BROMLEY CIVIC CENTRE, STOCKWELL CLOSE, BROMLEY BRI 3UH

THE LONDON BOROUGH
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To: Members of the

HEALTH AND WELLBEING BOARD

Councillor Peter Fortune (Chairman)
Councillor David Jefferys (Vice-Chairman)
Councillor Diane Smith (Vice-Chairman)
Councillors Reg Adams, Ruth Bennett, Robert Evans, Peter Fookes, Ellie Harmer, William Huntington-Thresher, Charles Rideout and Pauline Tunnicliffe

London Borough of Bromley Officers:

Dr Nada Lemic	Director of Public Health
Terry Parkin	Executive Director: Education, Care & Health Services (Statutory DASS and DCS)

Clinical Commissioning Group:

Dr Angela Bhan	Chief Officer - Consultant in Public Health
Dr Andrew Parson	Clinical Chairman

Bromley Voluntary Sector:

Sue Southon	Chairman, Community Links Bromley

A meeting of the Health and Wellbeing Board will be held at Bromley Civic Centre on **THURSDAY 26 SEPTEMBER 2013 AT 1.30 PM**

MARK BOWEN
Director of Corporate Services

Copies of the documents referred to below can be obtained from www.bromley.gov.uk/meetings

AGENDA

1 APOLOGIES FOR ABSENCE

2 QUESTIONS BY COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

In accordance with the Council's Constitution, questions to this Board must be received in writing 4 working days before the date of the meeting. Therefore please ensure questions are received by the Democratic Services Team by 5pm on Friday 20th September 2013.

3 MINUTES OF LAST MEETING ON 29TH JULY 2013 AND MATTERS ARISING
(Pages 1 - 6)

4 WORK PROGRAMME AND MATTERS ARISING
(Pages 7 - 14)

5 DEVELOPMENT OF INTEGRATED COMMISSIONING IN BROMLEY
(Pages 15 - 22)

6 2014 JOINT STRATEGIC NEEDS ASSESSMENT PLANNING MILESTONES
(ORAL UPDATE)

7 S.256 FUNDING
(Pages 23 - 38)

8 NOMINATION FOR THE NHS INNOVATION CHALLENGE PRIZE FOR DEMENTIA (FOR INFORMATION)
(Pages 39 - 52)

9 DATE OF NEXT MEETING

Please note that the next meeting will be at 1.30pm on 28th November 2013.

HEALTH AND WELLBEING BOARD

Minutes of the meeting held at 1.30 pm on 29 July 2013

Present:

Councillor Peter Fortune (Chairman)
Councillor Diane Smith (Vice-Chairman)
Councillors Reg Adams, Ruth Bennett, Judi Ellis, Robert Evans, Peter Fookes, Ellie Harmer, William Huntington-Thresher and Charles Rideout

Terry Parkin (Executive Director: Education, Care & Health Services (Statutory DASS and DCS))
Dr Angela Bhan (Managing Director BSU)
Sue Southon (Chairman, Community Links Bromley)

Also Present:

Dr Agnes Marossy (Bromley Health Authority) and Dr Mandy Selby (Bromley GP Consortia)

1 Apologies for Absence

Apologies were received from Councillor David Jefferys. Apologies were also received from Dr Nada Lemic and from Dr. Andrew Parsons and Agnes Marossy and Dr. Mandy Selby attended as their respective alternate.

2 Minutes of Last Meeting and Matters Arising

The minutes of the meeting held on 18th May 2013 were agreed subject to the following amendments:

Page 3, 2nd paragraph – after queried insert "why"
Page 4 4th paragraph – "alocal" corrected to "a local"

RESOLVED that the minutes of the meeting held on 18th May 2013 be agreed subject to the amendments above.

3 Questions by Councillors and Members of the Public Attending the Meeting

No questions were received by the deadline. However as some Board members had only received hard copies of the agenda on the day by which questions should be submitted it was agreed that these questions would be considered under any other business.

4 Joint Strategic Needs Assessment

The Board received an updated copy of the 2012 Bromley Joint Strategic Needs Assessment (JSNA). This document will underpin the work of the Board to assist with the identification of items that it will focus on in greater detail and would be included on the agenda as a regular item to monitor progress against priorities alongside the Health and Wellbeing Strategy Priorities.

RESOLVED the 2012 JSNA is agreed and that work commence on the 2013 JSNA.

5 ProMISE Programme Update

At its last meeting the Board had considered the Proactive Management and Integrated Services for the Elderly (ProMISE) programme which used the JSNA as its basis and was a co-ordinated response to meeting the needs of a vulnerable group. The aim was for early intervention and prevention and to maintain healthy individuals by good management of diseases and better case management at an earlier stage. At this meeting the Board had requested a further report giving more detail on the case management and integrated care.

Paul White, ProMISE Programme Director at Bromley CCG presented an update on these aspects of the programme.

St Christopher's Hospice now had an enhanced "end of life" programme so that patients were able to die at their preferred place. Within Bromley 60% of patients died in hospital compared to St Christopher's where only 20% died in hospital.

Case Management

39 GP practices had signed up to the programme and 18 were now referring to the programme. Work was underway with patients and carers to try and reduce hospital admissions for this vulnerable group.

The majority of patients were over 65, with only 7 patients under 65. There were also patients in the 90-100 year age group. The ProMISE team had brought in an IT lead. A lot of the data needed was in the practices and hopefully the team would be able to circumnavigate the current data access problems that were being experienced nationally.

Integrated Care

There was now a single point of entry to the integrated care model. Six teams were working with GP practices and patients to ensure the correct package of care. The key was to build on this and expand the cover to other areas such as mental health.

The number of referrals to the service was low but this was a positive indicator that

practices were trying to manage patients themselves.

Although most GP practices were actively involved in care management, some needed encouragement to "buy in". In September 2013 a GP event has been arranged to promote self-care.

One Member raised concerns that some estates were not fit for purpose and that money would be spent on buildings not people. In response, the Board was informed that work was underway to accommodate the teams but this would remain an issue until the future use of the Orpington hospital site was resolved.

In response to a question asking what the Local Authority was doing to prevent hospital admissions of the elderly, the Executive Director Education, Care and Health Services explained that the Local Authority was a part of the assessment team offering patient assessments in their own homes. The LA re-ablement service was one of the services that could be recommended to avoid hospital re-admissions but there were other providers giving input at different points. This included input from the voluntary sector.

It was agreed that an update would be presented to the Board at its November meeting to enable further discussion.

RESOLVED that:

1. **the report be noted**

2. **A further report on the ProMISE programme would be submitted to the November Health and Wellbeing Board.**

6 Integrated Diabetes Service Update

At its previous meeting the Board had considered the Joint Strategic Needs Assessment and had identified 3 areas it wished to consider in more detail. One area was the Diabetes service.

Usha Chapitti, Project Manager – Long Term Conditions at Bromley CCG addressed the Board.

Her report provided an update on the ongoing work that started with a Stakeholder event in October 2012.

Bromley currently spent £8.9m per annum on Diabetes. Ms Chapitti's Team had looked at various models used nationwide to deliver Diabetic Services, focussing on two models in particular; Derby and Portsmouth and using elements of both as a basis for an integrated service which could be adapted to meet the needs of Bromley residents.

She outlined how the old system compared with the new integrated Diabetes Service.

The benefits of the new service included enabling consultants and specialists to work more closely with GPs to support them. It meant speedier hospital admission if needed in addition to being a more effective use of resources.

There would be more investment in GP and nurse training and this would be ongoing with the aim of providing better care to diabetic patients. It will also give patients the confidence to know their care was ongoing. The training was being developed with Bromley Healthcare and King's College. GP practices had raised concerns that all practices needed to engage to enable a programme of training to be developed. Practices would also be encouraged to share expertise.

The service would also give patients better access to education more patient involvement. The Team was currently seeking the views of Bromley Healthcare on how to engage patients. Work was underway to develop the proposal and implement it in September 2013. The outcomes from the training would be shared with the HWB and Bromley Healthwatch. In addition Bromley Healthcare was establishing a Management Group composing of members from the voluntary sector, the community and patients.

The Chairman asked how patient satisfaction would be measured. In response, he was informed that this was one of the key performance indicators (KPI).

It was agreed that statistics showing the prevalence of diabetes in Bromley would be provided for the next meeting. The number of diabetics was increasing by 5% per annum but it was hoped the new service would help achieve one of the KPI's for reducing emergency hospital admissions.

Ms Chapitti reported that retinal screening was not within the scope of the project. However Dr Bhan continued that yearly screening for diabetics reached 100% and were often carried out more than once a year.

The Board asked what was being done to stop patients progressing up the Tiers. In response Dr Bhan explained that work included ensuring good control of blood sugar levels, regular checks and screening for eyes and kidney function and encouraging patients to attend the diabetes education courses; DAFNE and DESMOND.

The Board then asked about paediatric diabetes and were informed that, currently, there were not separate targets for children. The Programme would start with adults and older people and once the service was fully operational it was likely that the paediatric diabetic services would be reviewed.

The Chairman requested that Dr Angela Bhan and Mr Terry Parkin work up a proposal for how paediatric diabetes could be addressed jointly between the Local Authority and Bromley CCG focusing on a preventative approach.

When asked about the potential financial savings, the Project Manager explained that an estimated saving of £855k would be achieved over a three year period by the Clinical Commissioning Group.

RESOLVED that:

1. **The report be noted.**

2. **A report outlining the financial context would be submitted to a future meeting of the Board.**

3. **That Dr Bhan and Mr Parkin work up a proposal for how to jointly tackle paediatric diabetes in the borough.**

7 Bromley's response to Winterbourne View Recommendations

In response to the Winterbourne View inquiry, the Government commissioned a Joint Improvement Programme and each Local Authority was requested to provide a local response. Although Bromley does not have an Acute Treatment Unit (ATU) located within its boundaries it has conducted a stock take from the perspective of being a "placing" authority.

The Board considered Bromley's response. It noted that the Local Authority was currently undertaking a review of all its placements for children with complex needs and looking for other ways of supporting them. Each out of borough placement cost approximately £5-£6k and other more cost effective and innovative solutions were being sought out through extensive market testing.

It was agreed that an update report on the recommendations should be provided at every second Board meeting with the Board being informed of any information it might find useful in between.

RESOLVED that:

1. **The Report be noted**

2. **That the Board receive an update report at every second meeting**

8 Future Meetings and Agenda Items

Officers would provide a work programme and mattes arising report for each meeting to bring the Board in line with other committees.

9 Any Other Business

Sue Southon raised two queries:

1. Had the disabled children's charter been received by the HWBB?

   The Director responded that it had, and that these issues were identified in

the JSNA but he would ensure all the points were covered and would include these in a letter to Ms Southon.

2. What was the date of the adult stakeholder event and who would be invited?

   The event would be in mid-November and the date would be published in August. Representatives from the voluntary and community sector would be invited to attend.

   The children's stakeholder event would be in January 2014 and the date would be confirmed towards the end of September 2013.

Harriet Martyn

Harriet Martyn would be leaving Bromley at the end of August to take up a post researching Public health in Baltimore in the United States. The Chairman thanked her for all her hard work and the personal support she had given him as Chairman.

10 Date of Next Meeting

The next meetings of the Health and Well Being Board would be:

Thursday 26th September 2013
Thursday 28th November 2013
Thursday 30th January 2014
Thursday 20th March 2014
Thursday 22nd May 2014

All meetings would start at 1.30pm and a maximum length of 2 hours.

The Meeting ended at 3.20 pm

Chairman

Report No.
RES13

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**HEALTH AND WELL BEING BOARD**
Date:	**Thursday 26th September 2013**
Decision Type:	Non Urgent Non-Executive Non-Key
Title:	**Health and Wellbeing Board Matters Arising and Work Programme**
Contact Officer:	Helen Long, Democratic Services Officer Tel: 0208 313 4595 E-mail: helen.long@bromley.gov.uk
Chief Officer:	Director of Resources
Ward:	(All Wards);

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1. Reason for report

1.1 Members are asked to review the Health and Wellbeing Board's work programme for 2013/14 and to consider progress on matters arising from previous meetings of the Board.

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2. RECOMMENDATION(S)

2.1 The Board is asked to consider its work programme and mattes arising and indicate any changes that it wishes to make.

Corporate Policy

1. Policy Status: Existing Policy: As part of the Excellent Council stream within Building a Better Bromley, PDS Boards should plan and prioritise their workload to achieve the most effective outcomes.
2. BBB Priority: Excellent Council

Financial

1. Cost of proposal: No Cost:
2. Ongoing costs:: N/A
3. Budget head/performance centre: Democratic Services
4. Total current budget for this head: £363, 070
5. Source of funding: 2013/14 revenue budget

Staff

1. Number of staff (current and additional): There are 10 posts (8.55fte) in the Democratic Services Team
2. If from existing staff resources, number of staff hours: Maintaining the Board's work programme takes less than an hour per meeting

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Legal

1. Legal Requirement: No statutory requirement or Government guidance
2. Call-in:: This report does not require an executive decision

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Customer Impact

1. Estimated number of users/beneficiaries (current and projected): This report is intended primarily for Members of this Board to use in controlling their on-going work.

Ward Councillor Views

1. Have Ward Councillors been asked for comments? No
2. Summary of Ward Councillors comments: N/A

3. COMMENTARY

3.1 The Board's matters arising table is attached at **Appendix 1** this report updates Members on recommendations from previous meetings which continue to be "live". Currently there are six items, two have been covered at this meeting and four have been scheduled as future items on the Board's 2013/14 work programme.

3.2 The draft 203/14 Work Programme is attached as **Appendix 2.** This will be populated after each meeting or where members of the Board identify a need for particular reports. Other reports may come into the programme or there may be references from other NHS Boards, the Portfolio Holder or the Executive.

3.3 In approving the work programme members of the Board will need to be satisfied that priority issues are being addressed; in Line with the priorities set out in the Board's Health and Wellbeing Strategy and terms of reference which were approved by Council in April 2013.

3.4 At the meeting on 30 May 2013 the Chairman requested some background notes on procedures for the HWBB. **Appendix 3** outlines the procedures for submitting reports, circulation of the minutes and for asking questions.

3.5 For Information **Appendix 4** is a copy of the Terms of reference for HWBB as they appear in the Council's constitution.

Non-Applicable Sections:	Policy/Financial/Legal/Personnel
Background Documents: (Access via Contact Officer)	Previous work programme reports

APPENDIX 1

Matters Arising 2013/14 progress summary

Minute number/ title	Board Request	Update
5 – ProMISE Programme update	Update on Progress Report	November 2013
6 – Integrated Diabetes Service update	Statistics showing the prevalence of Diabetes in Bromley.	November 2013
	Dr Bhan and the Director to work up a proposal for how paediatric Diabetes could be addressed jointly between the Local Authority and Bromley CCG focussing on a preventative approach.	TBC
8 – Future meetings and agenda items	A work programme and matters arising be presented at each meeting in line with other committees.	Starting September 2013
	Development of a report template for the HWB Board	Starting September 2013
7 – Bromley's response to Winterbourne View recommendations	Update reports on the recommendations to be brought to every second Board meeting	Next Update November 2013

Appendix 2

HEALTH AND WELLBEING BOARD
WORK PROGRAMME 2013/14

Title	Notes
Health and Wellbeing Board – Thursday 28th November 2013	
Refreshed Health & Wellbeing Strategy 2013/14	
JSNA Update	Following first meeting of steering group
CCG integrated commissioning plan 2013-2016	
Update on Bromley's Response to Winterbourne View Recommendations	
ProMISE Programme Update	Info Item
Integrated Diabetes Service Update	Rescheduled from September – Info Item
Work Programme and Matters Arising	
Health and Wellbeing Board – Thursday 30th January 2014	
HWB Strategy 2013/14 Exception Reporting	As agreed in November
Pharmaceutical Needs Assessment	
Work Programme and Matters Arising	
Health and Wellbeing Board – Thursday 20th March 2014	
HWB Strategy 2013/14 Exception Reporting	As agreed in November
Governance of integrated health and social care (Bromley CCG and LB Bromley)	
HealthWatch Update	
Update on Bromley's response to Winterbourne View Recommendations	
Work Programme and Matters Arising	
Health and Wellbeing Board – May 2014 Date TBC	
HWB Strategy 2013/14 Exception Reporting	As agreed in November
Work Programme and Matters Arising	

Outstanding items to be scheduled
Proposal for how paediatric Diabetes could be addressed jointly between the Local Authority and Bromley CCG focussing on a preventative approach.

Appendix 3

Dates of Meetings and report deadline dates

The Agenda for meetings MUST be published five clear days before the meeting. Agendas are only dispatched on a Tuesday.

Report Deadlines are the final date by which the report can be submitted to Democratic Services. Report Authors will need to ensure that their report has been signed off by the relevant chief officers before submission.

Date of Meeting	Report Deadline	Agenda Published
Thursday 26th September 2013	Friday 13th September 2013	Tuesday 17th September 2013
Thursday 28 November 2013	Friday 15 November 2013	Tuesday 19th November 2013
Thursday 30 January 2014	Friday 17 January 2014	Tuesday 21st January 2014
Thursday 20 March 2014	Friday 7 March 2014	Tuesday 11th March 2014
Thursday 22 May 2014 *	TBC	TBC

*** this meeting date will be changed as it clashes with the Local and European elections.**

A link to the agenda is emailed to the Board on the publication date with a hard copy of the agenda being dispatched on the same day.

Questions
Members of the public can ask questions at the meeting. Each person can ask a total of 3 questions; each question should be no longer than 50 words. When questions are received they are sent to the relevant officer for a response and to the Chairman for information.

Questioners can attend to ask their question in person or ask for written responses. If they do not wish to attend then written responses are sent to them within 5 days following the meeting.

For each of their questions the questioner, if attending the meeting in person, can ask a supplementary question.

A list of the questions and answers will be appended to the corresponding minutes.

Minutes
The minutes are produced within 48 hours of the meeting. They are then sent to officers for checking. Once any amendments have been made they are sent to the Chairman and once he has cleared them they are sent, in draft format, to members of the board. Please note that this process can take up to two weeks.

The draft minutes are them incorporated on the agenda for the following meeting and are confirmed. Following this approval they are published on the web.

Appendix 4

London Borough of Bromley

Constitution

Health & Wellbeing Board

(11 Elected Members, including one representative from each of the two Opposition Parties; the two statutory Chief Officers (without voting rights); two representatives from the Clinical Commissioning Group (with voting rights); a Health Watch representative (with voting rights) and a representative from the Voluntary Sector (with voting rights). The Chairman of the Board will be an Elected Member appointed by the Leader. The quorum is one-third of Members of the Board providing that elected Members represent at least one half of those present. Substitution is permitted. Other members without voting rights can be co-opted as necessary.

1. Providing borough-wide strategic leadership to public health, health commissioning and adults and children's social care commissioning, acting as a focal point for determining and agreeing health and wellbeing outcomes and resolving any related conflicts.

2. Commissioning and publishing the Joint Strategic Needs Assessment (JSNA) under the Health and Social Care Act.

3. Commissioning and publishing a Joint Health & Wellbeing Strategy (JHWS) – a high level strategic plan that identifies, from the JSNA and the national outcomes frameworks, needs and priority outcomes across the local population, which it will expect to see reflected in local commissioning plans.

4. Receiving the annual CCG commissioning plan for comment, with the reserved powers to refer the CCG commissioning plan to the NHS Commissioning Board should it not address sufficiently the priorities given by the JSNA.

5. Holding to account all areas of the Council, and other stakeholders as appropriate, to ensure their annual plans reflect the priorities identified within the JSNA.

6. Supporting joint commissioning and pooled budget arrangements where it is agreed by the Board that this is appropriate.

7. Promoting integration and joint working in health and social care across the borough.

8. Involving users and the public, including to communicate and explain the JHWS to local organisations and residents.

9. Monitor the outcomes and goals set out in the JHWS and use its authority to ensure that the public health, health commissioning and adults and children's commissioning and delivery plans of member organisations accurately reflect the Strategy and are integrated across the Borough.

10. Undertaking and overseeing mandatory duties on behalf of the Secretary of State for Health and given to Health and Wellbeing Boards as required by Parliament.

11. Other such functions as may be delegated to the Board by the Council or Executive as appropriate.

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Report No.
HWB131002

London Borough of Bromley

PART ONE - PUBLIC

HEALTH AND WELLBEING BOARD

Date: **Thursday 26 September 2013**

Report Title: **Development of Integrated Commissioning in Bromley**

Report Author: Richard Hills, Strategy Manager - Commissioning, Education, Care & Health Services, London Borough of Bromley.
E-mail: richard.hills@bromley.gov.uk Telephone: 0208 313 4198

1. SUMMARY

The Bromley CCG Chief Officer and London Borough of Bromley Executive Director of Education, Care & Health commissioned a piece of work in June 2013 to assess the benefits of greater integration of commissioning arrangements across the two organisations. This work explored, with existing lead commissioners, clinicians and other key leads what LBB and CCG currently commission and how the commissioning functions are organised. In addition, the drivers and objectives for integration were assessed and a number of other health and social care economies visited to consider how they had approached integration and what they considered to be the benefits, risks and opportunities.

This briefing paper summarises the conclusions of this work and outlines a set of proposals for integrated commissioning in Bromley.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

1) That the Board should have local oversight and governance of moves towards integration across the health and social care economy as recommended by the Department of Health guidance.

2) That the Board notes and endorses the recommendations for officers to take forward the integration of commissioning in Bromley as set out in the conclusions on pg 6-7.

3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

1) That Mental Health commissioning should be used to explore the benefits, barriers and pitfalls of such a move.

2) Senior officers of both Bromley Council and the Bromley CCG, should work towards the positions described in this paper and summarised in the conclusions, and bring back regular reports on progress to the Health and Wellbeing Board.

Health & Wellbeing Strategy

1. Related priority: Specifically mental health services in the first instance with the potential for integrated commissioning across all of Care and Health community based adult services.

Financial

1. Cost of proposal: No specific financials have yet been agreed. See section 5 - Financial implications.

2. Ongoing costs: N/A

3. Total savings (if applicable): N/A

4. Budget host organisation: N/A

5. Source of funding: N/A

6. Beneficiary/beneficiaries of any savings: N/A

Supporting Public Health Outcome Indicator(s)

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4. COMMENTARY

Development of Integrated Commissioning

Closer integration of commissioning arrangements between health and local authorities has been a long held aim of successive governments for many years and numerous bills have been introduced to promote integration with initiatives such as Care Trusts, a duty of Partnership and most recently Wellbeing Boards being introduced. A recent and comprehensive study of joint commissioning, by the University of Birmingham, concluded that while joint commissioning has been perceived as being of varying levels of success in the past, a single agency working approach on its own may still be insufficient to tackle many of the issues we face in future. However, the work also concluded that faced with less money, an ageing population, rising need, higher demand and public expectations, health and social care will have to work together more than in the past.

To support closer integration of commissioning, the NHS Act 2006 makes provision for the functions (statutory powers or duties) of one partner to be delivered day-to-day by another partner, subject to agreed terms of delegation. This means the transfer of responsibility for undertaking the functions, activities or decisions from one partner to another to more easily achieve the partnership objectives. Although functions can be delegated, partners remain responsible and accountable for ensuring they meet their own duties under the legislation, and cannot pass on responsibility for services outside the agreed activity. Section 75 of this Act allows us to pool budgets and share responsibilities in a particular manner controlled by so-called s75 agreements. These should ensure:

- clarity about what any joint arrangement covers and in particular definition and scope of services to be commissioned jointly;
- the strategic aims and objectives of the partnership agreement;
- clarity re governance, operational accountability, day to day management , reporting, performance management, etc;
- duration of any agreement and arrangements for review , renewal, termination and handling of disputes;
- clarity around ‘’host /lead‘’ role and supporting arrangements;
- workforce issues and arrangements;
- information flows and information sharing;
- clinical governance and complaints;
- other legal issues such as liabilities;
- scheme of delegation for any pooled funds;
- clarity around opening contributions and other resources, how growth, efficiency and budget pressures are dealt with how any surpluses and deficits are applied;
- how client contributions impact; and.
- accounting, audit and technical matters such as VAT.

In order to inform the debate, a number of local Health and Social Care economies were approached to discover how they are dealing with integrated commissioning in practice. These organisations had very varied levels of integration but with several London Boroughs, such as Wandsworth and Lewisham, having either all or many service areas commissioned together. In Kingston, they have gone further as they have a joint CCG chief officer/Director of Adult Social care who is accountable for both management and commissioning of all CCG and LA services. In all of these areas, both Councillors and GP’s are happy with and signed up to the arrangements as they can see mutual benefits from economies of scale and opportunities for efficiency, savings and community based improvements. However, there are still issues to overcome such as different cultures and approaches generally and some’’ silo’’ working.

The organisations contacted consider that there are clear advantages from the integration of commissioning and the appointment of a host commissioning organisation which takes responsibility for the commissioning of groups of services through a joint commissioning team. Lead heads of commissioning have been employed by the host agency either across the board or for various specific services and budgets for commissioned services have been aligned although there as some examples of pooled budgets in operation. Section 75s have been developed to ensure the arrangements are clearly defined and agreed.

In governance terms, the general approach is that Health and Wellbeing Boards have strategic oversight and that a senior level officer executive established to steer key service redesign programmes and ensure control of any integrated budgets.

Benefits from the development of lead and joint commissioning are considered to include:

- The ability to have lead commissioners who are accountable for delivering on shared strategic objectives;
- The ability to pull together all commissioning activities under one team, thereby making better use of scarce commissioning resources and expertise;
- The opportunity to approach the market on a 'whole system' basis including opportunities to tender jointly for mental health services and align existing contracts;
- The opportunity to streamline financial management and ensure better value for money for the whole system.
- The opportunity to reduce duplication for work and complex joint contractual arrangements having to be underwritten through Section 256 agreements;
- Clarity of purpose to help both partners speed up the implementation of long standing reforms to service;
- The chance to redesign care pathways to deliver better outcomes and provide greater clarity to users and providers;
- The opportunity to move towards with one shared set off performance indicators for monitoring outcomes of service provision;
- the ability to agree a single point of entry for initial referrals providing an extended range of preventative health and care interventions;
- The opportunity to ensure wide clinical engagement in key changes that are required to reshape services; and,
- C-locating commissioning staff to model and promote joint working.

However, whilst it is recognised that there can be significant benefits from establishing joint and lead commissioning arrangements, there are also potential problems and risks including:

- Potential for blurring of responsibilities between organisations leading to a need for clarity on roles and responsibilities particularly in relation to delivery of statutory responsibilities;
- Feeling of loss of control for the organisation which is not leading and hosting the commissioning team;
- Differing organisational and financial requirements leading to need to ensure clarity and consistency in requirements;
- Impact on existing financial, information and procurement teams including requirement to cope with extra work in hosting organisation;
- Uncertainty for and potential conflicts with providers affected by changes in commissioning arrangements; and,

- Expertise in the non-host organisation is lost making them fully reliant on the host for delivery in the medium to long term.

The real issues that need to be overcome for full integration to take place revolve around aligning differing commissioning priorities which are in turn driven by organisational and jurisdictional boundaries and budgets. As a result, it requires organisations to have a high level of trust and maturity that allows leaders to take a wider strategic perspective when taking commissioning decisions which direct impact on health and care services in their locality. Senior leadership and individual relationships are critical to making significant progress in addressing the cultural and financial issues that will need unblocking throughout any work on integration.

Proposals for a new approach to Commissioning in Bromley

Discussion with key leads within both the CCG and LBB has shown that there is strong support for changes in commissioning and supporting governance arrangements in Bromley. In particular, there is support for the introduction of establishing lead commissioning arrangements headed up by a lead commissioner, supported by an appropriately resourced commissioning team. While numerous options exist for the level at which integration should occur it is advised that this approach should be tested with a single client type before the introduction of a fully integrated joint commissioning structure is considered, although any proposals that are tested should have the capacity to be expanded over time.

The recent announcements made by the Department of Health relating to previously separate funding streams being pooled and tied into the requirement for CCG's and LAs to co-produce a local plan for integration only serves to increase the importance of this agenda.

The Bromley CGG Chief Officer and London Borough of Bromley Executive Director of Education, Care & Health believe that Mental Health should be the first area of focus as integration is not a new agenda for mental health services. Many steps have been taken by both organisations to move in this direction over the past few years, including:

- Development of a joint commissioning strategy for Mental Health services with jointly agreed priorities and work streams;
- Mental Health planning and work streams are governed under the Mental Health Executive which has representation from the both the CCG and the Local Authority;
- Both LBB and the CCG both use Oxleas as their main Mental Health provider with the CCG commissioning a wide range of mental health services and LBB commissioning community based care;
- Both LBB and the CCG hold joint funded contracts with a range of 3rd sector providers;
- Assessments to meet a client's needs are already done holistically taking into account the clinical and care needs presented, with LBB care managers being seconded to Oxleas under a Section 75 agreement; and,
- Packages of care are presented to a joint mental health panel and decisions around suitable placements are made together based on the assessments produced by Oxleas.

The total commissioning budget for mental health services amounts to circa £42.5m with £37.2m coming from the CCG and £5.3m from LBB. Oxleas Foundation Trust is the main provider of acute and community mental health services for working age adults, older people services and CAMHS. The CCG also makes a contribution to LBB's contact with Bromley Y for CAMHS; Community Paediatric consultant support is available from Bromley Health Care (BHC) to support this service. BHC has been commissioned to provide a local IAPT (the national Improving Access to

Psychological Therapies programme) services with Bromley MIND and, in addition, there are a range of other mental health service providers such as Community Options, some of which are commissioned by both the CCG and LBB. Most specialist mental health services have in the main transferred to the NHS London.

The mental health programme focuses on shifting mental health care from a secondary care based model to one that is more comprehensive and takes account of the role of primary care, reducing acute beds, reprovision of residential services, reviewing of the existing Dementia care pathway and the remodelling of CAMHS services. Better value for money is being sought by driving efficiencies from these areas of service redesign

The general view of those consulted is that, should integrated commissioning for mental health services be adopted in Bromley, the CCG should be the host and lead organisation as it already commissions 87% of the spend on mental health across the borough. Also much of the strategic change proposed is being led by the new CCG programme team with GPs very clear in their wish for a new form of service based around primary care.

Enhanced leadership is proposed for mental health commissioning by the appointment, within existing resources, of a lead Mental Heath commissioner who will manage the team and take a holistic approach to commissioning activity using an aligned budget arrangement. This lead commissioner would be accountable for delivery of the agreed programme of work and identified savings targets. The post will also be accountable for evaluating, and reporting back on the success of these integrated arrangements with a view to expanding them beyond commissioning activity for mental health clients. Members of the existing team and others affected by the proposed changes will be made aware of any proposals and given the opportunity to comment on changes in general and changes impacting on them in particular.

Budgets for mental health commissioning will be aligned between the CCG and LBB, agreement reached regarding uplifts, efficiencies and savings plus an understanding about how and where savings will be applied and how any potential overspends are managed.

Finance, information and procurement support will continue to be provided by the corporate departments at both organisations and in the case of the CCG from the Commissioning Support agency or from external expertise as required.

Conclusion

In summary, the following approach is proposed to take forward the integration of commissioning in Bromley

1. Ensure that GPs and Councillors are happy with the proposals for the integration of commissioning.

2. Continue to utilise the Health and Wellbeing board for shared strategic oversight

3. Create a Joint Integrated Services Executive to oversee all strategic business relating to integrated commissioning. (This arrangement would take the place of the existing Mental Health Executive)

4. Integrate commissioning for adult mental health services and CAMHS to test the approach with a view to extending the brief of joint commissioning at a later stage if integrated commissioning for mental health services is successful.

5. Designate the CCG as lead and host for mental health commissioning and co-locate the commissioning staff at the CCG.

6. Appoint a lead joint commissioner to manage the mental health commissioning team and associated budgets and ensure delivery of agreed priorities.

7. Continue to use separate back office support in the first instance but consider the option of sharing in areas such as procurement and brokerage support.

8. Novate or delegate appropriate contracts to the host partner.

9. Align budgets initially and set out clear arrangements for annual negotiations concerning savings etc.

10. Develop an overarching section 75 setting to define the principles for joint commissioning activity and detail of governance and financial arrangements.

5. FINANCIAL IMPLICATIONS

No specific financials have yet been agreed although it is expected that one of the main drivers for integrating commissioning activity will be to secure longer term value for money by joined up commissioning across the whole of the adult care and health services.

6. LEGAL IMPLICATIONS

The use of a section 75 agreement to define the principles for joint commissioning activity and detail of governance and financial arrangements.

7. IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM

The CCG and Local Authority both agree to progressing the proposed approach and will notify stakeholders of their work to future Board meetings.

8. COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

The London Borough of Bromley Executive Director of Education, Health and Care Services, and the Chief/Accountable Officer of Bromley CCG have both endorsed the proposed approach set out in this paper and agree to working towards its delivery.

Non-Applicable Sections:	N/A
Background Documents:	N/A

Report No.
HWB131003

London Borough of Bromley

PART ONE - PUBLIC

HEALTH AND WELLBEING BOARD

Date: **Thursday 26 September 2013**

Report Title: **Section 256 funding**

Report Author: Richard Hills, Strategy Manager - Commissioning,
Education, Care & Health Services, London Borough of Bromley.
E-mail: richard.hills@bromley.gov.uk Telephone: 0208 313 4198

1. SUMMARY

Attached is the Section 256 for Bromley care and health service which has been produced in order to drawn down the Department of Health grant for 2013/14 which stands at £4.26m.

Both the Local Authority and Clinical Commissioning Group propose to use the funding to deliver against 6 'schemes' as they are referred to in the NHS England template attached. Details on each scheme can be found in the attached template but, by way of a summary, the 6 areas look to maintain and sustain key community based services important to both organisations that are otherwise struggling to be kept operational due to the significant cuts.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

To draw down the funding the Section 256 must be signed and agreed by both the Local Authority and the Clinical Commissioning Group. Finally it must be approved at the Local Health and Wellbeing Board before being formally submitted to the London branch of NHS England.

3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

This draft Section 256 requires the full endorsement of the Health and Wellbeing Board. Chief Officers at both the CCG and the LA will be responsible for securing the funding through the NHS England board on behalf of Health & Wellbeing Board.

Health & Wellbeing Strategy

1. Related priority: Funding to support adult social care

Financial

1. Cost of proposal: None – this is a one off funding coming in at £4.26m from central government. There would be considerable budget pressures if we were unable to draw down this funding.

2. Ongoing costs: These funds are used to continue to support priority areas of service

3. Total savings (if applicable):

4. Budget host organisation: Bromley Local Authority

5. Source of funding: Department of Health

6. Beneficiary/beneficiaries of any savings:

Supporting Public Health Outcome Indicator(s)

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4. COMMENTARY

Please see attached for the draft Section 256

5. FINANCIAL IMPLICATIONS

One-off funding from central government that needs to be secured through a formal Section 256 to NHS England. Nationally the funding is £859m and Bromley's allocation stands at £4.26m.

6. LEGAL IMPLICATIONS

The payments are to be made via an agreement under Section 256 of the 2006 NHS Act. NHS England will enter into an agreement with each local authority and will be administered by the NHS England Area Teams (and not Clinical Commissioning Groups). Funding from NHS England will only pass over to local authorities once the Section 256 agreement has been signed by both parties.

7. IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM

Future funding arrangements from DoH through NHS England will go further to create a pooled fund to which CCG and LAs have to jointly bid through their H&WBs. The Integrated Transformation Fund (ITF) for which we will need to produce a Local Plan by March 2014 means that this type of funding arrangement will become increasingly commonplace and that more and more of our funding will come through to both organisations in this way.

8. COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

This Section 256 has been produced by the LA and shared with the CCG for comment and feedback.

Non-Applicable Sections:	[List non-applicable sections here]
Background Documents: (Access via Contact Officer)	Please contract Richard Hills for detailed excel spread sheet breaking down the funding request.

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DATED **2013/14**

(1) NHS ENGLAND (LONDON BRANCH)

(2) BROMLEY CLINICAL COMMISSIONING GROUP

(3) THE MAYOR AND BURGESSES OF THE LONDON BOROUGH OF BROMLEY

MEMORANDUM OF AGREEMENT
SECTION 256 TRANSFER — NATIONAL HEALTH SERVICE ACT 2006
SOCIAL CARE AND HEALTH

Legal and Democratic Services
London Borough of Bromley
Civic Centre
Stockwell Close
Bromley BR1 3UH

Ref: L8 4/6/17/286

DATED2013/14

Memorandum of Agreement
Section 256 transfer — National Health Service Act 2006

Reference number:	**LBB/CCG/NHSENGLANDgrant/2013-14**
Title of scheme:	**NHS England allocation for DoH Social Care Grant**
Parties:	**NHS ENGLAND (London Branch)** 2nd Floor, Southside, 105 Victoria Street, London, SW1E 6QT **BROMLEY CLINICAL COMMISSIONING GROUP** Bassetts House, Broadwater Gardens, Orpington, Kent BR6 7UA (the "PCT") and **THE MAYOR AND BURGESSES OF THE LONDON BOROUGH OF BROMLEY** Bromley Civic Centre, Stockwell Close, Bromley, Kent BR1 3UH (the "Recipient")

1. **How will the Section 256 transfer have a beneficial effect on the wider health and care system in the area of the Local Authority?**

Both The London Borough of Bromley and Bromley's Clinical Commissioning Group are committed to *Building a Better Bromley* through designing and delivery integrated health and care services for our residents. These services are there to respond to local needs and to keep our residents well and cared for but they are also designed to, wherever possible, promote independence and support our residents to manage any long term conditions and associated care needs in their community.

Getting our shared community based services right with clear care pathways in place is one way to achieve these aims and to prevent residents going into crisis and requiring an avoidable hospital admission and unnecessary delay in an acute setting which can create avoidable stress and is much harder for families and carers to manage.

This Section 256 has been drafted in partnership and taken through our Health & Wellbeing Board on 26th September 2013 with a focus on our Joint Strategic Needs Assessment (JSNA).

Both organisations propose to use the funding to deliver against 6 'schemes' as they are referred to in the NHS England template attached. Details on each scheme can be found in the attached template but, by way of a summary, the 6 areas look to maintain and sustain key community based services important to both organisations that are otherwise struggling to be kept operational due to the significant cuts. Social care budgets since 2010 has been cut by around £2.7bn – or 20 per cent. A further 10 per cent cut was announced to local government spending which will also impact upon social care.

The proposed schemes though go further than simply sustaining existing services, as this on its own will not provide the answers to delivering effective community based care over the coming years. Some of these schemes also look to accelerate integration and to support both organisations to integrate their commissioning structures ready for the Integrated Transformation Funding in 2015/16 where a joint local plan must be submitted by March 2014. Positive steps to integrations are apparent across many of these schemes and include:

Drafting a shared Section 75 agreement
Creating a joint commissioning executive
Further integration of the dementia care pathway
Reviewing existing joint funded packages and moving towards pooled budgets
Targeted officer support to help develop the local Health and Wellbeing Board

The focus of all of these schemes of work is to maintain critical service levels and respond to pressure points in the system

Both organisations will be looking to use this funding for the commissioning of shared information, shared training and development as well as looking at clarifying shared governance arrangements to best manage limited resource across the CCG and LBB in the future.

2. **What will be the outcomes for service users which happen as a result of this Section 256 transfer?**

All the work that will be commissioned and service levels maintained will be in line with both partners' corporate objectives and will be championed collectively through the local Bromley Health and Wellbeing Board.

The main outcomes that both partners wish to achieve across the borough are:

- To reduce unplanned hospital admissions
- To reduce the need for long term care packages through proper crisis response and reablement
- To reduce the requirements for bed based care and provide more tailored health and care support in the home or in community settings
- To prevent any delays to discharge from acute into a primary care setting

3. **Financial details (and timescales):**

NHS England must make payments under either or both of subsections (1) and (3) of section 256 of the 2006 Act to the local authorities listed in the Schedule.

The minimum amount which the Board must pay to the local authority is listed in the Schedule in respect of the relevant financial year is the amount identified in the Schedule as the local authority allocation for 2013/14 in relation to that authority.

NHS England must make arrangements for the local authority to provide it with information as to how the payments made in accordance with these Directions is being used by the authority

Total amount of money to be transferred by NHS England (if this subsequently changes, the memorandum will be amended and re-signed)

Year(s)	Amount	Date of Payment
2012/13	£4,260,838	2013/14
Total	£4,260,838	

4. **Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.**

Progress reporting will be taken through the Health & Wellbeing Board and the clinical commissioning executive and reported to NHS England

4. The Grant Payment

NHS England hereby agrees pursuant to its powers under Section 256 of the National Health Service Act 2006 to pay the amounts set out in Clause 3 of this Memorandum on the dates specified in Clause 3 (subject to Clause 4.2 of the Terms and Conditions annexed).

The Recipient hereby agrees to expend the payments made to it under Clause 5 of this Memorandum for purposes detailed in Schedule 1 – The Service Specification

5. Terms and Conditions

The Terms and Conditions attached to this Memorandum shall be deemed to be incorporated in this Memorandum and the parties agree to abide by the terms of the attached Terms and Conditions.

The defined terms used in this Memorandum shall have the meanings ascribed thereto in the Terms and Conditions.

These arrangements are reviewed on an annual basis

IN WITNESS WHEREOF the parties hereto have duly executed this Memorandum of Agreement as a deed the day and year first before written

Executed as a Deed by Bromley Clinical Commissioning Group whose Corporate Common Seal was hereunto affixed in the

Authorised Signatory and Seal

The Common Seal of the Mayor and Burgesses of the London Borough of Bromley was hereunto affixed in the presence of:-

Councillor

Head of Legal Democratic and Customer Services:

Executed by the NHS London Delivery Team

Authorised Signatory

TERMS AND CONDITIONS (2007)

1. DEFINITIONS AND INTERPRETATION

1.1 In these Terms and Conditions the following expressions shall have the following meanings:

"Act of Insolvency"	in relation to a corporate body that:- (a) it is unable to pay its debts as defined in Section 123 of the Insolvency Act 1986 (referred to as "the Act" in the remainder of this definition) (and for the purposes of interpreting that section the words "it is proved to the satisfaction of the Court that" in subsections 123(1)(e) and 123(2) shall be ignored); or (b) a proposal is made for a voluntary arrangement under Part I of the Act; or (c) a petition is presented for an administration order under Part II of the Act; or (d) a receiver and (or) manager or administrative receiver is appointed whether under Part III of the Act or otherwise; or (e) it goes into liquidation as defined in Section 247(2) of the Act (other than a voluntary winding up solely for the purpose of amalgamation or reconstruction while solvent); or (f) a provisional liquidator is appointed under Section 135 of the Act or a proposal is made for a scheme of arrangement under Section 425 of the Companies Act 1985;
"this Agreement"	means the Agreement constituted by the Memorandum of Agreement, these Terms and Conditions and all documents supplemental thereto
"the Authorised Purposes"	means the carrying out of the Services
"Business Days"	means a day (other than a Saturday or Sunday) on which the Banks are open in the City of London
"the Capital Sum"	means the total sums payable by the CCG pursuant to Clause 5.1 of the Memorandum of Agreement in exercise of the PCT's powers under Section 256 of the National Health Service Act 2006 and in accordance with this Agreement
"Commencement Date"	means the date hereof
"the Memorandum of Agreement"	means the memorandum of agreement between the CCG and the Recipient to which these Terms and Conditions are attached
"the CCG"	means Bromley Clinical Commissioning Group of Bassetts House, Broadwater Gardens, Orpington, Kent BR6 7UA

"Recipient"	means The Mayor and Burgesses of the London Borough of Bromley of Bromley Civic Centre, Stockwell Close, Bromley, Kent BR1 3UH
"NHS England"	means the NHS England (London Branch) 2nd Floor, Southside, 105 Victoria Street, London, SW1E 6QT
"Repayment Event"	means any one or more of the following:-

(a) the Capital Sum or any part of it not being used at any time for the Authorised Purposes (and so that a Repayment Event shall be deemed to occur on each day that it is not so used);

(b) the Recipient committing or permitting an Act of Insolvency;

(c) any remediable material breach by the Recipient of any of the provisions of this Agreement which the Recipient fails to remedy within a reasonable time of notice given by the PCT specifying the breach ;

(d) any irremediable material breach by the Recipient of any of the provisions of this Agreement ;

(e) the Authorised Purposes ceasing to be carried out unless an alternative use has been agreed between the parties beforehand;

(f) any representation or warranty made by the Recipient under this Agreement or in any agreement certificate instrument or statement contemplated hereby or thereby or made or delivered pursuant hereto or thereto being incorrect or misleading in any material respect when made;

(g) it becoming unlawful or impossible for the Recipient to perform and observe any of its obligations under this Agreement to perform and observe any of its obligations under the Provider Agreement.

"**Services"**	The Services to be provided by or on behalf of the Council more specifically described at the Schedule 1 (Services Specification) hereto
"Terms and Conditions"	means these Terms and Conditions

1.20 In the interpretation and construction of these Terms and Conditions:-

121 words importing the singular number only shall include the plural number and vice versa and where there are two or more persons included in the expression "the Recipient" obligations contained in

this Agreement which are expressed to be made by the Recipient shall be deemed to be made by such persons jointly and severally

1.2.2 any reference to any Act of Parliament shall include any modification extension or re-enactment thereof for the time being in force and shall also include all instruments orders and regulations for the time being made thereunder or deriving validity therefrom

1.2.3 the headings in this Agreement are inserted for convenience only and shall be ignored in construing the terms and provisions hereof

1.2.4 reference to a clause without further definition shall be reference to the appropriately numbered clause of these Terms and Conditions

2 REPAYMENT

2.1 Subject to Clause 2.2 the Recipient agrees upon the occurrence of a Repayment Event to repay to NHS England or if requested to do so by NHS England to any other body nominated by NHS England.

2.2 NHS England may waive (in its absolute discretion) its right to make a demand under clause 2.1 in respect of any particular Repayment Event. Notwithstanding a waiver in respect of any Repayment Event NHS England shall remain entitled to make a demand in respect of each and every other Repayment Event which may occur or have occurred (whether before or after the particular Repayment Event which has been so waived).

2.3 On repayment pursuant to this clause 2 this Agreement shall automatically determine but without prejudice to any right of action of NHS England in respect of any breach by the Recipient of the terms of this Agreement

3 RECIPIENT'S COVENANTS

The Recipient hereby covenants with NHS England:

3.1 At all times to use the Capital Sums for the Authorised Purposes and no other purposes

4. PAYMENT OF CAPITAL SUM

4.1 The Recipient shall procure that the Recipient its employees or agents shall have reasonable access at all reasonable times during normal working hours to monitor the progress of the Services upon giving reasonable notice. The Recipient shall provide updates on the progress of the Works to the NHS England within 30 Business Days of receiving a request for the same

4.2 Subject to compliance by the Recipient with the terms of this Agreement, NHS England will

Pay the Capital Sum (or the relevant part thereof) to the Recipient as set out in Clause 3 of the Memorandum of Agreement within 30 days of receipt from the Recipient of valid VAT invoices up to the value of the Capital Sum provided that NHS England is satisfied that the Services have been carried out in accordance with this Agreement

4.3 The Recipient shall immediately repay to NHS England any part of the Capital Sum that is not

used for the Authorised Purposes

5. VOUCHERS

At the end of each financial year the Recipient shall provide to NHS England a voucher in the form specified by NHS England certified by the Recipient's auditors (and complying with any additional requirements of NHS England including without limitation requirements in respect of the authentication and certification of the voucher) in which the Recipient shall itemise the actual expenditure and certify that the conditions of the payment of the Capital Sum have been fully met or indicate such variations as have been agreed with NHS England.

6. ASSIGNMENT AND SUB-CONTRACTING

6.1 The rights and obligations of NHS England under this Agreement are freely assignable

6.2 The rights and obligations of the Recipient under this Agreement may not be assigned

7. GOVERNING LAW

This Agreement shall be governed by and be construed in accordance with English Law and the parties hereby submit to the exclusive jurisdiction of the English Courts

8. NOTICES

8.1 Any notice or communication under this Agreement shall be in writing

8.2 Any notice or communication to NHS England under this Agreement shall be deemed effectively served if sent either by registered post or delivered by hand to the Chief Executive at the address given in the Memorandum of Agreement or to such other officer and address notified from time to time to the Recipient for service on NHS England.

8.3 Any notice or communication to the Recipient hereunder shall be deemed effectively served if sent either by registered post or delivered by hand to the Recipient at the address given in this Agreement or to such other officer and address notified from time to time to NHS England for service on the Recipient

9. GENERAL

9.1 No delay or omission of NHS England in exercising any right power or privilege under this Agreement shall operate to impair such right power or privilege or be construed as a waiver of it and a single or partial exercise of any right power or privilege shall not in any circumstances preclude any other or further exercise of it or the exercise of any other right power or privilege

9.2 If at any time any provision of this Agreement is or becomes illegal invalid or unenforceable in any respect the legality validity or enforceability of the remaining provisions of this Agreement shall not in any way be affected or impaired thereby

9.3 The Recipient shall from time to time upon the request of NHS England execute any additional documents and do any other acts or things which may reasonably be required to effectuate the purposes of this Agreement

9.4 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the PCT and the Recipient do not intend that any other party shall have any right in respect of this Agreement by virtue of that Act

10. COUNTERPARTS

This agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this agreement, but all the counterparts shall together constitute the same agreement. No counterpart shall be effective until each party has executed at least one counterpart

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Report No.
HWB131001

London Borough of Bromley

PART ONE - PUBLIC

HEALTH AND WELLBEING BOARD

Date: **Thursday 26 September 2013**

Report Title: **NOMINATION FOR THE NHS INNOVATION CHALLENGE PRIZE FOR DEMENTIA**

Report Author: Melanie Place, Consultant Clinical Psychologist, Oxleas NHS Foundation Trust
Email: melanie.place@oxleas.nhs.uk Telephone: 01689 892336

1. SUMMARY

Innovation Challenges reward innovative healthcare practices and ideas that have already demonstrated a positive impact in a local context where they have been implemented, tried and tested but which have not yet received wider recognition. They are time-limited, so there are set dates for the entry and award process. They focus on finding solutions which improve both quality and productivity.

The integrated team working with people with dementia has nominated the project that has been working within Bromley Care Homes. The nomination is about bringing together health and social care agencies into more effective communication around people with challenging behaviour in dementia.

It uses existing ideas to create an individualised practical working document and allows for a stepped care approach. Through the systematic investigation of the attempt to communicate by the person with dementia, the carer can make more effective and efficient use of resources for the person with dementia. Meanwhile the person will benefit from an appropriate intervention which is person centred and based on the knowledge that the carer has built up through their relationship with that person.

The application is attached as appendix 1 and the outcomes report is attached as appendix 2.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

This report is for information only as an example of an integrated approach to providing services for people with dementia. This area was identified as a priority area in the JSNA and is monitored as priority of the current Health & Wellbeing Strategy.

3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

This is an information item only which shows one example of an integrated approach.

Health & Wellbeing Strategy

1. Related priority: Dementia, Supporting Carers

Financial

1. Cost of proposal: Not applicable

2. Ongoing costs: Not applicable

3. Total savings (if applicable):

4. Budget host organisation: Not applicable

5. Source of funding: Not applicable

6. Beneficiary/beneficiaries of any savings: Not applicable

Supporting Public Health Outcome Indicator(s)

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4. COMMENTARY

The Innovation Challenge Prizes exist to reward innovative healthcare practices and ideas that have demonstrated a positive impact in the local context where they have been implemented, but which have not yet received wider recognition. The Prizes will be awarded for innovations that respond to the specific challenges set, and will promote the widespread diffusion of these successful innovations throughout the NHS, and will also foster a culture that encourages the identification, development and spread of innovative ideas.

Innovation is an essential feature in any developing organisation, especially one that combines personal care and technology in such an intricate way, to deliver personally tailored services to every patient. It is all the more important at a time when the NHS has to meet ever-rising demands and improved patient outcomes within tight resource constraints. QIPP (Quality, Innovation, Productivity, Prevention) is at the heart of the NHS's approach to the current economic challenge; the Challenge Prizes aim to positively contribute to the wider QIPP agenda.

Successful applicants will be expected to demonstrate that their innovations have been designed in such a way that they can easily be disseminated or taken up by other NHS organisations. The Challenge Prize website and the award of prizes will draw attention to successful innovations. More generally the pressure on the service to improve quality and productivity, and the move towards commissioning for outcomes, should stimulate innovative practice – whether generated locally or copied from elsewhere.

Non-Applicable Sections:	Financial, Legal, Governance
Background Documents: (Access via Contact Officer)	[Title of document and date]

NHS INNOVATION CHALLENGE PRIZE FOR DEMENTIA IN COLLABORATION WITH JANSSEN HEALTHCARE INNOVATION

Application Form

Please complete all of the questions below, keeping to the word limits specified.

Once you are ready to submit, please send this application form, and up to three supporting documents, to ChallengePrizes@nhsiq.nhs.uk with the subject title **"NHS Innovation Challenge Prize for Dementia Application Form"**. You will receive a confirmation email receipt within 24 hours of submitting.

The deadline for submission is **midday on Wednesday 4 September 2013** and applications received after this date will not be considered.

Guidelines for completing this form are also available to download on our website together with our **Terms and Conditions**. Please ensure you have read and understood these before submitting your application.

Section 1: About you

Title

Give your innovation project a short title (**limited to 140 characters** – as long as a twitter feed): Promoting Well Being in Dementia through Sharing Effective Care

Lead Applicant

Name: Melanie Place
Job title: Consultant Clinical Psychologist
Organisation: Oxleas NHS Foundation Trust
Email: melanie.place@oxleas.nhs.uk
Telephone number: 01689 892336

Lead NHS organisation

Oxleas NHS Foundation Trust, *Anne Waterworth, Service Manager, Older Peoples' Directorate*

Current team running the programme:
Sheila Bishop (full time) *Oxleas NHSF Trust Occupational Therapist*
Iolanta Stefanovitch *(brief sessional input) Oxleas NHSF Trust Clinical Psychologist*
Melanie Place *(sessional input) Oxleas NHSF Trust Clinical Psychologist*
Tamsin Williams (full time) *Assistant Psychologist*
CPN (vacancy)

The following are people who have at any time been involved since the outset of the project, developing the tool and the workshops:

Ophelia Ankrah – Raymond *Oxleas NHSF Trust Community Psychiatric Nurse*
Hugh Baldwin *Oxleas NHSF Trust Memory Nurse*
Sheila Bishop *Oxleas NHSF Trust Occupational Therapist*

Yvonne Chapman *Oxleas NHSF Trust Community Psychiatric Nurse*
Patricia Higgins *Oxleas NHSF Trust Memory Nurse*
Edward Jay *Oxleas NHSF Trust Community Psychiatric Nurse*
Melanie Place *Oxleas NHSF Trust Consultant Clinical Psychologist*
Karen Saini *Oxleas NHSF Trust Community Psychiatric Nurse*
Iolanta Stefanovitch *Oxleas NHSF Trust Clinical Psychologist*
Carolyn Tilbrook *Oxleas NHSF Trust Assistant Psychologist*
Tamsin Williams *Oxleas NHSF Trust Assistant Psychologist*

The following are people who manage the Homes into which we have an input. This list is continuing to grow.
Glebe Court Nursing Home – **Gillian Davies**
Oatlands Residential Home – **Rishi Jawaar**
Fairmount Residential Home - **Riet Seward**
Greenhill Nursing Home - **Dee Gumbo**
Elmstead Residential Home – **Emma Staples**
Park Avenue Care Centre – **Arlette Beebeejuan**
Caloma Court –**Maria Covington**

The commissioner particularly involved with this project is:

Claire Lynn Strategic Commissioner- Mental Health and Substance Misuse

How you heard about us

Tell us how you heard about us e.g. Twitter, our Comms team, DH Bulletin, Media, Charity Newsletter etc
From the Director of the Oxleas Older Peoples Service

Section 2: Your innovation

a) Please briefly summarise your innovation, to explain what it is and how it meets the Challenge.

This innovation is a system for understanding the communication of a person with dementia who is unable to communicate clearly. It is currently known as the" Oxleas Dementia Care Tool".

The system is straightforward and uses guidelines from NICE on challenging behaviour in dementia. The tool allows care staff to use their knowledge of an individual to help them care for that person in a way which promotes wellbeing and aims to reduce challenging behaviour without the unnecessary use of medication. However it is also reducing the number of people with fairly straightforward problems, (such as pain or infection, boredom etc.) from being inappropriately referred on to other services .As the work develops we have seen people with challenging behaviour who formerly would have been sent into hospital as an acute admission being effectively cared for without an admission.

The tool and its workshop programme are now manualised. It is currently being brought into the acute dementia ward because we realise that it can be used wherever there is work being done with people with dementia, from informal care to highly specialist hospital care wards.

(185/200 words)

b) Indicate which best describes your innovation (please delete all that don't apply)

- Service Improvement

- ***Implementation of good practice***

- ***Development of a new technique***

- *Adoption of new technology*

- *New model of care*

- *Other (please describe in **30 words or less**)*

Section 3: Innovation

Innovation is defined as 'an idea, service or product that is new to the care of people with dementia, or applied in a new way'.

- Does your project comply with this definition?

This project is based on the solid foundations of the Person Centred Care approach in dementia first put forward by Tom Kitwood, (1990) and expanded on by others since such as Buz Loveday, Dawn Brooker, Graham Stokes, Esme Moniz-Cook. It has also used the principles put forward in the NICE Dementia guidelines covering challenging behaviour in dementia.

But it applies these ideas in a new way to create a practical and effective clinical tool which has the potential to be used across any care setting. It allows carers to use the knowledge they already have in their heads about the people they care for, in an effective way, and can be universally used across all settings where there are people with dementia.

- Is it <u>unique</u> in the care of people with dementia?

I think the tool and the workshops are unique as they are not aimed at teaching carers how to implement Person Centred Care but aimed solely at learning about and applying the tool.

- Do you know of others who are using a similar approach?

There is similar but slightly different work being reported from Newcastle by Ian James and also work reported in the PSIGE Journal of April 2013, (Journal by and for Psychologists working with older people.)

(189/200 words)

Section 4: Context

Briefly summarise what prompted your innovation. Please include what the specific problems were which you were seeking to address and over what timescale the project was undertaken

Concern about the use of anti-psychotic medication in 2009 brought into the focus the issues around challenging behaviour in dementia. The local secondary mental health teams said they were often getting phone calls asking for help with people in care homes where either it did not really seem to need the skills of a mental health team, (for example, the person had an infection), or the problem was so advanced that little could be done except admission to an acute dementia ward. The teams did not feel their expertise as experienced mental health workers was being well utilised.

Information from colleagues in Care Homes strongly indicated that the one issue where they wanted help from mental health teams was in challenging behaviour in dementia.

The initial aim was to find a method that would systematically address the inappropriate use of mental health service resources while supporting four Homes in the borough in their difficulties in caring for people with challenging behaviour in a

pilot project lasting a year. (2011-2012). Following the initial project a further two years funding was supplied to bring the total number of Homes in the scheme to 20.

(192/200 words)

Section 5: Meeting the Challenge

c) *Explain how your innovation meets the Challenge; does it address the specific wording of the Challenge? (You can provide evidence of this in response to Sections 6 and 7 below)*

Our innovation is bringing together health and social care agencies into more effective communication around people with challenging behaviour in dementia. It uses existing ideas to create an individualised practical working document and allows for a stepped care approach. Through the systematic investigation of the attempt to communicate by the person with dementia, the carer can make more effective and efficient use of resources for the person with dementia. Meanwhile the person will benefit from an appropriate intervention which is person centred and based on the knowledge that the carer has built up through their relationship with that person.

(99/100 words)

b) What did you do to make a difference?

We talked, and listened, to the people in the Care Homes who phoned the secondary mental health teams most often to ascertain what they felt they needed most help with. We based the input around their replies. At this point we put in a bid for some money.

We employed an assistant psychologist and part time CPN's.

We devised a programme of workshops based on NICE guidelines on challenging behaviour and delivered 6x4 hour workshops and then follow up sessions to 4 Care Homes.

We evaluated the outcomes, applied the learning to the next round of workshops and set off to provide more workshops.

Once ten weekly follow up meetings had been completed we instituted a system in each Home for an on-going monthly consultative visit when residents are discussed with a CPN or OT using the tool.

And what made the difference? Core to our input is that the carers, not the secondary care team, are the experts in caring for their residents with people with dementia. People with dementia are still communicating, we just had to listen to the people who pick up on those communications and provide them with a means of making sense of them.

(199/200 words)

c) What was the key enabler for you to make the change?

A huge interest and then willingness to look at alternatives to the use of anti-psychotic medication in the care of people with dementia which was fostered by the work around dementia led by Dr Sube Banarjee and NICE guidelines. That shift in attitudes to the care of people with dementia, supported by the media and recently by the Prime Minister was the key. Locally it was our service manager Helen Jones who took the opportunity to apply for and gain funding from the PCT with further input from the London Borough of Bromley in the following year.

(97/100 word limit)

Section 6: Outcomes Achieved for People with Dementia

Please give quantified, as well as qualified, evidence:

a) Provide evidence of what you have actually achieved in terms of outcomes for people with dementia and their carers (for example, hospital admissions avoided, number of reduced admissions to care homes, more timely diagnosis, improved experience for people with dementia, or other outcomes)

At the end of each four Care homes input measures are taken to find out whether there are any discernible benefits from the programme. Mostly these measures seem to show positive results.

People in Care Homes who were brought to case discussion in the follow up sessions with the Care Homes team over the last 6 months have not ended up in acute dementia care wards. Out of the 25 discussed only 1 was subsequently admitted to an acute hospital.

None of the people presented to the Care Home Team with challenging behaviour have been put on anti-psychotic medication over the past 6 months with other inputs, pain medication, activities etc. producing beneficial change. Of those 19 already on medication, 11 were brought to the attention of the Care Home team and reviewed. 1 resident had their medication stopped and 1 resident's was reduced. The other 9 remained the same. It is important to note that anti-psychotic medication can be appropriate and this work is aimed at preventing its inappropriate use not its use.

None of the 15 people with challenging behaviour in residential care who were discussed were moved into Nursing Homes across the time of the project. (18 months).

There are therefore savings in the use of hospital care and also savings in Nursing Home Care as people with challenging behaviour are treated more holistically and individually. Apart from them benefitting from more appropriate care, avoiding the upsetting disruption of a move, Care staff are gaining confidence in their ability to manage challenging behaviour.

Reports from the Care Staff, (see attached report) also demonstrate that they increase in confidence to work with people with dementia although this is not a training programme on dementia but a method for using person centred care.

(294/300 word limit)

b) What was the local baseline for these outcomes before your innovation was implemented?

Baseline measures on carers understanding of challenging behaviour and their confidence in working with it all increased over all the Homes according to the self report scales used. (See attached report). We also asked them about their definitions of "challenging behaviour" at the beginning of the work and then again at the end. The changes, (see report) demonstrate marked and positive changes in their approach to the issue. We think this self reported change in carers results in measurable benefits for the residents.

We have a baseline audit in the Homes followed by a later audit which shows, using the NICE audit tool, a positive improvement in the care plans of residents with challenging behaviour after the workshops.

We have tried to capture this improvement in the Homes by measuring the number of the referrals to the Community Mental Health Team from the Care Homes. This is showing a steady but not yet significant decline over the 6 monthly intervals (17,16,15). Interestingly though CPN's are reporting that they have noticed a decrease in the number of urgent phone calls they are dealing with from Care

Homes. Disappointingly, this was not a measure we had thought to take at the outset.

(200/200 word limit)

Section 7: Achieved Value for Money

a) Please give quantified evidence where possible: What results did you actually achieve in terms of value for money (e.g. cash released savings and reduced costs)? We have addressed this in the evaluations completed to date and 24 out of 25 people avoided hospital over the most recently evaluated 6 months. This is a saving of the cost of 24 acute dementia admissions.

15 people with challenging behaviour in Residential Homes have been discussed as part of the project and none of these then needed to be moved into Nursing Home Care but were able to stay in residential care. In those Residential Care Homes where the tool has become established there seems to be greater confidence on the part of the staff that they have the skills to manage challenging behaviour.

(106/250 word limit)

b) What investment did you have to make to achieve these savings or reduced costs, in terms both of people and other resources?

The Care Home Team currently costs £55,000 to run annually. In the last six months of the project we think we avoided hospital admission of 24 people with challenging behaviour. Please see the Outcome report for the case studies of people who looked destined for a move to hospital at the point of case discussion in follow up. The current average length of stay in the acute dementia ward is 8 weeks.

Savings over the last 6 months are therefore:

(Cost of acute dementia ward care per week) x 8 x 24 - £55,000/2

(94/250 word limit)

Section 8: Impact

A high impact innovation would affect a large number of people with dementia and/or deliver a substantial health benefit. We would like to understand the impact of your innovation.

a) What is the population (or number of cases per annum) that benefits locally and could benefit regionally and nationally?

The most immediate benefactors from this scheme are those in Care Homes where the work has been introduced. At the last outcome report this was 427 people with eight Care Homes being added each year.

The number of people with challenging behaviour discussed over the last 6 months in those homes was 24.

The aim is to build up to visiting all 60 Care homes in the Borough, approximately 1,800 people. The advantage of the tool is that it does not just need to be applied to people with challenging behaviour but can be used as the basis of the care plan for all care home residents. The care home staff only need to bring the residents where there is challenging behaviour to the consultative sessions with the secondary mental health team.

However we have also discovered, (through the memory nurses) that the tool can be useful for informal carers too and we are also using it in the acute dementia ward. We therefore think it can potentially be used for all people with dementia. This means about 3,000 people locally, about 9,000 across the whole of the Oxleas area and 700,000 across Britain.

(194/200 word limit)

b) To what extent is this impact sustainable?

Once the Care Home Project team have completed the workshops and the 10 follow up meetings there is a need for a monthly visit lasting 2 to 3 hours by a Community mental Health team member until "the end of unrecorded time". While we think this is "new work" or "extra" currently and will need resourcing as the number of Homes builds up we think this is going to result in a more sustainable model of consultative work from the team in the long term.

This is a model for the long term and aims to become self sustaining as the staff reap the benefits of the approach. However we have also understood after the first four Homes that the manager of the home is a key figure in this work. We are looking to encourage managers to form a "managers' group" to help them to maintain the work.

We had positive comments from CQC who inspected one of the Homes running the model and this also helps its interest for managers and its sustainability.

When all care Homes have the system we would like to run twice yearly refresher courses for new Home Care staff across the borough.

(199/200 word limit)

Section 9: Diffusion

How easy would it be for your innovation to be spread to other systems caring for people with dementia?

The tool we are now using is very easy to use across a number of different systems. In some of the Care homes it is called the "Bus Stops" as it has been devised as a bus journey on which the care worker embarks with their resident. In others it adopted the title of the detective tool. The question the carer is invited to ask by the tool is, "What is the person with dementia trying to tell us?" The tool provides a systematic investigation of the possible answers. If at the end of the pathway the challenging behaviour is still present the resident is referred to the secondary mental health team.

What would you have to do to codify what you did?

The tool is already ready for dissemination. It may need to be presented slightly differently in different settings but the breaking down of the investigations into the challenging behaviour remains in the same seven categories.

Have you already been able to spread your innovation to other systems?

The tool started in the Care Homes but is currently being introduced to the acute wards so that a tool is filled in as people leave, improving communication with the Care Homes. We think it could also be used with informal carers as a way of supporting people at home.

(197/200 word limit)

Section 10: Other Remarks

Please feel free to add any other relevant comments about your achievement that are not covered above:

This was work which has been firmly rooted in the every day care of people with dementia who show challenging behaviour but actually we are aware the tool could be used for every person with moderate to advanced dementia and not just those with challenging behaviour. It addresses the need for all people with dementia to have fun and fulfilment in their lives just like the rest of us.

(69/200 word limit)

Once you have completed your application form you can email it to: challengeprizes@nhsiq.nhs.uk. You are also able to add up to three attachments to support your application including: journal articles, measurement reports, images and photographs etc.

Don't forget to look at our FAQs on: www.nhschallengeprizes.org and guidance notes for tips on a successful application.

Good luck!

Outcome Report

Presently, the Care Homes Project works with eight care homes: four residential homes and four nursing homes. However, when we consider that 30 beds are equal to 1 unit, we are in fact working with 14.2 care homes.

Though we are confident that the Care Homes Project has indeed contributed to the prevention of hospital admissions, this is very difficult to quantify; there is no formal system currently in place, either with the care homes or the CHMT which documents an avoided hospital admission. We have, therefore, included a series of case studies in this report which documents some of the rich, person centred support we provide to care homes. The case studies below serve as a sample of the work we presently do. Such work has, in turn, empowered care home staff and lessened some pressures for the CMHT. As such, the Care Homes Project is cost effective in terms of both time and money. The case study, Tim, for instance, was almost certainly about to be readmitted to hospital having already spent two months on a ward prior to admission to the care home in question. Tim's previous length of hospital stay is indicative of the financial cost to NHS services and we feel that we have saved the service a comparable amount with our work with the care home.

Names, ages - and in some cases, genders - of the all clients and staff we worked with, have been changed to ensure full anonymity.

Primary Outcomes

	Time 1 10/2012	**Time 2 01/2013**	**Time 3 03/2013**
Number of residents: TOTAL	**205**	**324**	**427**
Number of residents in Residential Homes	94	94	197
Number of residents in Nursing Homes	111	230	230
Number of residents with dementia and Behaviour that challenges (number of residents who have a care pathway tool): TOTAL	**27**	**39**	**42**
Number of residents with behaviour that challenges in Residential Homes	12	12	15
Number of residents with behaviour that challenges in Nursing Homes	15	27	27
Number of residents with an open referral to the CMHT: TOTAL	**45**	**99**	**99**
Number of residents with an open referral in Residential Homes	24	61	61
Number of residents with an open referral in Nursing Homes	21	38	38
Number of residents referred to the CMHT service over past 6 months:	**17**	**16**	**15**
Number of residents currently on anti-psychotic medication:	**9**	**16**	**17**
Number of transfers to Nursing home:	**0**	**0**	**0**
Number of transfers avoided:	**27**	**12**	**3**
Number of hospital admissions in last 6 months:	**0**	**1**	**0**

Case studies

All names have been changed to protect client and carer identity.

Client: Tim is a 75 year old gentleman. During his working life he was a chief executive of company. He comes from a science background. Tim and his wife enjoyed travelling and walking events. He was a great lover of DIY and refitted a number of their homes. Tim has a diagnosis of fronto-temporal dementia. Tim has been living in a care home for 18 months, having come from an Oxleas older people's hospital ward.

The CHP became involved with Tim after the CMHT received a call from the care home stating that Tim was hitting out at staff, had been turning furniture over, and had pulled a door off its hinges. Tim was known to the CMHT. The training had just started with the care home.

Interventions: Several joint visits were carried out alongside the CPN to the care home. CPN input reviewed and monitored medication. The focus for the CHP was to explore Tim's level of level of engagement and opportunities to engage in activity, the Pathway tool was completed.

Life History: Tim had severe difficulties expressing himself in spoke language (expressive dysphasia). It was felt by the team that this could be causing Tim tremendous distress, frustration and could be a factor for hitting out at staff. Linking Tim's life history and his working life he would have had great control and authority. Tim's expertise in DIY was felt to be a very important factor. We felt this needed to be acknowledged.

Communication:

The CHP team provided some education and discussion around communication e.g. remaining cognitive and emotional abilities. Despite expressive language challenges it was very likely Tim could understand aspects of verbal language and would be able to pick up on non-verbal communication, body language, facial expression, tone of voice and proximity. The CHP team felt it was important for Tim to feel that care staff, were very aware he was trying to tell them something and that they wanted to know what it was but were also aware that he was having difficulties finding the right words. "We can see you really want to tell us and it must be so frustrating."

Activity engagement:

Tim spent a lot of his time exploring his environment in a very tactile way, examining and running his hand along bannisters in hallways, exploring and repositioning furniture in his bedroom and communal areas. Tim was engaging in his environment and activities in a very sensory manner and likely to be very much in his DIY role. The care team developed a rummage box for Tim and provided him with some plastic tools to support his role in DIY. There was also a sensory approach suggested for showering Tim to help cue him into showering.

Outcomes:

- Joint working with the care team and Tim's wife, staff are working very much to preserve Tim's sense of self, maintaining his identity and respect and facilitating meaningful activity.
- Tim's wife and care team have relayed that there have been times when Tim has become more vocal and verbalised a short sentence.
- Care home staff have said 'Tim's happy we're happy. He's nice to have around.'
- We are continuing work with Tim in supporting and increasing his involvement in his personal care

Client: Mary is an 89 year old woman. She has lived in a care home for 15 months. Mary lost her sight about 20 years ago. Changes with her sight changed plans for her retirement. Mary appears very philosophical when she talks about life changes. Mary describes herself as a private person. Mary has always expressed her keen wish to stand and take some steps when she can. She enjoys spending some time of her own to listen to her radio. Mary has a diagnosis of Lewy body dementia. Mary was reviewed by the team as she had been experiencing an acute episode of hallucinations. During this time she was being hoisted and not able to stand with staff.

Physical Health:

Joint sessions with physiotherapist and care staff involved exploring physical health factors. A home exercise programme was recommended. The recommendations suggested that staff continue to use the exercise programme with Mary.

Life History:

Mary consented to a personalised plan for leisure activity. 1-1 discussion and London working life reminiscence focused sessions. Mary has a great sense of humour and fun. With a supportive style of discussion Mary has a wealth of knowledge and appeared to working life food markets in London, especially billingsgate market, sporting life. Discussions with activity coordinator lead to recommendations being made regarding activity ideas.

Environment:

Chair height raised but did not lead to consistent ability to stand from sitting. During joint sessions with Physiotherapist it was observed that standing was possible from a height variable bed.

We worked with care home staff to promote of the importance of maintaining physical activity and functional ability, even acknowledging variability within someone's day and within that day.

We recommended equipment to promote physical independence.

Outcomes:

- Information has been fed back to carers, and we have encouraged a consistent use of 1.1 time with Mary, and not to only engage with Mary when she experiences behaviour that challenges. This has been challenging as staff have not always been consistent with this.
- Equipment recommendation for a rise-recline armchair has been made to maintain and maximise opportunities to participate in sit-stand and walking
- We will review activity engagement with clinical lead and activities coordinator in the care home.

Client: Doris is a 92 year old lady with a diagnosis of Alzheimer's type dementia. She has a history of depression and had, over the past few weeks, not left her bed. Staff found that she was particularly challenging during personal care. They described her as being physically and verbally 'aggressive'. A functional analysis was performed to try and identify the key triggers for the behaviour that challenges.

Interventions: A functional analysis is a systematic psychological assessment that looks at environmental and psychological cues that could be contributing to behaviour that challenges. In the case of Doris, we wanted to try and detect such triggers and work consultatively with care home staff so that we could formulate a care package that would support them in caring for Doris.

Doris was fed in her bed and was assisted by carer Mark. Doris was able to pick up her sip cup to drink her tea and put toast to her mouth to eat independently. No discernible environmental issues were noted, the room was warm and well lit, however, her bedroom door was open and a hoover could be heard in the distance. Doris was able to use non-verbal communication to communicate her feelings. She appeared dissatisfied with having assistance to eat breakfast. She was able to pull napkins from the carers hand to wipe her own mouth and did this whilst looking at Mark. She would use her arms and hands to push Mark's hands away when she didn't want something offered to her e.g. toast. Though Doris spent the majority of her time making verbal and physical suggestions that she was dissatisfied with Mark assisting her with breakfast, she did eat and drink most of her breakfast and said 'thank you' to Mark once she had finished.

Findings:

We were able to communicate to care home staff that it could be that Doris is frustrated with her declining independence. In addition, it may be in Doris' nature to be head strong, and her need to be independent is expressed through pushing, and verbally expressing her dissatisfaction. We felt that it should be noted that Doris is now in bed all of the time and her contact with other people can be sparse. She may be using her time with carers to reinforce her independence. This, therefore, could be an expression of Doris as a person, and carers may wish to perceive this as a positive thing.

We were able to communicate to the care home staff that, by allowing Doris to express herself in this way, they were affording her an opportunity to gain a sense of empowerment that she may not otherwise feel. We were able to reinforce staff by helping them see that they were doing a good job with Doris and that by supporting her in being a powerful woman they were actually empowering her. Staff said that they had not considered Doris' behaviour from this perspective and were able to take our comments on board. We tried to shift staff attitudes in what constituted 'aggressive' behaviour and, through training and follow up work, we have been able to effectively communicate that actions such as moving carer's hands away is actually a form of communication, as opposed to aggression.

Outcomes:

- We then focused on formulating a care plan so that staff members supported each other in delivering care to Doris.
- Arrangements were made whereby different staff attended to Doris during the day so that one or two members of staff did not feel overwhelmed by the level of care needed.
- We discussed that it may be useful to recognise that, though it can be hard when a person with dementia declines care, it shouldn't be taken personally and that it can be helpful to share such experiences with the team.
- Staff felt that they were able to continue to support Doris within their care home.