2 went into permanent placement and 2 were readmitted

3.14. **Pathway 2 – Interim Placement (22 individuals)**

6 clients stepped down from interim placement to more independent settings, either returning home or to Extra Care Housing

3 required long term placement

7 were readmitted. Further audit into this group is being undertaken to better understand the reasons for readmission which will further influence the development of the pilot

7 remained on the service at the time of the evaluation

3.15. **Pathway 3 – Long term placement (41 individuals)**

At the point in the evaluation 28 individuals remained in their placement with no final outcome agreed. Of the remaining 13 who had been discharged from D2A, 10 individuals remained in their initial placement, 2 moved due to family choice and 1 moved due to funding.

100% of clients requiring enhanced care in placement (6) at the point of discharge (requiring above the ceiling rate funding and often costly 1:1 support) no longer required this long term, post D2A intervention. Resulting in all placements post D2A, being made within the ceiling rate. This was achieved through effective MDT working to address presenting challenging behaviour with close working between the GP, care manager and therapists to support people in the best way possible.

1,025 delayed bed days were saved during the period of the pilot against the same period of the previous year achieving a cost avoidance to the LA of £103,000 in Trust charges

3.16. **General**

80% of clients surveyed (N=28) said they would recommend discharge to Assess to others

30 admissions were avoided

Local authority cashable cost savings to the local authority of £419,000 (net of costs in a full year) with a further £206,000 cost avoidance of potential DToC charged.

As a result of the 6 month pilot, a more sound basis for modelling going forward has been identified and provides the basis for the pilot extension proposal.

3.17. GP, therapies and provider input into the care act assessment is creating a much more rigorous assessment of long term care and support needs.

3.18. 5 members of the hospital team have transitioned into the D2A team to date with further expressions of interest being received. The financial spend of £781,000 for the pilot was spent against a budget of £818k. A further £53k in associated costs were covered by the CCG for the GP liaison role. The pilot identified £234,000 worth of cashable savings in the 6 months for the LA with £103,000 worth of DToC charges avoided.

3.19. £474,000 worth of cost benefits to the health system were also realised throughout the period of the pilot in reduced hospital bed days and admission avoidance.

Development and way forward

3.20. 9 people, following a period of rest and recovery became eligible for reablement, this however is showing an upward trend with more people likely to be able to transition into reablement throughout the summer months and with a strengthened interface between the two services. However the significant majority of people on D2A are too complex to be supported under the traditional reablement service. Recent work with the domiciliary care provider to embed reablement principles in their approach to supporting people post discharge is resulting in initial positive outcomes with gains being made for people with even the most complex needs. Further evaluation of this over a longer period of time is required to understand the full benefits.

3.21. The creation of a D2A programme Board joint chaired by the Director of Commissioning and the Director of Adult Social Care is being created to manage the ongoing monitoring and tracking of the pilot as well as the scoping and development of any mainstreaming activity. This Board will provide formal governance for ensuring activity progresses in line with the recommendations of this report.

3.22. An initial monitoring and tracking infrastructure was put in place to provide basic utilisation and performance data while Carefirst was adapted. Now fully mobilised, a full Quality Assurance and Performance Management Framework (PMQAF) is in place able to also begin to understand longer-term benefits and impact of D2A. The QAPMF encompasses long term impact data alongside user feedback, dip sample auditing to test decision making and progress at key points in the process with a twice weekly group supervision discussion to review all individuals on the pathway and problem solve complex cases. The full impact of the QAPMF and adaptation are yet to be realised but will be a key focus of the pilot going forward. An additional Project Management role is also being suggested to ensure all performance and finance information has a robust monitoring and tracking infrastructure. The weekly performance and finance meetings will continue with a monthly report to the D2A Programme Board.

3.23. Undertaking assessments post discharge has an impact on the wider system and reduces the need for many follow up reviews previously provided for those leaving hospital. Further streamlining of wider processes will ensure improved efficiencies in the system.

3.24. A dedicated domiciliary care provider for hospital discharge and ring fenced D2A beds provided not only essential capacity for D2A but also a significant bridging resource where existing commissioned services were unable to react to demand. This included 384 hours for reablement, 2,081 hours for framework providers to pick up packages of care – with a particular issue around double handed care and remote areas during key festive holidays and weekends. 31 weeks of placements were provided while availability in the market became available with 7,45 weeks temporary accommodation for unfit inhabitancy. Learning will significantly influence the options around domiciliary care framework commissioning with further work to be done in the system before D2A can be fully mainstreamed.

3.25. Out of borough placements were not successful with challenges for the MDT to support people efficiently out of borough. It is therefore recommended that all placements are ring-fenced and made in borough. Learning from winter placements provided a positive methodology for D2A placements going forward.

3.26. Communication with individuals and families improved throughout the development of the pilot following feedback from users of the service. Going forward the pilot aspires to be able to provide the name and contact details of a named worker and likely assessment date before someone is discharged to further improve communication.

Next Steps

3.27. Early findings from the pilot have been extremely positive showing encouraging results in reduced levels of care, improved outcomes and more efficient service delivery. However, due to the short period in which the pilot was mobilised and the extremely challenging context it is difficult to understand the full potential benefits to the system.

3.28. It is therefore recommended that the pilot be extended throughout 2018/19 to:

- Provide sufficient time for the recently established Quality Assurance & Performance Monitoring Framework (QAPMF) to be fully embedded to understand the impacts, outcomes and long term benefits of D2A as well as achieving a more robust monitoring framework going forward.
- Continue to streamline assessment and planning processes to reducing duplication in the system
- Recruit a Project Manager to support the extension of the pilot and the programme of work associated with scoping and implementing any mainstreaming activity. The Project Manager will have a key role in ensuring robust monitoring and tracking processes are embedded and required governance processes are followed for all D2A pilot and mainstreaming activity.
- Allow the D2A Programme Board to scope and understand the options associated with mainstreaming D2A activity producing required Procurement and HR plans where necessary, achieving appropriate approval and managing any implementation.
- Set up a D2A Programme Board joint chaired by the Director of Commissioning and Director of Adult Social Care to scope, undertake a robust options appraisal and develop required Procurement and HR plans to be formally approved as required in line with the Councils Policy and Procedures for any potential mainstreaming activity.

4. POLICY IMPLICATIONS

4.1. The **Care Act** promotes assurance that 'people do not remain in hospital when they no longer require care that can only be provided in an acute trust.'

4.2. Discharge to Assess is one of the 8 High Impact changes endorsed by ADASS and NHS England to reduce Delayed Transfers of Care. As part of the BCF approval and monitoring arrangements, local areas are required to report on how they are implementing Discharge to Assess to transform out of hospital pathways for people with ongoing care and support needs

4.3. Integration and Better Care Fund Planning Guidance 2017-2019 requires health and social care partners to work together to:

- Invest in NHS commissioned out-of-hospital services;
- Support implementation of the High Impact Change Model for Managing Transfers of Care

4.4. The High Impact Change 4: Home First/Discharge to Assess (D2A) is described as

'Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital.'

4.5. There is a risk of penalties against the iBCF should the local DToC target not be reached

4.6. A charge from Trusts of £155 per day to organisations in which DToCs are attributed is possible.

5. FINANCIAL IMPLICATIONS

5.1 The table below shows the 2018/19 assumptions at the onset of the pilot against a revised budget using the actual spend following the pilot, with ongoing 19/20 costs.

	2018/19 £'000 Original from the Pilot	2018/19 £'000 Revised Budget	2019/20 £'000 Revised Budget Full year
Discharge to Assess Team	0	300	200
Domiciliary Care Packages (Pathway 1)	312	600	600
Long Term Placements (Pathways 2 & 3)	480	600	600
Infrastructure, tracking and evaluation	100	50	50
	892	1,550	1,450
Savings from Dom Care (Pathway 1)	-951	-872	-1,308
Savings from Resi Care (Pathway 2 &3)	-53	-374	-561
Cost/(saving) from D2A	**-112**	**304**	**-419**

5.2 The original pilot was modelled against a neighbouring borough. However, once mobilised in Bromley, there was a significant difference in the local infrastructure and activity which resulted in the pilot developing a Bromley specific service which varied from the original model. For example there was significant variations in the cost of domiciliary care as people remain on D2A longer in Bromley as their needs are more complex and were unable to access the local Reablement service. As a result they remained in D2A for a longer period to allow all gains to be made regardless of complexity. In addition due to challenges in recruiting and the pressure across the system during the winter, it was not possible to fully transition all staff during the pilot period as planned. However, 4 FTE have been transitioned from the hospital social work team into D2A with plans to transition the remainder of the MDT through existing resources over the coming 12 month pilot extension. Further consultation with HR will take place to support this activity. The increase in demand however has resulted in the need for an on-going staffing budget associated with D2A. The further year of the pilot which will run throughout all seasons will allow for a better understanding of this need going forward.

5.3 It is assumed that 324 service users will through Pathway 1 in a 12 month period resulting in additional domiciliary care costs of £600k. The estimated number of clients has fallen from the original pilot and the costs have increased. This is due to the nature and complexity of clients coming through the system.

5.4 It is assumed that 124 service users will through Pathway 2 and 3 in a 12 month period resulting in additional residential costs of £600k. The estimated number of clients has fallen from the original pilot and the costs have increased. This is due to the nature and complexity of clients coming through the system.

5.5 The original report projected for £100k during 2018/19 for the tracking and evaluation of D2A. As this activity has now been embedded in carefirst the external support for this is no longer required and only £50k for a Project Manager to record and track the data is being suggested. This post will also have a key role in supporting the Discharge to Assess Programme Board in

the scoping and development of any mainstreaming activity that is required.

5.6 As you will see from the table above, whilst costs have increased from £892k to £1,450k in a full year, the outcomes have also delivered greater savings from ongoing care costs delivering an overall net saving of £419k in 2019/20, up from £112k in the original pilot. As part of the increased monitoring and tracking processes, progress against the savings target will also be monitored.

5.7 The table below gives further details of non cashable savings to LBB and costs and savings to the CCG

	2018/19	2019/20	2020/21
Cost/savings to LBB (CASHABLE)	304	-419	-419
Less potential DToC charges	-206	-206	-206
Total Cost/savings to LBB	98	-625	-625
Costs CCG			
GP Spend	106	106	106
CCG Savings			
Hospital beds saved	-820	-820	-820
Admission avoidance	-128	-128	-128
Saving to CCG	-842	-842	-842
Savings across the piece	**-744**	**-1,467**	**-1,467**

5.8 There are also non cashable savings of £206k by 2019/20 which is the avoidance of DToC charges (that have not yet to date been charged to LBB).

5.9 There are also considerable savings to the CCG of £842k by 2019/20, although non cashable at this time

5.10 The savings from 2018/19 onwards are still estimates and based on current activity. The pilot will continue to be monitored by the service to ensure that the targets are being met and will report back towards the end of the pilot with outcomes.

5.11 The six month pilot was funded by BCF. It is recommended that this be extended for a further 12 months for the pilot to take effect and make a full impact. It is recommended that this is funded from BCF as well. Only when the savings kick in to their full effect does the funding from BCF cease. Therefore there is no cost to the Council from core funding whilst the pilot is bedding in and not financially fully effective.

5.12 Funding of £304k would be required to fund the pilot for 2018/19. This covers the Councils net costs in 2018/19 (£1,550k costs less £1,246k of savings in 2018/19). There is sufficient funding in the BCF reserve to accommodate this. In 2019/20 onwards the full year effect of the savings are realised and funding from BCF will no longer be required.

6. PERSONNEL IMPLICATIONS

6.1 The additional recruitment of a Project Manager to support the pilot for the period of the 12 months is required.

6.2 Further discussions with HR will take place to support mainstreaming the D2A service. Any proposals arising from these discussions, which have staffing implications, will be managed in line with the Council's managing change procedures, which will include engagement/consultation with staff and their representatives.

7. LEGAL IMPLICATIONS

7.1 The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund (BCF). It allows for the Mandate to NHS England to include specific requirements to instruct NHS England over the BCF, and NHS England to direct Clinical Commissioning Groups to pool the necessary funding.

7.2 Guidance is provided by the Department of Health and Department for Communities and Local Government in March 2017: 2017-2019 Integrated and Better Care Fund which support the aims of this proposed pilot scheme.

7.3 The report author will need to consult with the Legal Department at the time of procuring the services.

8. PROCUREMENT IMPLICATIONS

8.1 Currently the CCG are responsible for the Procurement arrangements and the position (or intent) post pilot is not yet sufficiently detailed to develop the future procurement strategy, but theses would appear to require a quick response service provider with an extended service brief that needs to be developed by the commissioners, until that is done its not possible to say if our current service providers could cover, either through inclusion in their current contracts or a separate tender process – or our next provider refresh process.

8.2 Any future procurement arrangements will need to be completed in line with the appropriate legal requirements, and these will need to be included in any commissioning plan developed, with sufficient time allowed to agree and implement any required arrangements.

Non-Applicable Sections:	Not Applicable
Background Documents: (Access via Contact Officer)	CS18068 – Discharge to Assess (D2A) Pilot

King's College Hospital NHS Foundation Trust

NHS Bromley Clinical Commissioning Group

Bromley THE LONDON BOROUGH

Discharge to Assess

Information for patients

What is "Discharge to Assess"?

"Discharge to assess' service is being introduced in several parts of the country that aims to help people to leave acute hospital setting as soon as medically safe to do so with ongoing care and support to recover in an appropriate environment.

This service will:

- encourage you to regain your confidence in your own ability to manage
- provide ongoing support and care to recover at home safely that will help your general physical and emotional wellbeing
- give you time to make important decisions about your future
- reduce the risk of contracting an acute hospital acquired infection.

Who makes the decision?

You will be included in the decision-making process along with the doctors and staff who will discuss why they feel this is the best next step for you.

What to expect?

Once it is medically safe for you to do so, it is best for you to move from the acute hospital setting. Home' should always be considered as the first option. If this can happen straight from the hospital, then plans will be put in place to support your transfer home.

What happens when I go home?

You will be seen at home within few days of discharge from the hospital by a member of Discharge to assess team to carry out their assessment. This will help them to identify on-going care or long-term support requirements to ensure you recover at home safely.

What support do I get when I go home?

We can support you with a range of daily living tasks. Tasks include support with getting in and out of your bed/chair, moving around your home, washing and dressing, toileting or managing catheter/stoma/pads, managing medication, preparing drinks and meals. Unfortunately, we cannot help with cleaning, laundry, shopping, gardening but may be able to assist with advice on getting help.

How long is the support provided at home?

The support is provided for a short period and it depends on your needs which will be assessed within the first few days of discharge from the hospital

What happens if I am not able to return home?

Our aim is to work with you to identify your ongoing care and support requirements in a more suitable environment. In some cases, where home is not an option at the time of discharge or inevitable then you will be placed in a care home selected specifically that can best meet your needs. This will allow you to have assessments of your ongoing care needs, as well as the

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Discharge to Assess Team Structure

1 FTE – Team Manager (BCF funded)

Care Management Staff

2 FTE Senior Care Managers
- SCM 1 – Transitioned from the hospital CM Team
- SCM 2- Vacant (BCF Funded)

3 Care Managers
- Care Manager 1 – In post (BCF funded)
- Care Manager 2 – Vacant – plans for existing hospital CM to transition across
- ECH Care Manager – new post – to be recruited to via iBCF

2 x FTE Care Management Assistants
- CMA 1 – Transitioned from the hospital team
- CMA 2 – New permanent recruit (BCF funded)

Health staff

1 x FTE Occupational Therapist (OT)– interim (BCF Funded)
1 x FTE Physiotherapist (BCF Funded)
1 x FTE GP (BCF Funded)

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APPENDIX C

Out of Hospital Health and Social Care Pathways

All services accessed via Transfer of Care Bureau (TOCB)

Voluntary & Community

Bromley Well – VCS organisations providing a range of services including hospital discharge focus e.g.:

- Age UK Take Home & Settle
- Age UK Handy Man
- Age UK 24 hour sitting services
- MIND Psychological therapies
- Long Term Conditions self management

Social Care

Restart existing care package where there is no change in need

Reablement

Extra Care Housing (ECH) Step-down flats to assess appropriateness for permanent ECH provision

Discharge to Assess **(D2A)** for social care clients with no previous input from LBB or following significant change of need enabling clients to be discharged to the community for an assessment of their long term care and support needs in a more familiar setting following a period of recovery.

Rehabilitation

Bed based rehab (Lauriston House - BHC)
Intense rehabilitation nursing unit for people who are unable to be safely supported at home

Home based rehab (BHC)
intensive rehab including PT and OT at home for up to 6 weeks

Neuro Rehab (BHC)
Intense rehab at home for people following neurological issues/injury

Frank Cooksey/Ontario (Kings)
Tier 4 acute-hospital based inpatient rehab for people with neurological brain injusries

Stroke rehab service (Lewisham and Greenwich Trust)
Home based intensive rehab for people following a stroke

Community Health Services

BHC provided services including District Nursing, Community Matron & ongoing therapy

End of life

St Christopher's Personal Care Service – care at home for people whose wish it is to die in their own home

Bromley Care Coordination (St Christopher's)
Proactive Care planning and support for people in the last 12 months of life

Community Palliative Care Teams (BHC)
Providing palliative care support in the community including residential and nursing care

Continuing Health Care (CHC)

Access to health funded care at home or placement for people meeting CHC threshold

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Discharge to Assess Case Studies

Pathway 1: Supporting people back to independence following hospital admission

- Mr A is an 83 year old single Irish gentleman who was admitted to the Princess Royal University Hospital on 19/12/2017 following a fall and a long lie. He had been unable to get up and had acute confusion. He was treated for community acquired pneumonia with a course of Antibiotics. Mr A has a past medical history of mixed dementia, Myocardial infarction and chronic obstructive pulmonary disease.
- Mr A was discharged from hospital with D2A Pathway 1, which provided an interim package of care twice daily to support him with his personal care, nutrition and a put to bed call. This also ensured additional short term medication prescribed by the hospital was taken.
- It was important to Mr A to be able to be fully dressed in his traditional clothes daily and to maintain his social engagement around the sheltered accommodation in which he lived. This was therefore the focus of the interim care in order to try and reduce the acute confusion and return to his pre-admission functioning.
- The D2A MDT was led by the care manager and supported by the BeeAktive carers, the supported living scheme and engaging regularly with Mr As next of kin.
- The D2A process undertook a strength based approach building up a range of formal supporting infrastructures through his niece and sister who visited on a weekly basis supporting with shopping, laundry, housework, finances and social support , the scheme also put in place an additional morning welfare call and a range of assisted technologies were fitted. The D2A carers, through maintaining Mr As pre-admission routine and using encouraging and enabling principles were able to report after a short period of time Mr A was able to undertake his daily tasks safely and on his own without support.
- The Care Act 2014 Assessment therefore concluded there was no further care or support requirements long term.

Mr A and his family reported
" Mr A has lived happily in his flat for 2 years and it is his ability to maintain his social networks and things that are important to him including being dressed formally daily and being able to laugh and joke with others we think is what made his improvement possible. The D2A services really got to know him and what was important to him which meant, even with his dementia he was able to go back to where he is most happiest."

Pathway 2: Giving everybody a chance

- Mrs W, a 63 year old lady admitted to the PRUH with reduced oral intake and decline in physical mobility and health.
- Diagnosed with Encephalopathy and Polyneuropathy, a disease of the brain which was having a significant impact on both physical and mental functioning of Mrs W.
- Mrs W was also severely depressed following the death of her son several months earlier with little motivation. She was unable to sit up straight unaided and was requiring 2 people to hoist into a specialist chair.
- It was agreed by the Acute MDT that Mrs W would benefit form a further period of assessment in a non clinical environment
- Mrs W was admitted to D2A nursing home with some specialist equipment including a tip and tilt wheelchair provided by D2A. D2A coordinated psychological support alongside weekly neuro physio rehab. The Liaison GP undertook a weekly review working closely with the neuro consultant. The whole MDT met weekly with the family to ensure all support was co-ordinated against agreed goals.
- Mrs W had graduated from being standing hoist dependant to able to step transfer and walk with hand held assistance from one person. Mrs W was assessed for Continuing Health Care, mental capacity and Care Act assessment. Mr W has full capacity and was able to express a desire to go home with her husband.
- A twice per day package of care was provided to support the transition home.

Mrs W and her husband said:
"Following the diagnosis in hospital and seeing just how little Mrs W was able to do it felt like there wasn't much hope and Mrs W was going to a nursing home at 63 to be nursed bedbound forever – we were devastated. The MDT under D2a were just incredible, they give us hope and all worked so hard to get us back to what we never thought possible. I really don't think if we didn't have all of the different professionals working together we would have gotten to where we were. We have our lives back and we are better then ever."

Report No.
CS18153

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**ADULT CARE AND HEALTH POLICY DEVELOPMENT AND SCRUTINY COMMITTEE**
Date:	**Wednesday 27th June 2018**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**NURSING CARE BEDS CONTRACT UPDATE**
Contact Officer:	Wendy Norman, Head of Contract Compliance and Monitoring Tel: 020 8313 4212 E-mail: Wendy.Norman@bromley.gov.uk
Chief Officer:	Deputy Chief Executive & Executive Director: Education, Care and Health Services
Ward:	Borough-wide

1. Reason for report

1.1 The Council awarded a contract for 70 nursing home beds to Mission Care on 28th March 2018. Care Services PDS Committee scrutinised the award report on 14th March 2018 and requested that Officers provide an update on quality monitoring in these Mission Care nursing homes at a future meeting of Adult Care and Health PDS Committee.

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2. RECOMMENDATION

2.1 The Adult Care and Health PDS Committee is requested to comment on and note the contents of this report and the ongoing arrangements for contract monitoring.

Further updates on the quality monitoring of the Mission Care contract will form part of the update from the Deputy Chief Executive and Executive Director: Education, Care and Health Services at future meetings of Adult Care and Health PDS Committee.

Impact on Vulnerable Adults and Children

1. Summary of Impact: The contract with Mission Care ensures that there are nursing home beds in the borough to support vulnerable adults.

Corporate Policy

1. Policy Status: Existing Policy:
2. BBB Priority: Excellent Council Healthy Bromley:

Financial

1. Cost of proposal: Not Applicable
2. Ongoing costs: Not Applicable
3. Budget head/performance centre: various across Adult Social care
4. Total current budget for this head: £5.5m
5. Source of funding: Core funding

Personnel

1. Number of staff (current and additional): Not Applicable
2. If from existing staff resources, number of staff hours: 2.2FTE Contract Compliance Team

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Legal

1. Legal Requirement: Statutory Requirement
2. Call-in: Not Applicable: No Executive decision.

Procurement

1. Summary of Procurement Implications: None.

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): 70 service users funded by Bromley Council at any one time.

Ward Councillor Views

1. Have Ward Councillors been asked for comments? Not Applicable
2. Summary of Ward Councillors comments: Not Applicable

3. COMMENTARY

3.1 The Council awarded a new contract for 70 nursing care beds to Mission Care on 28th March 2018. The beds will be made available across all four Mission Care Homes. The start date of the new contract was back dated to 2.1.2018.

3.2 The new contract requires Mission Care to ensure that all the homes included within the contract sustain a CQC rating of Good or above for the duration of the contract. This requirement is in line with the change of policy agreed by Portfolio Holder for Adult Care Services in January 2018 whereby the Council will only fund new placements in homes with a CQC rating of good and above.

3.3 When Mission Care submitted their bid for this contract all the homes included were rated as good, however, during the procurement process the ratings for Greenhill and Elmwood were changed to requires improvement following inspections by CQC. The contract award report was discussed at Care Services PDS on 14th November 2017 and 14th March 2018. The contract award was authorised by Executive in March 2018. During discussion at the meeting officers explained that the ratings had been published some months after inspections had taken place and that Mission Care had been working on action plans which would enable them to achieve a good rating at their next inspection. Officers were confident that one home, Greenhill was now delivering a 'Good' provision, and that the other home would shortly be achieving this standard; however the homes would continue to be rated as 'Requires Improvement' until the CQC undertook a further visit. This report provides an update on this activity.

3.4 The Council is not currently making new placements at Elmwood Nursing Home. Quality improvement work is ongoing there and it is anticipated that the Council will resume making placements there within the next couple of months following satisfactory completion of the protocol referred to in paragraph 3.3 above.

3.5 The Contract Compliance Team makes frequent inspections of the Mission Care homes because of the significant contract with the Council and the high proportion of Council funded residents in these homes. The team has made monthly visits to Elmwood, checking not only that the requirements set out by CQC are met but that the provider meets the required standards on the Council's Quality Assessment Framework. Considerable progress has been made against these action plans. Officers also noted significant improvements in the care delivered at Elmwood during their last visit in early May 2018.

3.6 The role of one officer in the Contract Compliance Team is to closely observe care delivered by staff and their interactions with service users, also to gather information and views from relatives and advocates. This officer has been recording comments about improvement in the care delivered at Elmwood since January 2018.

3.7 Mission Care have taken significant actions to ensure that the quality of the care in their homes is improved and sustained. They appointed an independent auditor to review each home and produce a report and action plan. The auditor has continued to work with home managers, particularly at Elmwood to complete this plan. Mission Care quickly reviewed and changed the management arrangements at their homes so that there was a dedicated registered manager at both Homefield and Elmwood. The existing manager was allocated to Elmwood and a new one has been recruited for Homefield. This has enabled the manager to increase her visibility in the home for service users and relatives and to increase the quality assurance activity undertaken on a daily basis.

3.8 Mission Care have also reviewed their senior management structure and have recruited a Deputy Chief Executive to take responsibility for managing the HR function and Clinical and

Operational affairs. This additional resource should ensure that Mission Care can sustain the enhanced quality assurance activities they have put in place.

3.9 The Director of Adult Social Services (DASS) is satisfied that Mission Care have made progress in improving quality. Officers have developed a clear protocol for actions to be taken when a home receives a Requires Improvement rating. The protocol also covers the procedure that can be followed when a care home has improved the quality of its care, but is still awaiting a new CQC inspection. Quality assurance reports are scrutinised, views are sought from Care Managers and Health colleagues who can comment on the care delivered to individual residents. Any complaints or safeguarding alerts are also reviewed. The DASS makes the final decision to re-commence placements. Full details of this protocol are detailed elsewhere on this agenda. The protocol was used to assess the improvements made in Greenhill Nursing Home run by Mission Care and the Council resumed making placements.

3.10 Officers have met with Mission Care Directors to mobilise the new contract and will continue to meet quarterly in order to ensure that the new contract delivers to expectations.

3.11 Officers have updated the Portfolio Holder and her Assistant regularly on the monitoring activity and findings. Officers have developed a dashboard of quality indicators which gives an "at a glance" view of the quality ratings of all care homes in Bromley.

4. IMPACT ON VULNERABLE ADULTS AND CHILDREN

4.1 The quality monitoring activity described above assures Councillors that the vulnerable adults living in the Mission Care homes are being well cared for and are safe.

5. PROCUREMENT IMPLICATIONS

5.1 There is no risk that Mission Care will be unable to fulfil the contract for 70 beds as the 2 other homes in the group are rated "Good" by CQC. The increased quality assurance work has extended to all the Mission Care Homes.

6 LEGAL IMPLICATIONS

6.1 The contractor's performance should be closely monitored and the terms and conditions of contract enforced with regards to performance should the need arise.

Non-Applicable Sections:	Policy, Financial and Personnel Implications,
Background Documents: (Access via Contact Officer)	CS18127-1 (CS1807-2)