City of BRADFORD
METROPOLITAN DISTRICT COUNCIL

Helen Whately MP
Minister of State for Care
39 Victoria Street
London
SW1H 0EU

Sent via email

Office of the Chief Executive

City Hall, Bradford, West Yorkshire BD1 1HY

Tel: (01274) 432002
Email:kersten.england@bradford.gov.uk

Date: 28th May 2020

Dear Helen

I am pleased to enclose the Bradford District Care Home Resilience Plan. This has been developed in conjunction with our partners in the health sector and the independent care sector and been presented to all partners involved in our District Gold Covid response. Close partnership working is a strength of our system.

This was reflected in the CQC system review in February 2019 and our national discharge performance in higher/upper quartile.

We have a service improvement board (SIB) between the local authority commissioners, CCG commissioners and the Bradford Care Association (BCA) which addresses:

- Market size and shaping;
- Agreed approaches to funding;
- We have recently completed a fair cost of care exercise;
- We have agreed joint inflationary uplifts for Council fees and continuing health care payments ;
- Quality improvement for CQC rating;
- We have jointly funded two senior officers from the BCA to lead on sector led improvement.

Therefore the approach that we have taken builds on this work and takes us into a shared position for long term recovery and resilience.

The plan was originally developed in late April. It was agreed at Council Gold Command on the 1st May. It focussed on four outcomes which are:

- To reduce infection and mortality rates;
- To support the wellbeing of residents and staff;
- To support the resilience of the care sector (including the financial requirements);
- To address inequitable outcomes in the sector;

It focussed on three stages:

Phase 1	1-3 weeks	Emergency Response.
Phase 2	3-8 weeks	Plateau period dependent upon reliable supply of PPE and whole System testing.
Phase 3	8-12 weeks	Recovery programme including financial sustainability and accelerated market shaping.

The main outputs for each of the phases are more detailed in Appendix 1 – (Care Home Resilience Action Plan), but briefly our commissioning approach in phase 1 included a very clear public health message relating to PPE. This had been patchy and problematic in the early part of the lockdown, but we developed an easier more definitive approach, supplemented by the joint purchasing power of the Local Authority and Health Partners to supplement care homes usual supplies. We have provided £5 million worth of PPE and provided emergency supplies and mutual aid whenever a system partner faced shortages these requests were prioritised and met within 24 hours. We also had a very robust response from the infection control team to advise and support all providers and provide additional support to those home experiencing outbreaks. We put additional capacity into this team via redeployment.

We built the discharge to assess programme into this plan, including MDTs (Multi Disciplinary Team), Care Pathways and clinical support through the Super Rota and TeleMedicine offer to the homes. The major difference was combined testing of people in hospitals with a period of isolation of up to 2 weeks. We have developed the isolation guidance to be very specific about the ability of the care setting to keep the person separate from others and significantly limit the number of staff supporting them. If the care home is unable or unwilling to receive the person back from hospital, then the default position is for that person to have the period of isolation in a Local Authority short stay setting. We matched our capacity to discharge rates and have comfortable capacity to deliver. As a back up we also have a new unused extra care development next to our in house short stay service but it is hopefully not needed.

A further strand of the emergency response was the rapid recruitment process for frontline entry level care workers targeted on hospitality staff and others that had been furloughed. Within 3 weeks we had a three day course running at our local college as an introduction to care, approved by Skills for Care, Fast track DBS check and 1 weeks paid induction subsidised by the Local Authority and organised through Skills House as a central recruitment hub. We then developed a bank staff as well as permanent recruitment to support the care homes and limit the use and cost of agency staff which would allow us to limit the work to single establishments. It also allows us to have oversight of this section of the plan.

As we enter week 4 we are seeing the rate of infection and mortality slowdown from 33 homes affected to 24 (as at w/c 27th May) and are hoping that this is a trend. However we still need to ensure consistent vigilance and on-going improvement.

As we enter phase 2 we have a much more reliable supply of PPE and have audited our weekly needs to ensure the most effective procurement and supply.

We have extended the in-house offer to those attending A&E departments as well as those being discharged.

We have developed with very strong CCG leadership and input from our DPH a very robust local offer for care home staff testing, which is proving both effective and efficient but more importantly allows us to track progress, target non compliance and refine our priority actions based on the data. This compliments the national programme which unfortunately still poses logistical problems and is unable to provide the granular detail that enables us to take targeted and remedial actions. We are now able to offer periodic retesting of staff and would welcome the opportunity with more capacity to swab, the same with residents. It allows us to understand the need for cohorting in isolation in units/ wings etc.

We expect to see testing become more systemised as with PPE and the development of track and trace plans.

- We are increasingly focussed on wellbeing;
- We have supported limited visiting at end of life;
- We have a series of system mental support mechanisms for staff;
- We have worked with our regional CQC colleagues to offer direct and targeted support to managers;
- We have invested in technology and use of telemedicine;
- Use of Ipads and tablets for residents and families to maintain vital contact from family and social workers and this has been supported by our extensive voluntary sector;

As we look to our recovery and long term sustainability of the market we are addressing the research and evidence base that suggests links poor quality CQC ratings and areas of deprivation, potential links to the BAME communities. This evidence base will inform our approach to market shaping we aim to build a high quality market delivering the best outcomes and positive experiences for individual staff and families alike. We are determined we will not simply return to what was previously before Covid but see this as an opportunity to develop a better offer older and vulnerable residents based on care at home as a default option.

Finally I would want to draw attention to the financial impacts of the approach. The local authority allocated £1.3 million of the unringfenced Covid funding to go to the care homes. This was based on the expectations of the LGA but extended that approach. It was equivalent to 10% of the base rate for a 7 week period covering the 1st lockdown. The IPC funding is to be directly transferred to care settings in its entirety and amounts to £5.2 million.

75% going directly to care homes based on number of registered beds.

25% to be distributed between domiciliary care, registered provider, home care and supported living.

The 75% is full agreed with partners and will be going out w/c 01st June 2020. The details of the 25% is still being internally worked out and will be distributed around the same time.

There is agreement in principle from the voids payment for both LA and CCG and is work in progress. It is expected that these monies are transported as quickly as possible to the sector. This is in addition to the subsidies for PPE and rapid response/bank staff.

I can further confirm that we have a robust approach to infection regarding shielded individuals and a daily tracker for PPE, infections, mortality rates and emerging issues overseen by the Director of Health and Wellbeing and the DPH. Proactive support by commissioners is monitored at Health and Care Silver command.

In signing this plan I can also confirm that through our governance processes this plan is understood and supported by the system leaders and has been expressly approved by the Chief Operating Officer of the CCG. You will also find enclosed a complete template addressing:

- Infection prevention
- Testing
- PPE
- Workforce Support
- Clinical Support

As detailed in the guidance notes provided, I have also included the Care Home Resilience Action Plan for reference purposes.

Yours sincerely

Kersten England CBE
Chief Executive