ADULT CARE AND HEALTH PDS COMMITTEE
19th September 2018

WRITTEN QUESTIONS TO THE ADULT CARE AND HEALTH PORTFOLIO HOLDER

Written Questions to the Adult Care and Health Portfolio Holder received from Mrs Susan Sulis, Secretary, Community Care Protection Group

With regard to the closure of Elizabeth Ward at Orpington Hospital (ref: Minute 16: Special Health Scrutiny Sub-Committee on 30th July 2018):

1) How will you ensure that these elderly frail patients with a "*higher complexity of need than expected*" *will* be reliably better managed in (i) their own homes or (ii) private care homes and nursing homes?

Reply:

King College Hospital are working with the Bromley Clinical Commissioning Group and local partners in primary and community care to launch several initiatives based on a 'hospital at home' (@Home) model which has been successfully implemented in many areas of the country. This model will launch in the week commencing 1st October 2018. It will support frail older people to maintain their health in their normal place of residence, be it their own home, nursing or care home. This prevents the need for avoidable hospital-based care which is well evidenced to have a significant impact on poor outcomes and functioning of elderly patients as well as reducing the risk of a hospital acquired infection.

The following initiatives, which are being developed alongside one another, make up the @Home offer in Bromley providing a comprehensive range of services with the main focus of supporting people in the community and avoiding hospital admission wherever possible:

Implementation of an ambulatory frailty model*. The model will provide Geriatrician-led care for frail and elderly people with declining health needs. The day assessment and intervention unit will provide comprehensive Geriatric assessments alongside hospital diagnostics and interventions that will prevent the need for a future hospital admission. The model will work closely with the Integrated Care Network as well as the @Home service and Primary Care to identify residents that could benefit from this enhanced level of care.*

Development of Bromley @Home Service. *Previously known as the Virtual Ward, the @Home service is a multidisciplinary health (GP, Advanced Nurse practitioners, End of Life specialist, mental health and therapists) and social care team working to support people in their own home providing assessment, diagnostics and interventions for up to 5 days to prevent the need for hospital-based care and maintain people independently in their own home. The model aims to bridge the gap between primary and secondary care providing holistic interventions in the usual place of residence for sub-acute presentations e.g.*

urinary tract infections, increased falls and declining health presentation which, if not treated would likely result in an acute episode.

In addition there is ongoing work in Bromley to further develop community-led services building on the success of many to date. This includes continuing to develop the ***Integrated Care Networks*** *(ICNs) including expanding the range of lead professionals that can identify and refer people to the ICNs as well as social care involvement which is now also in place. The ICNs are a key place to proactively develop and manage the care plans of people with complex health and social care needs with the @Home service and Ambulatory Frailty Unit offering a reactive intervention when patients managed under the ICN become unwell – as a part of a planned intervention. This is especially beneficial for end of life patients and those with long term conditions or advanced frailty that are at increased risk of requiring additional care.*

Further Developing End of Life Care *– building on the significant success of end of life (EOL) services in Bromley which have seen a large increase in the number of people identified and supported in the last 12 months of life to ensure they have the correct care and support in place to fulfil their full potential in their last 12 months as well as die in their place of choice. EOL services are well integrated into the ICNs, @Home service and the hospital with further work to provide more seamless care between hospital and community-based palliative care services planned over the coming months. Commissioning a single* ***Visiting Medical Officer provision****. The model will be managed by a single provider which will ensure parity in the level of medical care, support and quality provided to nursing homes to manage their residents' health.*

Continuance of Discharge to Assess *(D2A) which has shown great results since the pilot launch in November 2017, supporting more people to be discharged in a timely way for their ongoing care needs to be assessed in a more familiar environment. The model provides wraparound care for patients to be discharged back to a community-based setting, and home wherever possible, with multidisciplinary input to assess for long term care and support needs following a hospital admission. The majority of residents that have been supported under D2A have seen a reduction in their long term care needs following earlier discharge and the D2A intervention improving their levels of independence as a result.*

2) Will these patients be expected to pay for their alternative provision, instead of receiving free NHS-funded nursing care or residential intermediate care?

Reply:

Any patients who require NHS care will continue to receive NHS-funded services where appropriate. This includes patients who are eligible for continuing healthcare (subject to CCG assessment). The @Home model and ambulatory frailty unit are both NHS-funded service and patients will not be charged for these.

Additionally in line with current practice after their medical treatment has been completed, an assessment by the hospital's multidisciplinary team may result

in patients being identified as being appropriate for a period of rehabilitation in order to maximise their independence. Rehabilitation could be delivered either at Churchill Ward, one of Bromley Healthcare's rehabilitation facilities, or at home with a community rehabilitation/reablement team dependant on their needs.

Some patients may leave the Princess Royal University Hospital and move to a 'discharge to assess' bed or to their home where they will be supported by the discharge to assess team as highlighted above.

For patients who require admission to a residential, nursing, or care home bed, this may be NHS funded, Local Authority funded, or private depending on the package of care and the person's circumstances. This is no different from at present where residents are supported in the most appropriate setting for them with some elements being fully NHS funded and others being means tested as part of social care provision.

3) The plethora of alternative models of provision/initiatives suggested are not explained and are confusing to members of the public. Please give definitions and describe how each would be appropriate to satisfy particular patient needs and circumstances?

Reply:

The Bromley Clinical Commissioning Group and Local Authority are developing a single message to be communicated to the public to ensure it is very clear how and where to access the level of care they require. This will be a simple message which provides key access points for example via the GP, 111 or the hospital depending on their presentation. From there it is for the range of professionals to ensure patients are appropriately triaged into the right services which will be fully explained to patients and their families. It is not the expectation that patients will have to know about all of the services available, rather they will make an appropriate presentation to one of the aforementioned areas and the professionals involved will make the required judgement on where the best place to receive care will be.