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DATE: 29 September 2017

To: Members of the
EXECUTIVE

Councillor Colin Smith (Chairman)

Councillors Graham Arthur, Peter Fortune, William Huntington-Thresher, Kate Lymer, Peter Morgan and Diane Smith

A meeting of the Executive will be held at Bromley Civic Centre on **TUESDAY 10 OCTOBER 2017 AT 7.00 PM**

MARK BOWEN
Director of Corporate Services

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

A G E N D A

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Report No.

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**EXECUTIVE**
Date:	**10th October 2017**
Decision Type:	Non-Urgent Executive Non-Key
Title:	**BETTER CARE FUND - LOCAL PLAN 2017-19**
Contact Officer:	Jackie Goad, Executive Assistant, Chief Executive's Tel. 020 8461 7685 Email. Jackie.goad@bromley.gov.uk
Chief Officer:	Ade Adetosoye, Deputy Chief Executive and Executive Director of Education, Care and Health Services
Ward:	All Wards

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1. Reason for report

1.1 On the 7th September 2017 the attached report was presented to the Health and Wellbeing Board requesting the board to formally sign off Bromley's Local Plan for the Better Care Fund. The Health and Wellbeing Board's authorisation and the Chairman's signature on the plan is a formal requirement by NHS England.

1.2 The Board resolved "that (subject to final adjustments) the HWB agree the BCF Local Plan, and consent to its submission to NHS England".

1.3 Following approval from the Health and Wellbeing Board and final adjustments to the plan, the Local Plan was submitted to NHS England on 11th September 2017.

1.4 For completeness and in line with our local governance the final Local Plan is presented to Executive to note. Unfortunately due to the tight submission timetable it was not possible to present the plan to an earlier Executive meeting.

1.5 The full local plan for 2017-19 is attached to this report.

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2. RECOMMENDATION(S)

That Executive note:

2.1 The report to the Health & Wellbeing Board and the Board's decision to approve Bromley's Local Plan for 2017-19.

2.2 The Local Plan submission to NHS England on 11th September 2017.

Impact on Vulnerable Adults and Children

1. Summary of Impact:

   Whilst the Better Care Fund has general overarching regard to local health and care priorities, the BCF plan places special focus on services which support vulnerable people by facilitating hospital discharge, supporting better and speedier recovery following a period of hospitalisation, and preventing vulnerable people going into crisis by providing the necessary ongoing support within the community so that they can remain independent in their own homes.

Corporate Policy

1. Policy Status: Existing policy
2. BBB Priority: Healthy Bromley, Supporting Independence, Children & Young People

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Financial

1. Cost of proposal: £22,125k for 2017/18 and £22,670k for 2018/19
2. Ongoing costs: £22,125k for 2017/18 and £22,670k for 2018/19
3. Budget head/performance centre: n/a
4. Total current budget for this head: n/a
5. Source of funding: Top slicing of existing budgets (primarily BCCG budgets) to create the BCF in 2015/16

Personnel

1. Number of staff (current and additional): Not applicable
2. If from existing staff resources, number of staff hours: Not applicable

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Legal

1. Legal Requirement: Statutory Requirement
2. Call-in: Not Applicable:

Procurement

1. Summary of Procurement Implications: Not Applicable

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): Borough wide

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Ward Councillor Views

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

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**7th September 2017**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**Better Care Fund – Local Plan 2017-19**
Contact Officer:	Jackie Goad, Executive Assistant, Chief Executive's Tel. 020 8461 7685 Email: Jackie.goad@bromley.gov.uk
Chief Officer:	Ade Adetosoye, Deputy Chief Executive and Executive Director of Education, Care and Health Services, London Borough of Bromley Angela Bhan, Chief Officer, NHS Bromley Clinical Commissioning Group
Ward:	All

1. Summary

1.1 The Better Care Fund brings together health and social care budgets. The fund puts a requirement upon Clinical Commissioning Groups (CCG) and Local Authorities (LA) to pool budgets. Commissioners are then expected to use the pooled fund to integrate and join up services for the benefits of local residents using health and care services.

1.2 For the years 2015/16 and 2016/17 individual annual spending plans were developed and approved by the Health & Wellbeing Board prior to being submitted to NHS England for approval. A key change to the policy framework since 2016-17 is the requirement for plans to be developed for the two year period 2017-2019.

1.3 The Government considers the Better Care Fund to be a key tool in driving forward the agenda for integration of health and social care services and the BCF plan must set out how local authorities and CCGs are going to achieve further integration by 2020.

1.4 It is a requirement that the plan for the fund be signed off by the Health and Wellbeing Board.

2. Reason for Report going to Health and Wellbeing Board

All plans must be taken through and formally signed off by local Health and Wellbeing Boards before the final plan can be submitted to NHS England on 11th September 2017

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

Formal agreement and consent to the final plan being submitted to NHS England

Health & Wellbeing Strategy

1. Related priority: General overarching regard to local health and care priorities.

Financial

1. Cost of proposal: £22,125k for 2017/18 and £22,670k for 2018/19

2. Ongoing costs: £22,125k for 2017/18 and £22,670k for 2018/19

3. Total savings: Not Applicable:

4. Budget host organisation: Local Authority

5. Source of funding: Top slicing of existing budgets (primarily BCCG budgets) to create the BCF in 2015/16

6. Beneficiary/beneficiaries of any savings: n/a

Supporting Public Health Outcome Indicator(s)

Yes:

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4. COMMENTARY

4.1 The full plan for submission has been attached for Members, which sets out in detail the plans for 2017-19. The narrative plan also provides an insight into the work of BCCG and the Local Authority to transform local services and address the national conditions placed against the fund.

4.2 The submission and assistance process is detailed in the timetable below

Milestone	Date
Publication of Government Policy Framework	31 March 2017
BCF Planning Requirements, BCF Allocations published	4 July 2017
Planning Return template circulated	w/e 7 July 2017
First Quarterly monitoring returns on use of IBCF funding from Local Authorities.	21 July 2017
Areas to confirm draft DToC metrics to BCST	21 July 2017
BCF planning submission from local Health and Wellbeing Board areas (agreed by CCGs and local authorities). All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net	11 September 2017 Scrutiny
Scrutiny of BCF plans by regional assurers	12–25 September 2017
Regional moderation	w/c 25 September 2017
Cross regional calibration	2 October 2017
Approval letters issued giving formal permission to spend (CCG minimum)	From 6 October 2017
Escalation panels for plans rated as not approved	w/c 10 October 2017
Deadline for areas with plans rated approved with conditions to submit updated plans	31 October 2017
All Section 75 agreements to be signed and in place	30 November 2017
Government will consider a review of 2018-19 allocations of the IBCF grant provided at Spring Budget 2017 for areas that are performing poorly. This funding will all remain with local government, to be used for adult social care	November 2017

4.3 The submission timetable is exceptionally tight as final guidance was not published until 4th July. As such there was no earlier opportunity to present this item to the Health and Wellbeing Board for discussion. However, officers have been meeting through the Joint Integrated Commissioning Executive (JICE) to produce and finalise the plan.

4.4 Policy requirements

4.4.1 The two key changes to the policy framework since 2016-17 are:

- A requirement for plans to be developed for the two year period 2017-2019 rather than a single year
- The number of national conditions which local areas are required to meet has been reduced from eight to four.

4.5 National Conditions

4.5.1 The four national conditions that Bromley are required to meet are:

1. The BCF Plan must be jointly agreed and signed off by the HWB
2. The NHS contribution to Social Care is maintained in line with inflation
3. An agreement to invest in NHS commissioned out-of-hospital services
4. Implementation of the High Impact Change Model for managing Transfer of Care

4.5.2 The onus is on local areas to demonstrate how they will use the pooled fund created under BCF to address these specific requirements. NHS authorisation will be on the basis of the local plan addressing each of these conditions.

4.6 Further Integration of health and social care

4.6.1 The 2015 Spending Review set out the Government's intention that, by 2020, health and social care will be more fully integrated across England. BCF plans for 2017-19 must also therefore set out the joint vision and approach for integration and how CCGs and local authorities are working towards better co-ordinated care, both within the BCF and in wider services.

4.7 An example of further integration and joint commissioning through BCF

4.7.1 The re-procurement of BCGG's community health services contract has involved developing innovative models of integrated community-based care that meet the needs of a growing population, many of whom have complex health needs.

4.7.2 The tender has included Children's Community Services, Adult Community Based Services and Integrated Rapid Response and Transfer of Care Services and also the joint commissioning of social care services including Reablement and Intermediate Care.

4.7.3 The specification for the new social care services were jointly developed by officers from BCCG and LBB to ensure that they meet the needs of all Bromley residents and by aligning social care services as part of the wider community health contract it has been possible to procure a holistic service that offers residents a seamless approach to care in the community and an integrated approach to working across the various hospital discharge pathways.

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

5.1 Whilst the Better Care Fund has general overarching regard to local health and care priorities, the BCF plan places special focus on services which support vulnerable people by facilitating hospital discharge, supporting better and speedier recovery following a period of hospitalisation, and preventing vulnerable people going into crisis by providing the necessary ongoing support within the community so that they can remain independent in their own homes.

6. FINANCIAL IMPLICATIONS

6.1 The Better Care Fund Allocation for 2017/18 is £22,125,000 and £22,670,000 for 2018/19 and is made up of both revenue and capital expenditure streams. The funding is ring fenced for the purpose of pooling budgets and integrating services between Bromley Clinical Commissioning Group and the local authority.

6.2 Monitoring of the expenditure takes place on a quarterly basis and has to be reported back to NHS England. Regular updates of the progress on expenditure will also be reported to the Health & Wellbeing Board.

6.3 The BCF expenditure assumptions for 2017/18 and 2018/19 are detailed in the table below.

BCF 2017/18 AND 2018/19

Responsibility	BCF Heading	Description	2017/18 budget £'000	2018/19 budget £'000
LBB	Reablement services	Reablement capacity	853	870
CCG	Intermediate care services	Winter Pressures Discharge (CCG)	646	659
LBB	Intermediate care services	Winter Pressures Discharge (LBB)	1,027	1,048
CCG	Assistive Technologies	Integrated care record	433	441
CCG	Intermediate care services	Intermediate care cost pressures	625	638
LBB	Assistive Technologies	Community Equipment cost pressures	422	431
LBB	Personalised support/ care at home	Dementia universal support service	520	531
CCG	Personalised support/ care at home	Dementia diagnosis	620	632
LBB	Improving healthcare services to care homes	Extra Care Housing cost pressures	418	427
CCG	Improving healthcare services to care homes	Health support into care homes/ECH	314	320
CCG	Assistive Technologies	Self management and early intervention (inc Vol sector)	1,047	1,068
CCG	Support for carers	Carers support - new strategy	633	646
CCG	Risk Pool	Risk against acute performance	1,347	1,374
CCG	Risk Pool	Transfer of care bureau	611	623
LBB	Personalised support/ care at home	Protecting Social Care	8,977	9,156
LBB	Personalised support/ care at home	Disabled Facilities Grants - CAPITAL	1,838	1,976
CCG	Support for carers	Carers Funding	527	538
CCG	Reablement services	Reablement Funds	952	971
LBB	Reablement services	Reablement Funds	315	321
		Total Recurrent Budget	**22,125**	**22,670**

7. LEGAL IMPLICATIONS

7.1 The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund and which requires that in each area the CCG transfer minimum allocations into one or more pooled budgets established under S75 of that Act. NHS England and the Government allocate the Better Care Fund to local areas based on a framework agreed with Ministers. NHS England will approve the plans for spend in consultation with Department of Health and Department for Communities and Local Government.

7.2 For 2017-18 and 2018-19, the allocations are based on a mixture of the existing Clinical Commissioning Group allocations formula, the social care formula, and a specific distribution formula for the Disabled Facilities Grant element of the Better Care Fund.

8. COMMENT FROM THE CHIEF OFFICERS OF EACH ORGANISATION

The plan for 2017-19 represents significant progress over the last year and towards our ambition to transform local health and care services supporting our providers to deliver joined up community care that provides better outcomes for our residents. Over the next two years we will continue to build on our joint programmes and further explore opportunities for greater levels

of integration in order to maximise the efficient use of resources and the improved effectiveness of our services.

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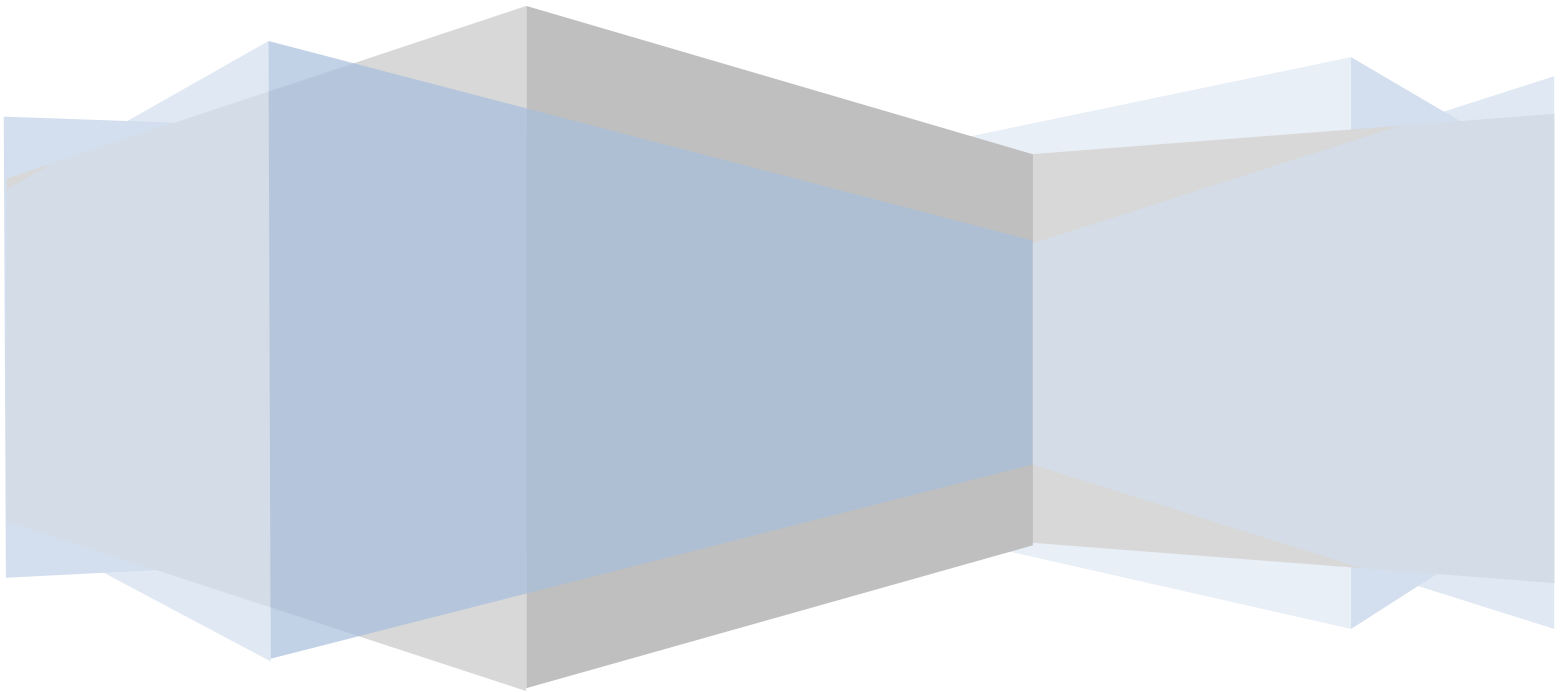
Bromley's Better Care Fund 2017-19

A Local Plan

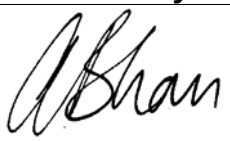
BCCG & LBB

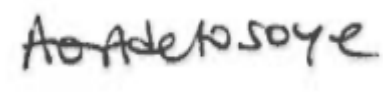


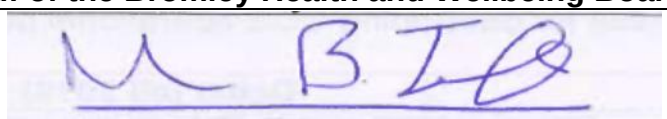
Contents

1. BCF Allocation for Bromley and Authorisation

Local Authority	London Borough of Bromley
Clinical Commissioning Group	Bromley
Date agreed at Health and Wellbeing Board:	7th September 2017
Date submitted to NHS England:	11th September 2017
Minimum required value of pooled budget 2017/18	£22,125,000
Total agreed value of pooled budget 2017/18	£22,125,000
Minimum required value of pooled budget 2018/19	£22,670,000
Total agreed value of pooled budget 2018/19	£22,670,000

Signed on behalf of Bromley Clinical Commissioning Group	
Signature	
By	Angela Bhan
Position	Chief Officer
Date	7th September 2017

Signed on behalf of the London Borough of Bromley	
Signature	
By	Ade Adetosoye
Position	Deputy Chief Executive & Executive Director Education, Care & Health Services
Date	7th September 2017

Signed on behalf of the Bromley Health and Wellbeing Board	
Signature	
By	Councillor Jefferys
Position	Chair of Health and Wellbeing Board
Date	7th September 2017

2. Introduction and Background

2.1. The Better Care Fund (BCF) grant is ring fenced for the purpose of pooling budgets and integrating services between Clinical Commissioning Groups (CCG) and Local Authorities (LA) for the benefits of local residents using health and care services.

2.2. For 2017/18 the total Better Care Fund will be increased from £3.9 billion to £5.128 billion and to £5.650 billion in 2018/19 with the inclusion of an additional £1.115 billion social care grant funding for 2017/18 increasing to £1.5 billion in 2018/19 as announced at Spring Budget 2017. £3.582 billion will be taken from NHS England's allocation to CCGs to establish the fund in 2017/18, with a further £431 million contributed from the Disabled Facilities Grant to Local Authorities.

2.3. There are two key changes to the policy framework since 2016/17. The first main change is that the framework covers the two financial years 2017-19 and the requirement for plans to cover the two year period rather than a single year as before. The second change sees a reduction in the number of national conditions that areas are required to meet, reducing from eight down to four. Areas will however be encouraged to maintain progress on the policy areas which are no longer national conditions through their BCF plans, as they remain important for the delivery of wider integration commitments.

2.4. With the Government's ambition that all areas graduate from the Better Care Fund to be more fully integrated by 2020 areas are asked to set out how they are going to achieve further integration by 2020. The plan should therefore align with the local NHS five year Sustainability and Transformation Plan (STP) produced jointly by NHS partners, local authorities and other partners and which set out plans for the future of health and care services.

2.5. In this Local Plan Bromley sets out a joint spending plan to be approved by NHS England as a condition of the NHS contribution to the Fund being released into pooled budgets. The plan sets out a strategic approach to administering the BCF in line with local and national drivers. It recognises the need to address the national conditions that come with Better Care Funding but also seeks to utilise the fund to make longer term systematic changes to the overall structure of the health and care economy in the borough.

2.6. This plan should be read in conjunction with other local strategic documents including the ***Health and Wellbeing Strategy***, the ***Out of Hospital Strategy*** and Bromley's ***Integrated Commissioning Plan*** attached at the end of this plan.

2.7. On 7th September 2017 the Health and Wellbeing Board met to formally discuss the plan. The board has cross representation from elected Members, commissioners and Healthwatch and fully endorsed the Local Plan.

2.8. The minimum required value of pooled budget for Bromley for 2017/18 is £22,125,000 and £22,670,000 for 2018/19.

3. National Timeline

3.1 The submission and assistance process will follow the timetable below

Milestone	Date
Publication of Government Policy Framework	31 March 2017
BCF Planning Requirements, BCF Allocations published	4 July 2017
Planning Return template circulated	w/e 7 July 2017
First Quarterly monitoring returns on use of IBCF funding from Local Authorities.	21 July 2017
Areas to confirm draft DToC metrics to BCST	21 July 2017
BCF planning submission from local Health and Wellbeing Board areas (agreed by CCGs and local authorities). All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net	11 September 2017 Scrutiny
Scrutiny of BCF plans by regional assurers	12–25 September 2017
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All Section 75 agreements to be signed and in place	30 November 2017
Government will consider a review of 2018-19 allocations of the IBCF grant provided at Spring Budget 2017 for areas that are performing poorly. This funding will all remain with local government, to be used for adult social care	November 2017

4. Local Vision and Evidence Base

4.1. Our vision is to reduce health inequalities and improve the health and wellbeing of people living and working in Bromley by delivering integrated health and care that focuses on maximising people's health, wellbeing and independence. Our current Health and Wellbeing Strategy, developed with key health, local authority and community stakeholders describes its strategic vision for every resident as, "Live an independent, healthy and happy life for longer".

4.2. To improve the quality of life and wellbeing for the whole population of Bromley and particularly those with complex health needs and to ensure that more of our population stays well, avoiding the need for hospitalisation or institutional care, we must continue to work more collaboratively and in more integrated ways with cross sector partners, commissioners and providers, including local residents, voluntary organisations and community groups.

4.3. Locally we face similar challenges that are experienced nationally. The numbers of older people in Bromley are rising and health and social care provision needs to reflect the increased need.

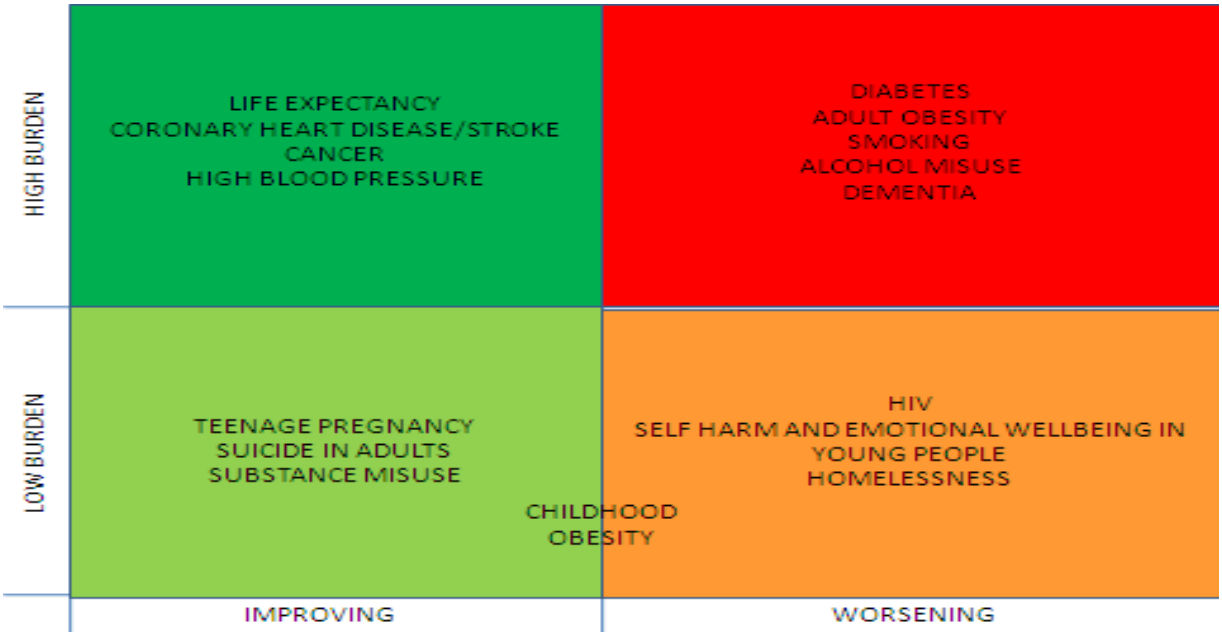
4.4. Our priority areas are defined through the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy The headlines for Bromley's population of over 326,000, as set out in the JSNA 2016 are:

- Bromley has a greater number of older residents than any other London Borough. The proportion of older people (65 years and over) is currently 17.7% and is predicted to rise to 19.1% by 2026.
- Life expectancy at birth in Bromley has been rising steadily over the last 20 years, currently at 81.4 years for men and 84.9 years for women.
- There is an 9.7 year gap for men and 6.7 years for women between the highest and lowest life expectancy wards in Bromley
- Mortality in Bromley is chiefly caused by circulatory disease (29.1%) and cancer (29%) with higher mortality rates for both conditions in more deprived areas of the borough.
- There is evidence to show that there are many people living in Bromley with undiagnosed hypertension, and a number of people with known hypertension which has not been adequately controlled
- Diabetes represents a continuing challenge in Bromley. The number of people affected has continued to rise since 2002.
- The number of people in Bromley with dementia continues to rise, especially in the over 85 year age group
- The number of live births has increased since 2002, but is projected to decrease by 2021.
- Bromley has the sixth highest proportion of adult overweight and obese in London, 63.8% and rising.
- Over 2,500 people in Bromley (almost 1% of the adult population) have been identified by GPs as experiencing serious mental illness.
- Estimates suggest that the level of drinking in people in Bromley is similar to that for London and England, with 17% of people in the increasing and high risk categories.
- Local GP data suggests that 21% of men and 6% of women drink above the recommended levels of alcohol each week and this is most prevalent in those aged between 40 and 69 years.
- The volume of households faced with homelessness continues to rise

- The number of people with learning disabilities under the age of 64 years is predicted to rise by 9.2% over the next eight years.
- The number of people in Bromley with physical disability or sensory impairment continues to increase.
- Data from the 2011 census indicates that 10% of Bromley's population (approximately 31,000 people) are carers. Just over 6000 of these carers provide more than 50 hours of unpaid care per week.
- There were a significant numbers of attendances relating to conditions which might be better dealt with in settings other than A&E e.g. attendance for intramuscular or intravenous injections, catheter problems, blood tests, feeding tube problems.

4.5. *Figure 1* below shows our relative priorities of the key health issues. The highest priority is allocated to the issues creating the highest burden which appear to be worsening over time.

Figure 1: JSNA Priorities



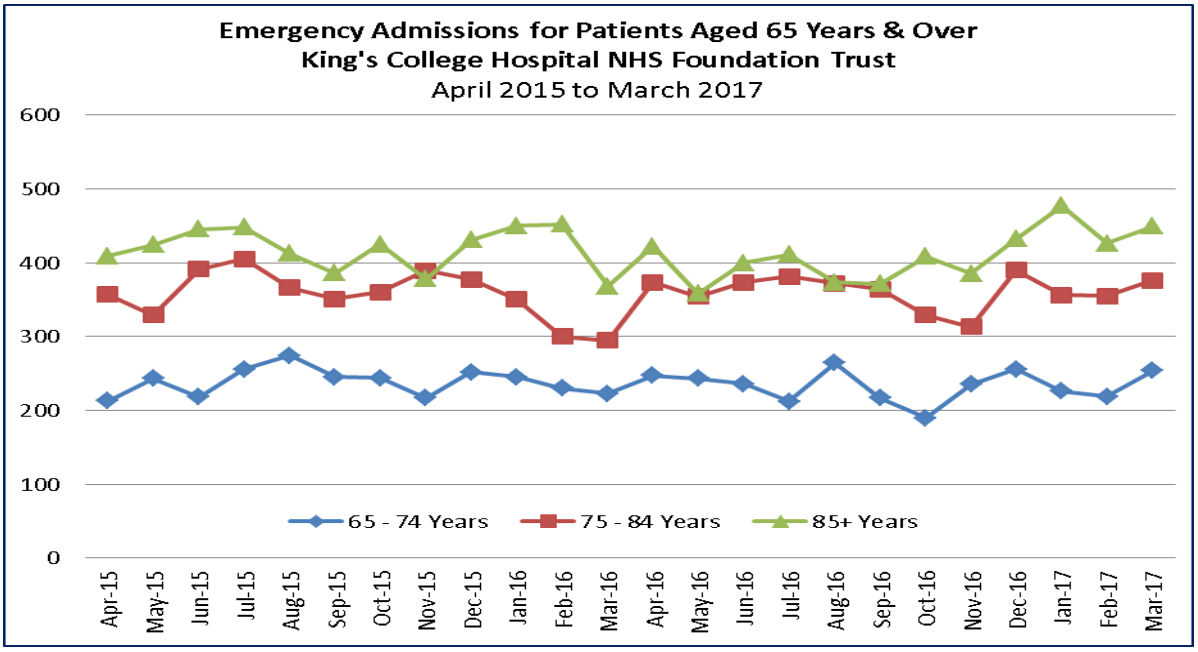
4.6 Following a recent review of our JSNA for 2016, our new HWB Strategy for 2017 will be produced towards the end of this year and will be based on pathway based priorities for vulnerable groups. This will include the elderly, the socially isolated and those with mental health issues. The health and wellbeing of children will also be integral to the revised strategy.

Evidence from analysis of emergency admissions

4.7. Analysis performed on hospital admissions data for Bromley patients shows that around 57% of emergency admissions are for patients aged 65 years and over.

4.8. *Figure 2* below sets out these admissions by age band for this cohort of patients from April 2015 to March 2017 at Kings College Hospital (PRUH & Denmark Hill).

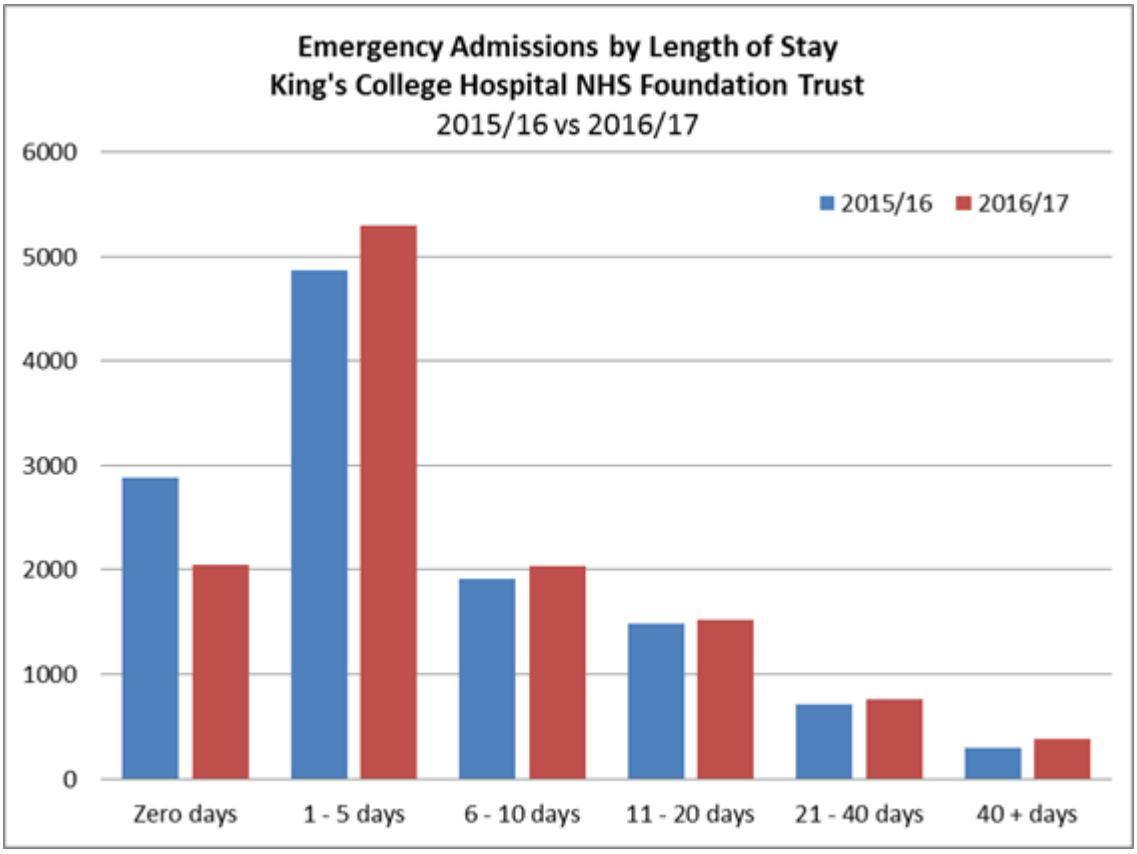
Figure 2: Emergency Admissions for Patients aged 65 years and over



4.9. Whilst admissions for this cohort of patients appears relatively static (a 1% decrease year on year), there has been some significant changes to length of stay bands for these patients when 2016/17 is compared with 2015/16.

4.10. *Figure 3* sets out the length of stay bandings for the two years. It shows a 28.3% increase in admissions where patients stay in hospital for more than 40 days, this equates to 83 more long stay patients in 2016/17.

Figure 3: Emergency Admissions length of stay for Patients aged 65 years and over



4.11. This may suggest the number of complex admissions is rising. The number of zero length of stay admissions decreased by 835 (28.9%) in 2016/17.

4.12 The decrease is most likely due to changes in coding by the Trust; whereby Ambulatory Care Unit activity is now recorded as outpatient attendances rather than emergency admissions as it was in 2015/16.

5. Delivering Integrated Care - Our Progress to Date

5.1 To meet the increasing care needs of our rising population, in a way that enables people to live more independently with complex long-term conditions, Bromley commissioned two significant change projects in 2015/16, in line with the national conditions and the metrics within the BCF and the wider policy directives set out in the Health and Care Act 2012, Care Act 2014 and NHS Five Year Forward View

5.2 The BCF plan for 2016/17 was therefore aligned with our change programmes and rather than a sequence of small impact projects, funding was used to underpin the wider objectives to move care from an acute setting into the community. As such BCF spend was targeted in community based services from preventative services through to supporting winter pressures through increased discharge capacity.

5.3 *Figure 4* below details how all our shared projects within the BCF aimed to reflect back to the outcomes below.

Figure 4: Golden Thread from National conditions to local outputs

An increase in planned community based activity (especially prevention and targeted interventions)	**A decrease in unplanned acute activity (and where an admission is unavoidable improved outflow back into an appropriate community services)**
Local Change Programme 1: **Integrated Care Networks**	**Local Change Programme 2**: **Discharge team and step up/ step down service recommissioned**
Outputs that require investment: ➢ Shared MOU between 'Pillar' Providers ➢ Outcome based incentives ➢ Outcome based contracts ➢ Social prescribing and prevention ➢ Self-management ➢ Single point of access/ Demand management ➢ Comprehensive IAG services ➢ 3 clear ICNs co-ordinating resources ➢ Risk stratification of local population ➢ Personal health budgets	**Outputs that require investment:** ➢ Multi-professional discharge team ➢ One referral route ➢ New workflow for packages and budget management ➢ 7 day operation all year round ➢ Wider range of step up/ step down services ➢ Improved reablement capacity ➢ Flexible innovative interventions ➢ Increase in step up services

5.4 The national Five Year Forward View (5YFV) sets out a clear direction for the NHS to develop new models of care, aiming to have more integrated services with patients at the centre. To turn this vision into a reality, barriers between primary, community and hospital care will need to be removed so that we focus on systems of care and not organisations. This will help in providing more personalised and coordinated health services for patients. The 5YFV recommends that more care needs to be provided out of hospital, and services need to be integrated around the patient so that all their health needs are met.

5.5 Over the last year in Bromley we have started to make this vision a reality for our most vulnerable patients. Following the publication of our Bromley Out of Hospital strategy in the Autumn of 2015, 2016/17 saw the successful implementation and development of proactive and frailty pathways of care and the establishment of three Integrated Care Networks (ICNs) to provide a framework for delivering joined up care.

5.6 The three integrated care networks have been developed with local partners, clinicians and patients with staff from a range of services and organisations working together in multidisciplinary teams. Each ICN covers one-third of the population and brings together services delivering proactive care for patients with complex care needs. The aim is to keep these patients well and avoid a crisis, which may lead to them having to go into hospital. This new method of working is changing the way these patients receive care and how it is arranged for them.

5.7 The Proactive Pathway was mobilised at the end of October 2016 and good progress has been made with weekly integrated Multidisciplinary Team meetings (MDTs) now happening across all three networks. Patients are proactively identified by their GP and assessed by a community matron before a discussion with a multidisciplinary team of staff working within the ICN. This team works very closely together to support those patients and help keep them well. New ‘Care Navigator’ roles have also been created to support patients and signpost them to the services they need, including voluntary sector services where suitable.

5.8 The ICN’s have now seen around 700 patients through the pathway with a number of patients benefiting from onward referrals on to Age UK for additional support, we are currently working through the data to get a break down of those patients who required a referral to social care post MDT and those that had a change to their care package.

5.9 While it is too soon to assess the full impact of the pathway there have already been positive case studies.

5.10 The following two case studies illustrate examples of positive outcomes, including a reduction in the number of emergency contacts.

Case Study 1: "SG"

"SG" is a 59 year old male known to the community mental health team. He has had a series of emergency calls to 111 and visits to the PRUH Emergency Department. A visit to the patient showed that home hygiene is compromised, he is struggling to survive on benefits and his home was cold through lack of heating.

Advice was given on benefits and the need to maintain provisions e.g. buy non-perishable items. Contact was made with a food bank to provide assistance, EDF energy to place credit on his meter and credit was added to his Oyster card to enable him to travel to planned medical appointments.

In the six weeks before the MDT intervention, SG had called 111 on 16 occasions and visiting A&E 4 times. Six weeks after there have been no emergency contacts.

Case Study 2: "CS"

"CS" is a 74 year old female currently receiving reablement following an inpatient episode. She lives alone in an upper floor flat. Her carer is a friend but she doesn't live nearby.

She has a complex history of severe COPD (known to Community Respiratory team), Ischemic Heart Disease and confusion. Oxygen was prescribed but later removed on safety grounds. In the last two years she has had an acute myocardial infarction and breast cancer. She will not accept support with personal care, is non-compliant with medication and refuses to attend a memory clinic.

Actions include memory assessment, establishment of power of attorney with next of kin, a social care package following reablement, review from Medicine Optimisation Service, and oxygen re-established following disconnection of unused gas cooker. Bromley Care Coordination are now providing support.

Medicine compliance is now greatly improved resulting in a reduction in calls to primary care. Measures are now in place to prevent secondary care admission.

5.11 Some patients, particularly those who are older and frail, may need to have some hospital inpatient care, so the CCG has also invested in two new community wards at Orpington Hospital. The aim of the inpatient element of care is to provide short-term hospital care for frail patients who either need an assessment and a little bit more help so they can get back to independent living, or who have been in the Princess Royal University Hospital (PRUH) and need additional support to help prepare them to leave hospital.

5.12 A dashboard is being finalised to monitor patient activity before and after the patient enters the Proactive Pathway and it will be monitored via the ICN steering group. An independent quantitative and qualitative evaluation of the ICN Proactive Pathway has also been commissioned and should be finalised during September.

5.13 The next workstreams that have been agreed by the ICN Board are :

- Care Homes
- Urgent Care Admissions for People at End of Life
- Integrated Discharge (Therapies)
- Integrated Heart Failure service

5.14 The focus for 2017-18 will be the complete mobilisation of Proactive and Frailty pathways and to continue to monitor progress in order to improve with the overall aim of embedding into business as usual.

5.15 A key enabler to the ICNs progress to date has been the current Memorandum of Understanding (MOU) put in place with system providers. The MOU runs until September 2017, as such, an Alliance contract is currently being drafted with the aim of moving even further with strengthening integrated working across the system. This is being discussed through the summer with the aim of having it in place for the Autumn/Winter.

5.16 The Alliance Agreement (AA) helps to build on the current MOU and aims to help the system move forward to a potential Accountable Care System in the future. If the AA is delayed, an extension to the MOU will be put in place to mitigate any potential gap.

Figure 5: Current ICN Governance Structure

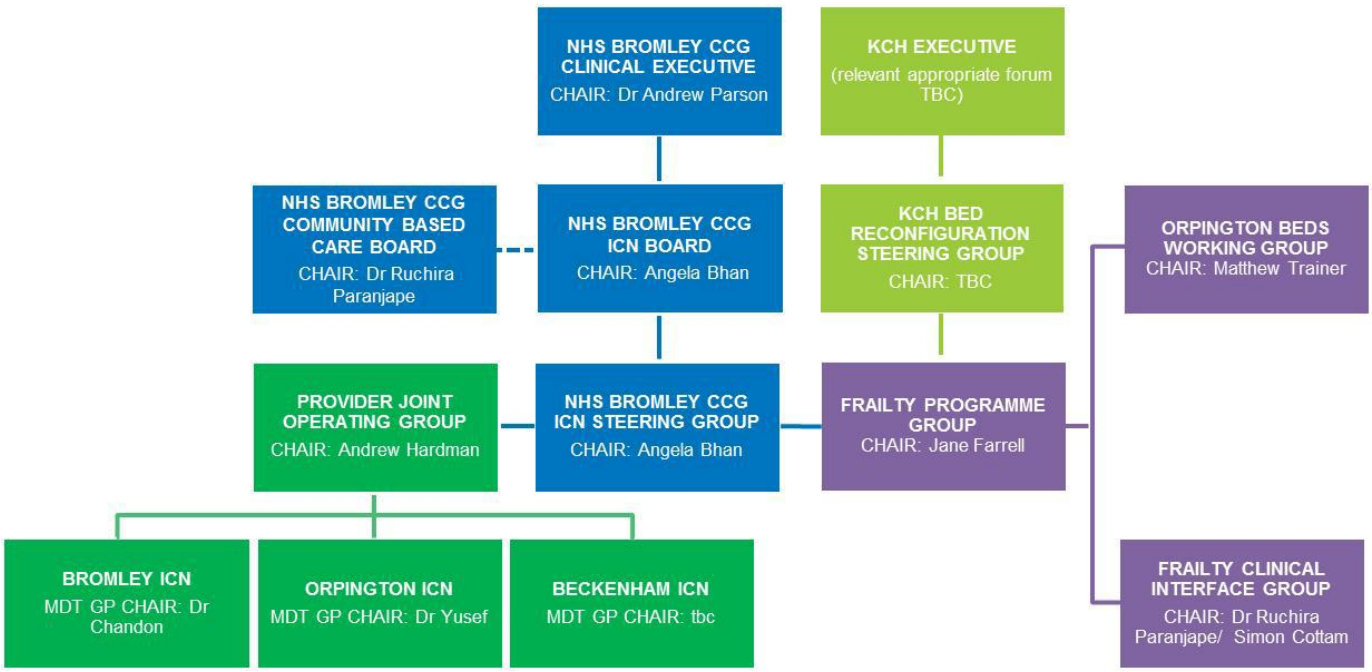


Figure 6: High Level Programme Plan for 2017

	Start	End	Work Days	Week ending 19/05/2017	26/05/2017	02/06/2017	09/06/2017	16/06/2017	23/06/2017	30/06/2017	07/07/2017	14/07/2017	21/07/2017	28/07/2017	04/08/2017	11/08/2017	Month 31/08/2017	30/09/2017	31/10/2017
Prog 1: PROACTIVE CARE	**21/11/16**	**05/09/17**	**202**																
Rec't - GP Chairs	21/11/16	01/12/16	9																
Rec't - Social Prescribing Admin.	21/11/16	28/02/17	72																
Rec't - MDT Coordinator	21/11/16	15/02/17	63																
Rec't - Care Navigators / Mgr.	21/11/16	23/01/17	46																
Rec't - Mental Health Support	21/11/16	28/02/17	72																
Technical Capability delivered	21/11/16	09/12/16	15																
Patient Information Leaflet (JOG)	21/11/16	21/12/16	23																
Confirm LIS alignment	01/12/16	01/12/16	1																
Risk Strat method workshop	01/12/16	01/12/16	1																
SOP agreed (ICN Board)	12/12/16	12/12/16	1																
GP Training	01/12/16	23/12/16	17																
Indep Eval - Interim Report	16/01/17	16/01/17	1																
MDT Training	24/02/17	24/02/17	1																
Data Sharing, Integrated Records	01/12/16	31/03/17	87																
Social Prescribing Portal Live	20/01/17	14/07/17	122																
Independent evaluation - draft	21/08/17	21/08/17	1																
Independent evaluation - final (SG)	05/09/17	05/09/17	1																
Prog 2: FRAILTY	**22/11/16**	**14/08/17**	**186**																
Pathway approved (Prog Grp / CIG)	22/11/16	22/11/16	1																
Patient Focus Group meeting	28/11/16	28/11/16	1																
SOP incl Med Mdl agreed (CIG)	05/12/16	09/01/17	26																
CQUIN aligned Q3 & Q4 [Q]	05/12/16	05/12/16	1																
Pathway approved (Steering Group)	06/12/16	06/12/16	1																
Eligibility Criteria - 2nd audit	06/12/16	07/12/16	2																
SOP incl Med Mdl agreed (Prog Grp)	08/12/16	08/12/16	1																
Eligibility Criteria agreed (Prog Grp)	08/12/16	08/12/16	1																
Trust Training and Education Plan [Q]	09/12/16	09/12/16	1																
Pathway & criteria appr. (ICN Board)	12/12/16	12/12/16	1																
Pathway & criteria appr. (Clinical Exe	15/12/16	15/12/16	1																
Trust Comms Plan (incl. Hotline) [Q]	15/12/16	15/12/16	1																
Hot Clinic plan (PR & Orp) [Q]	16/12/16	16/12/16	1																
Recruitment - Geriatrician	09/01/17	09/01/17	1																
Ward open - 19 beds	09/01/17	09/01/17	1																
Hot Clinics bookable [Q]	23/01/17	31/03/17	50																
Post Go Live Audit	31/01/17	09/03/17	28																
Single CGA used in/out Hospital [Q]	31/01/17	30/04/17	62																
Ward open - all beds, Step Up	31/03/17	30/04/17	19																
Reconvene Frailty Steering Group	14/08/17	14/08/17	1																
Prog 3: NEXT DEVELOPMENT	**22/02/17**	**27/06/17**	**86**																
Agree priorities at Senior Leaders	22/02/17	22/02/17	1																
Advise Clinical Executive of Priorities	02/03/17	02/03/17	1																
Agree delegate list for groups	13/03/17	27/03/17	11																
Agree CCG Clinical Leads	27/03/17	31/03/17	5																
First Meetings and ToR agreed	10/04/17	21/04/17	8																
Develop Proposals	01/05/17	31/05/17	21																
Update to Senior Leaders	27/06/17	27/06/17	1																
Next Steps Development	02/07/17	31/07/17	21																

Community Health Services

5.16 The ambitious and extensive process to re-procure BCGG's community health services contract which ends in November 2017 has involved developing innovative models of integrated community-based care that meet the needs of a growing population, many of whom have complex health needs; testing these models with local people, and agreeing who will provide these services.

5.17 The tender has included Children's Community Services, Adult Community Based Services and Integrated Rapid Response and Transfer of Care Services and also the joint commissioning of a number of Social Care services including Reablement and Intermediate Care.

5.18 By aligning social care services as part of the wider community health contract it has been possible to procure a holistic service that offers residents a seamless approach to care in the community and an integrated approach to working across the various hospital discharge pathways.

Primary and Secondary Intervention Services

5.19 Also in line with the NHS five year forward view the new model of care for Bromley makes a concerted effort to bring in the third sector as a core provider. The newly formed Bromley Third Sector Enterprise has been a result of the sector coming together, with support from commissioners, to form a collegiate. The local voluntary sector now has a place on the Executive Leaders board along with all the main providers in the local system.

5.20 The proposal to create a Primary and Secondary Intervention fund within the Better Care Fund for the provision of primary and secondary intervention services was jointly approved in September 2016. The joint strategy set out a framework through which to design a set of Third Sector services that support people in the community to maintain their independence and delay and prevent the need for high cost care packages and early admissions to care homes and/or hospital.

5.21 The procurement process commenced in November 2016 and the contract award recommended for the Primary and Secondary Intervention Services in July 2017. The new services are due to mobilise from 1st October 2017.

5.22 The Primary and Secondary Intervention services will provide the following eight services:

- ✓ Carers Support Services
- ✓ Services to Elderly Frail
- ✓ Services for Adults with Long Term Health Conditions
- ✓ Services for Adults with Physical Disabilities
- ✓ Services for Adults with Learning Disabilities
- ✓ Mental Health Support Services
- ✓ Single Point of Access
- ✓ Support to the Sector

5.23 The services will deliver a cohesive set of targeted preventative services where the impact can be evidence and measured by tracking service users through the NHS number. The outcomes of the new services will be:

- ✓ To reduce the requirement for unplanned care and resulting emergency admissions
- ✓ To prevent and delay the requirement for long term care packages
- ✓ To support residents to remain independent in their local communities
- ✓ To build capacity in local communities by demonstrating economic impact and leveraging in further funding from other sources
- ✓ To leverage in further external funding to the sector
- ✓ To shape local services to facilitate social benefit to service users creating added value

5.24 The services are universal but are targeted at vulnerable groups. The services sit in front of eligible services and manage demand to reduce increasing demographic pressure on social care and health services.

5.25 The services will work within a larger system in order to provide effective Primary and Secondary Intervention for Bromley residents. The BCCG Out of Hospital Transformation Strategy outlines the creation of an integrated and sustainable programme to keep people within their community, primarily through the work of the ICNs. The Primary and Secondary Intervention Services link with the Care Navigator role which is a fundamental part of the ICN development. The navigators will signpost residents to the appropriate channels for support, including these services, thereby avoiding more formal interventions from social care and health.

5.26 A percentage of the total funding envelope will be kept as an innovation fund. This is to encourage innovation within the service and respond to any changing or developing needs for service users. This will promote sustainability and allow flexibility within the service provision.

5.27 Whilst the funding at this stage is primarily focused on adult's preventative services in line with the ICNs, there is nothing to preclude utilising this model if it proves successful to support wider preventative agendas. It could also be used to support public health preventative activities where these providers may be suitable to deliver their programmes.

Dementia Hub

5.28 The Dementia Hub was commissioned to establish a clear pathway for people with dementia and their carers following diagnosis. The service supports people in the early stages to ensure that support planning is in place, which will allow people to remain independent for as long as possible and delay or prevent the need for social care or health crisis as far as possible.

5.29 The service was tendered in February 2016 and went live in October 2016. It is provided by a partnership of organisations: Bromley and Lewisham Mind, Age UK Bromley and Greenwich, Oxleas NHS Foundation Trust and Carers Bromley. This collegiate approach provides a wraparound service for people who are diagnosed with dementia, their families and their friends.

5.30 This is particularly important as Bromley's ageing population means that the level of people suffering from dementia in the borough is higher than any other London borough.

5.31 Whilst there were existing services established, there was no clear pathway and finding out about these services was challenging for many people. This service provides ‘a one stop shop’ in terms of information, advice, support and planning for both the service user and the carer.

5.32 This is primarily encouraged through a direct route from the Memory Clinic. Anyone who is diagnosed with dementia at the Memory Clinic is signposted to the Dementia Hub for support. This means that people diagnosed with dementia have support in the community that is quickly and clearly communicated by clinicians.

5.33 People are also encouraged to self-refer to the Hub. This is predominantly used by people who were diagnosed before the Hub was in place, or for people who have had a worsening in their condition since diagnosis and may need more ongoing support than their initial engagement with the Hub.

5.34 Anyone diagnosed with dementia can be visited in their own home to plan support around their needs and receive information about dementia, their rights and local services. Everyone is treated individually and provided with information and support that is right for them.

5.35 Families and friends caring for a person with dementia can benefit from information, training and workshops to learn about dementia. Local activity and support groups are available for people with dementia and their carers to meet other local people with similar experiences of dementia. Personalised coaching in the home is also available for individual carers and family groups. This ensures that carers are better equipped to offer support and help manage changing dementia care needs, as they plan for the future.

5.36 The Bromley Dementia Support Hub volunteer befrienders are available to provide companionship, support to carry out everyday activities in the home and local community, help for people to stay active and give family carers a break from caring. It is crucial that whilst living with dementia, people are not isolated.

5.37 Since going live in October 2016 the number of cases allocated to a dementia advisor has increased with 43% of referrals being allocated in the first quarter 2017/18 compared to an average of 31% across 2016/17 and positive outcomes are being achieved.

5.38 The case studies provide examples of positive outcomes for both a carer of a person with dementia and a person diagnosed with dementia.

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Case Study 1:

Number of contacts
6 telephone calls
1 letter
2 office visits
Length of engagement: From 16th March 2017 – case still open

Outcomes:
• Carer attended Family Carers Information workshops for carers of a person with a dementia. This helped to enhance her knowledge and understanding of Dementia and to find out about the help and support available in the community.
• Carer is now attending the Carers Coffee Morning at Carers Bromley which provides a space for her to meet other carers, have discussions with other carers in similar situations and alleviate some of the isolation she was experiencing.
• Carer received emotional support and was given the opportunity to be listened to and discuss her caring role and the effect on her.
• Carer is now aware of the support available to her and receives the Carer Bromley newsletters.
• Carer was assisted in contacting Bromley Council Tax services regarding her husband's council tax discount.

Case Study 2:

Number of contacts
7 phone calls
1 home visit
2 personal contacts at a dementia café
Length of engagement: From 6.02.2017 – case still open

Outcomes:
• M. now able to bathe safely and potential injury accident, from faulty bath lift prevented.
• Social Services now engaged with client, exploring options to make stair lift safer.
• M. now has access to chiropody which both improves her mobility and her wellbeing.
• M. now has access to financial support around taxis
• M. and her family are currently considering information sent around meals and reading and health and welfare power of attorney.

5.38 The Better Care Fund supported the development of the Dementia Hub through aligning the CCG and Council's priorities around dementia diagnosis and support. This is evident through the unique clinical and third sector partnership that provides the services.

5.39 The success of the hub has led to more early intervention and prevention services being jointly commissioned using the Better Care Fund, which are due to go live in October 2017

Care Homes

5.40 The Bromley Joint Strategic Needs Assessment 2015 gave an in depth analysis of people in care homes identifying that people in care homes are more likely than the general population over the age of 65 years to have two or more comorbidities. Extra care housing residents tend to have a higher number of comorbidities than the care home residents, but care home residents are more likely to suffer from dementia, and to have mobility problems than the extra care housing residents.

5.41 The care home population present a more complex healthcare challenge. Compared with the over 65 population as a whole, care home residents are far more likely to have a diagnosis of dementia or stroke, and overall more likely to be suffering from heart disease, kidney disease, cancer or diabetes.

5.40 Our primary goal is to support people in their own home for as long as possible. If this is no longer viable, it is important to ensure that the best possible care within the allocated resources is provided to those in residential settings.

5.41 Bromley has 67 Care Homes, 18 nursing, 45 residential and 4 mixed and 6 Extra Care Housing schemes. There are approximately 829 nursing home residents, 971 residential home residents and 285 extra care home residents.

5.42 Bromley is keen to develop stronger oversight of Care Homes and the development of shared priorities is important to ensure that this happens.

5.45 The outcomes for improving the joint oversight and work with care homes are:

- Ensuring higher quality of care for care home residents
- Reducing hospital admissions and delayed transfers of care
- Supporting independence for vulnerable residents
- Creating a sustainable and diverse care home economy in Bromley

5.46 *Table 1* summarises Bromley's care home projects currently in progress

Table 1

Workstream	Owner	Status	By
Care home strategy	LBB and CCG	A joint care home strategy is being developed to provide the strategic focus and vision statement for LBB and the CCG's work with care homes going forward.	Oct-17
Discharge to assess pilot	LBB and CCG	A range of discharge to assess beds are being procured over the winter period to reduce delayed transfers of care. The beds will be supported by increased community care support.	Oct-17
Shared monitoring information	LBB and CCG	The Continuing Healthcare and LBB contract monitoring team are developing a shared quality assessment framework to provide stronger oversight of the quality of care in care homes.	Sept-17
Block nursing beds procurement	LBB	LBB is procuring a new block nursing beds contract. This aims to increase the number of providers who have block contracts with LBB and ensure continued provision for social care funded residents.	Jan-18
Red bag implementation	CCG	The CCG is rolling out the hospital discharge bag to all care homes. This will improve communication with the hospital and reduce the length of hospital stays.	Apr-18
VMO support to care homes	CCG	The CCG is procuring a new model of GP support to care homes to ensure a parity of care from primary care providers.	Apr-18
MDT support to care homes	CCG	The CCG is expanding the new ICN model of care in Bromley to provide additional and targeted support to care homes. This will improve the health of residents in care homes and prevent unnecessary hospital admissions.	Jul-18

Children's Services

5.47 The joint partnership is now in year three of the Five Year Forward View for Mental Health and Future in Mind and the local emotional wellbeing and mental health plans have resulted in additional resources being allocated across the referral and care pathways. The additional resource has been focused, to date, on adding capacity in the system. There has been a significant uplift in the number of referrals entering the system as a result of the new Single Point of Access model.

5.48 CCG investments, via the Better Care Fund, have been allocated to support the capacity issues in the single point of access, early intervention service. In addition, the CAMHs Transformation Plan investments have resulted in the early intervention being able to offer longer and more intense interventions for those young people with a need greater than can be met through early intervention, but whose needs are not such as to require specialist mental health provision.

5.49 Investment in a co-production programme to lead on the emotional wellbeing and mental health system and service transformation aims to involve communities, voluntary sector, providers and health and local authority commissioners in developing a transformed model of care to support the aims of keeping well and improving accessibility to the right service in the right place at the right time.

5.50 A joint programme to improve access to physical and mental health services for young offenders has recently been set up by the CCG and Bromley's Youth Offending service. Investments have been made to co-locate early intervention services at the front door and this will be supported by access to physical health services and specialist forensic CAMHs available through the YOS.

5.51 LB Bromley and CCG are also leading a programme to develop the joint funding protocols, policies and procedures for complex cases and out of area placements. The development of joint funding and commissioning approaches will allow for improved oversight on outcomes for children and young people placed out of Borough as well as identifying opportunities to repatriate children and young people closer to home where clinically appropriate.

5.52 Supported by partners and providers, and as a result of the community health contract re-procurement, the CCG will commission a single access point/no wrong door policy so that any young person needing physical, mental or emotional health care can go to one place for the care they need. It is anticipated that as a result of this approach along with the community health contract re-procurement that there will be a reduction in the number of presentations to A&E by children and young people with fewer admissions and when admitted, the length of stay will be reduced.

5.53 Work is also in progress with providers and the voluntary sector to implement best practice care and treatment for asthma, epilepsy, ADHD and diabetes using modelling from across the London area and aligning the referral and care pathways with Health London Partnership guidance on standards and transformation of out of hospital care.

5.54 The CCG has initiated the development of a personal health budget offer for young people with long term conditions to provide greater flexibility and control over their care. The vision is that this initiative will align with local authority personal budget policies and procedures to facilitate seamless provision and improved service experience by children, young people and their families.

Local Change Programme 2 – Discharge Team

5.55 In 2015 partners from across the system came together to co-produce a response to the increasing number of patients with complex health and social care needs that required support to be discharged from the PRUH in a safe and timely way.

5.56 There have been many successes since the implementation of the Transfer of Care Bureau (ToCB) in October 2015 including;

- ✓ Key organisations and professionals have been brought together to work from a single place within the PRUH with additional GP, Continuing Health Care and out of borough capacity creating a specialist discharge function and single point of access to community services.

- ✓ Delayed Transfer of Care (DTOC) reduced significantly and patients are being transferred in a more timely way.

5.57 The ToCB, with single oversight of all complex discharges, provided a fresh insight into systemic challenges and issues in the transfer of patient care and identified growing areas of unmet demand across the system. As a result several out of hospital pathways have been streamlined and a major procurement of community health services has been undertaken to ensure a robust community infrastructure that is responsive to the changing needs in secondary care.

5.58 The new contract will be fully mobilised from December 2017 and brings together rehab (home, bed and neuro) and reablement alongside hospital in-reach and rapid response services accessed through a single point of access in the community. Rapid access to packages of care within 12 hours by care managers (and earlier when necessary), equipment delivered within 4 hours with major adaptations within 24 hours is now available with ring fenced step down accommodation available via the ToCB to support more timely discharge from hospital.

5.59 End of life pathways have been strengthened through proactive in-reach to identify and pull patients out of hospital and provide responsive, home based care and support for those in the last 12 months of life. Early outcomes from this work are showing a reducing in length of stay post medical optimisation from eight days to 1 day, reduction of readmissions and less people dying in hospital unnecessarily.

5.60 In addition further improvements across the acute hospital including the introduction of the SAFER bundle, fully functioning Multi Disciplinary Team (MDT) Board rounds and dedicated discharge transformation programme is continuing to improve patient flow and have a positive impact on reducing delayed transfer of care. The ToCB are fully integrated within MDT Board rounds at the front and back end of the hospital ensuring discharge planning commences from the point of admission.

5.61 Further work to strengthen hospital diversion is planned from September 2017 building on the success of discharge co-ordinators, a GP and care managers in front end departments. The co-ordinated team which will also benefit from a Community Matron and frailty nurse will work much earlier in the patient journey to ensure more people who do not require an acute intervention are diverted away from urgent and unplanned care and back to the community. MRT continues to provide a rapid response to those in crisis at home preventing the need for hospital attendance and possible admission.

5.62 The recruitment of a joint appointed Discharge Commissioner with responsibility for CCG and LA commissioning activity is showing positive results in developing co-ordinated, integrated out of hospital pathways that support both health and social care outcomes. The post has oversight of the whole hospital to home pathway to address potential blockages and ensuring on-going patient flow.

5.63 The post, alongside the solid foundations provided by transformation work to date will be key enablers to implementing the Eight High Impact Changes to further improve performance around delayed transfer of care.

6. Delivering Integrated Care – Future Direction

6.1 Bromley recognises the need to address the national conditions that come with Better Care Funding and is committed to utilise the fund to make longer term systematic changes to the overall structure of the health and care economy in the borough.

6.2 Our focus over the next 2 years is to further develop and embed our local integrated care networks as outlined in Section 5 above and to continue to implement our joint programmes with the aim of keeping people independent in their own homes where appropriate, thereby reducing the need for residential care and hospital admissions. Ensuring that we are maximising opportunities with the Third sector will be crucial.

6.3 Whilst Bromley has not put our local area forward for consideration for the first wave of BCF graduation, we are committed to working together towards a greater level of integration and we will continue to prepare for submission in a later wave.

6.4 To support this commitment we have already a number of joint funded posts in place and have recently agreed to appoint a joint Director of Integration to provide a key role for transformational change and to drive the delivery of key operational integration projects. We aim to have an interim post holder in place by mid-September.

6.5 Discussions are also progressing with regards to furthering joint working opportunities for example joint working with the Integrated Commissioning Unit.

6.6 Whilst many of the programmes will be long term for example the ICNs and the Transfer of Care, additional shorter term commissioning projects will evolve resulting in opportunities to explore the more efficient use of resources and the improved effectiveness of services.

7. Better Care Fund Plan 2017/19

7.1 Our BCF plan for 2017-19 continues to be aligned with the new model of providing services, with funding to underpin the wider objectives to move care from an acute setting into the community.

7.2 *Table 2* below provides a summary of the BCF schemes for 2017-19.

Table 2. BCF Schemes and Funding for 2017-19

Commissioner	Scheme Name	2017/18 budget £'000	2018/19 budget £'000
LBB	Reablement Capacity	853	870
CCG	Winter Pressures Discharge (CCG)	646	659
LBB	Winter Pressures Discharge (LBB)	1,027	1,048
CCG	Integrated Care Record	433	441
CCG	Intermediate Care Cost Pressure	625	638
LBB	Community Equipment Cost Pressure	422	431
LBB	Dementia Universal Support Service	520	531
CCG	Dementia Diagnosis	620	632
LBB	Extra Care Housing Cost Pressure	418	427
CCG	Health Support into Care Homes/ECH	314	320
CCG	Self Management and Early Intervention (inc. Vol sector)	1,047	1,068
CCG	Carers Support - New Strategy	633	646
CCG	Risk against acute performance	1,347	1,374
CCG	Transfer of Care Bureau	611	623
LBB	Protection Social Care	8,977	9,156
LBB	Disabled Facilities Grants - CAPITAL	1,838	1,976
CCG	Carers Funding	527	538
CCG	Reablement Funds	952	971
LBB	Reablement Funds	315	321
	Total Recurrent Budget	**22,125**	**22,670**

7.3 Current and planned performance against metrics is provided within the BCF plan excel spreadsheet submitted alongside this narrative.

7.4 It is expected that with the additional funding from non-BCF funded activity as outlined in the DToC Action Plan there will be a significant impact on DToC during 2017/18. Local analysis has suggested, with activity at the PRUH remaining in line with seasonal expectations and the totality of all projected actions to support discharge and help maintain patients in the community, we should achieve performance in line with expected DToC targets.

7.5 The schemes that will have the greatest impact are:

- ✓ Reablement Capacity
- ✓ Discharge to Assess (planned addition for 2017/18)
- ✓ Winter Pressures Discharge
- ✓ Dementia Universal Support Services
- ✓ Health Support into Care Homes
- ✓ Transfer of Care Bureau

8. National Conditions

CONDITION 1: Plans to be jointly agreed

8.1 Members of the Joint Integrated Commissioning Executive (JICE) continue to meet monthly to discuss and oversee integrated working and the Better Care Fund remains a standing item on the agenda. Officers from Bromley CCG and the Local Authority continue to build relationships and discuss options for how the fund can be best used to meet competing pressures of reduced resources across the local care and health system as a whole.

8.2 Plans, considered and drafted through JICE are then presented to the Health and Social Care Integration Governance Board (HSCIGB) which include decision makers from both commissioning organisations. Standing members include elected Councillors, CCG board members; clinical leads and the Chief Executive from both organisations (see governance section 10). This governance structure has allowed the organisations to have mature conversations about the funding available through the BCF and to set out this jointly agreed plan for how it will be jointly commissioned to meet the other national conditions.

8.3 **Disabled Facilities Grant** meetings between Housing and Social Services and the PRU hospital Discharge Bureau were held in February 2016 to identify how DFG funding could be used to improve health and wellbeing, reduce hospital admissions and keep residents safely in their own home. The principles were shared and discussed with the CCG through the JICE and then taken through each organisation's governance structures.

8.4 The following items have been implemented

- ➢ A Rapid Hospital Discharge bed moving service is in place and allows hospital staff to request works in the home to facilitate a timely discharge. Consideration is also being given to follow up works to reduce re-admissions e.g. minor works or repairs that put clients at risk and move beds back upstairs following reablement. Extending the scheme to allow access to prescription system for minor works to improve health and safety in the home accessible to Care Managers, OTs, GPs and District Nurses, Wheelchair Service and Carers is due to be trialled in phases.

- ➢ The Specialist Housing OT post in the Housing and Homelessness teams to link properties to the right disabled client has been trialled and is now confirmed as a full time post. This role includes matching clients to suitable properties, increasing and maintaining the stock of adapted properties in the social rented sector and advising on adaptations to provide sustainable and effective housing for long term use.

- An assessment of the current mandatory DFG process to identify blockages for major adaptations. This included an assessment of our DFG process by Foundations, the Government funded national body who oversee Home Improvement Agencies. As a result a fast track route is being trialled, the inclusion of an OT in the Home Improvement Agency and using a schedule of rates instead of a tender process are also being considered.

- Provision of fire misting systems and of fire retardant bedding for high risk clients unable to escape unaided in the event of a fire.

8.5 The following items are under active consideration.

- Assistance with removal and relocation costs to help move clients to more suitable accommodation where a property cannot be appropriately adapted

- The use of discretionary grants for both adaptations and repairs (to deal with issues that put the client at risk) with minimal bureaucracy with consideration to remove the means test for works under £5000. The proposals are aimed at supporting works to prevent admissions or readmissions, to assist with accident prevention and to assist with the care of terminally ill patients. Proposals to accept direct referrals from a number of health care professionals are to be considered. Potentially charges will be recorded as a local land charge to assist with the recycling of funding.

- The introduction of grant funded rapid adaptations linked to and necessary for emergency housing provision to allow properties to be adapted in a timely fashion and keep clients close to their support network.

- Payment of client's contribution for mandatory grant, where hardship can be shown.

- Grants to remove adaptations and make good in private rented sector properties where the landlord would otherwise refuse permission for works to be carried out.

- To record NHS numbers on all grant applications in a searchable format, subject to clarification as to how this will be used to make the change appropriate.

- Housing Improvement team staff to be trained as trusted assessors and employment of an Occupational Therapist to work solely an adaptation work within the team.

- The annual payment of service agreements for lifting and hoisting equipment for safety and longevity reasons.

CONDITION 2: NHS contribution to social care is maintained in line with inflation

8.7 A considerable percentage of the fund has been set aside again in 2017/18 and for 2018/19 for the direct provision of social care.

8.8 Existing grants included in the fund that were originally from social care continue to be protected and are still fully accessible to social care services e.g. DoH Social Care Grant £4.49m.

8.9 Since the commencement of the BCF, the NHS contribution to social care has been increased in line with inflation as set out by NHS England. For 2017/18, this uplift was 1.8% as per the CCG allocation notifications.

CONDITION 3: Agreement to invest in the NHS commissioned out of hospital services

8.10 In Bromley this requirement equates to £5.76m of the total fund. As the BCF plan (excel spreadsheet) demonstrates Bromley have exceeded that target with the CCG directly responsible for commissioning £6.41m of the fund.

8.11 The BCF plan for 2017-19 will continue direct investment in the following specific NHS commissioned out of hospital services.

- ✓ Winter pressures funding
- ✓ Dementia diagnosis and support
- ✓ Community equipment
- ✓ Intermediate care
- ✓ Health support into care homes
- ✓ Discharge team

CONDITION 4: Implementation of the High Impact Change Model

8.12 There has been significant work across the local system to align, develop and co-produce local plans to fully implement the eight High Impact Changes (HIC). Overseen by the A&E Delivery Board, plans look to build upon solid foundations already in place locally and to provide significant investment in order to establish and fully mobilise all eight changes.

8.13 Early Discharge Planning (HIC 1) is in place for planned procedures and all unplanned admissions are allocated an expected date of discharge from point of admission. Further work to ensure Expected Discharge Dates (EDDs) are challenging and appropriate and led by clinical optimisation is underway at the PRUH.

8.14 Implementation of the SAFER Bundle initiative has started with a programme of activity to identify, review and improve red/green days across the hospital by the senior management team (SMT) including twice weekly scrutiny of all patients with a current or imminent EDD and those Medical Stable For Transfer (line by line) as well as regular SMT and site management team input into Board Rounds to drive SAFER Bundle implementation. The multimillion pound IT investment programme due to be rolled out across the PRUH will provide robust systems to monitor patient flow (HIC 2) and allow demand and flow issues to be proactively managed.

8.15 The Transfer of Care Bureau (ToCB) is a well-established multidisciplinary discharge team (HIC 3) with further worked planned to enhance the role of the voluntary and community sector through the BCF funded Primary and Secondary Intervention Support Services (PSIS) including the Age UK 'Meet and Greet Service' which enables patients, without carers or family, to be transferred home safely.

8.16 Bromley's philosophy is that 'home is best' and should be the first consideration for all hospital discharge with a range of commissioning activity to support this. For example the joint commissioning of community health services including rapid response, rehabilitation and reablement into a single point of access will provide more responsive community infrastructure to meet the needs of patients leaving the acute hospital and support more people to return home sooner for their long term care and support needs to be assessed.

8.17 The Trusted assessor model which is used for health professionals at the front end of the hospital to restart packages of care is being rolled out to the back end of the hospital for patients whose care and support needs have not changed. In addition trusted assessor is being used to maximise the impact of ward based multi-disciplinary teams including rehab pathways to improve patient flow and continuity of care into the community.

8.18 Seven day working (HIC 5) is in place across the hospital with community health providers providing full services seven days per week. A reduced ToCB offer is available at the weekend and further work is required to ensure agencies are able to start and re-start packages of care, as well as access placements during evenings and weekends.

8.19 Recent implementation of trusted assessor (HIC 6) for acute therapists to access community rehab services and the roll out of restart of packages of care by any allied health professional is recuing unnecessary waste it in the system and improving timely patient transfer ensuring patients are in the right place, at the right time to meet their needs.

8.20 A localised discharge leaflet has been developed and is provided to all patients admitted to the hospital. A robust Choice protocol (HIC 7), shared across the local Acute Trusts, is in place with a fair and transparent escalation process. Patient and family engagement is done early to ensure individuals have the opportunity to fully consider their option while also ensuring a timely discharge form hospital. Care Home Select are commissioned via Kings Collage Hospital Trust to provide support, advice and guidance to self funders and are successful in brokering packages of care and placements in a timely way for this cohort of patients.

8.21 The red bag scheme has been rolled out across the whole of the borough to improve patient journey from care home to hospital and back again. Additional services are commissioned to support care homes including end of life care, Mobile Response Team (MRT) crisis response service and a Visiting Medical Officer (VMO) model. Further work to align existing activity to Enhanced Health in Care Homes (HIC 8) Guidance is underway with a Joint Care Home Strategy in development to provide a single vision and co-ordination of health and local authority resources to ensure a thriving and quality placement economy locally.

8.22 Going forward there are robust plans to further ensure all High Impact changes are realised fully locally. (See Section 13 – High Impact Change Areas).

9. Performance against the National Metrics

9.1 Bromley is responding to the national metrics within the BCF. *Figure 9* below sets out the planned position for 2017/18 and improvement targets for 2018/19.

Figure 9: Metrics for Bromley

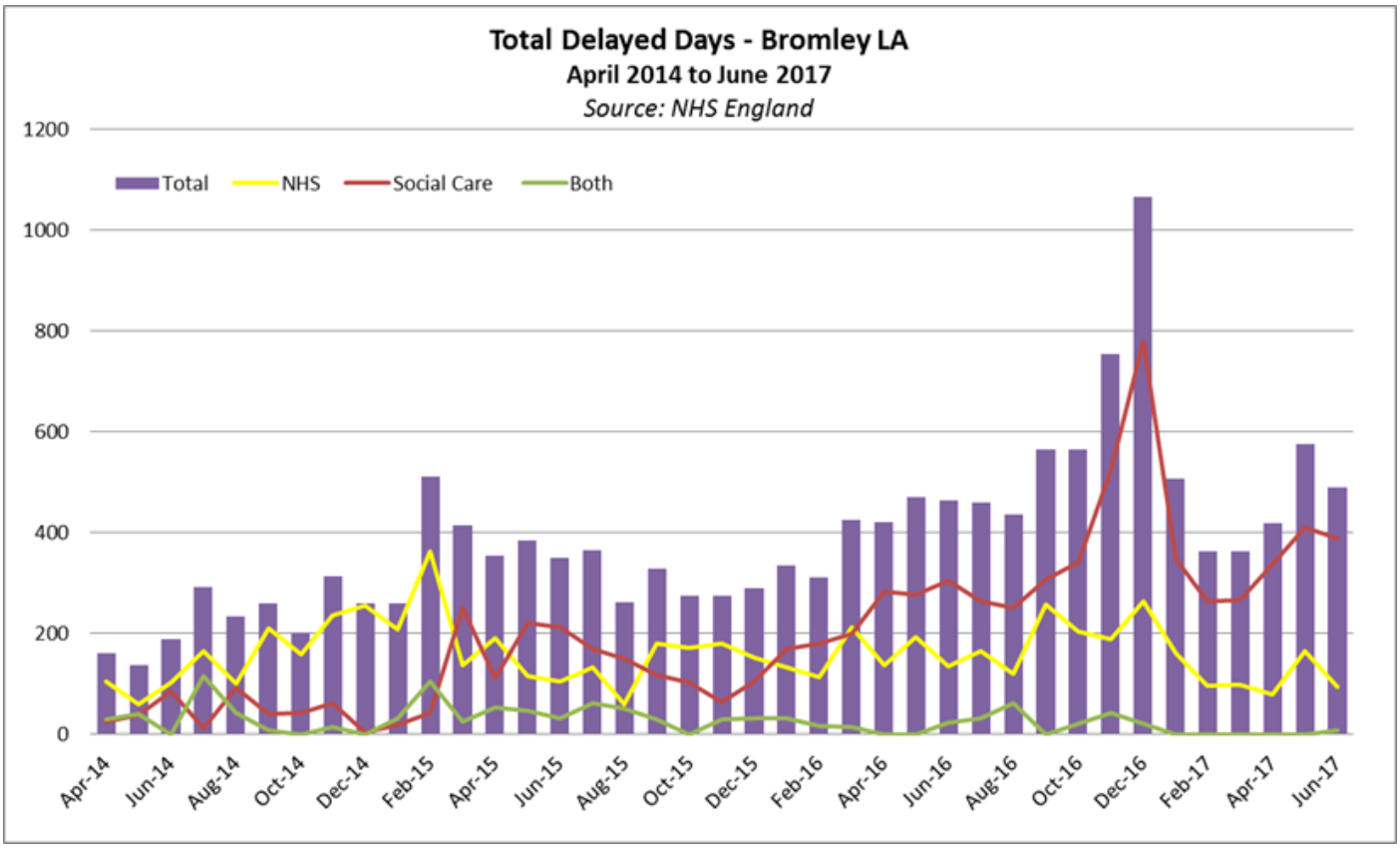
Metric	2016/17	2017/18 Plan	2018/19 Plan	Comments
Non-elective admissions (General and Acute)	26,856	26,353	26,518	The plan seeks to support the reduction of emergency admissions and stem growth against the 2016/17 outturn position for Bromley.
Admissions to residential and care homes	432.2 (per 100,000 population)	425.0 (per 100,000 population)	425.0 (per 100,000 population)	Analysis of 2016/17 performance has been undertaken and Bromley plan to maintain robust performance against this measure in 2017-19 by maintaining people at home with domiciliary care where appropriate
Effectiveness of Reablement	89.3%	90.1%	90.1%	Analysis of 2016/17 performance has been undertaken and Bromley plan to further improve performance against this metric in 2017-19 by commissioning enhanced reablement services
Delayed transfers of care*	6,435	4,725	3,666	Historic performance analysis shows deterioration in performance against this metric over the last year. Bromley is planning to improve performance in the number of delayed days in 2017-19 and plans are in place to support this across the health and social care system predominantly driven by the further development of the Transfer of Care Bureau

9.2 Over the last year Bromley has seen a decrease in emergency admissions at the local acute hospital, with 661 fewer admissions in 2016/17 than in 2015/16. This is, in part, due to a change in the coding of Ambulatory Care Unit activity but also a positive impact of admission avoidance schemes. In 2015/16 this activity was recorded as emergency admissions and it is now coded as outpatient activity. A number of initiatives are in place

across the health economy to support a reduction in avoidable emergency admissions including; support to care homes (including extra care housing), single point of entry (SPE) to community services via the Care Co-ordination Centre and continued development of Bromley's integrated Care Networks to facilitate a strong multi-disciplinary approach to the management of patients with complex health and social care needs.

9.3 For admissions to residential/care homes and the effectiveness of reablement historic and 2015/16 performance has been assessed to ensure that ambitious but realistic targets are put in place for 2017-19. A significant level of investment is planned for 2017-19 through both prevention services and reablement (see section 5) to support people to remain well for as long as possible and provide increased capacity for reablement when appropriate and needed, which should positively influence performance against these targets but with an increasing aging population maintaining a steady state may be the achievable position.

9.4 The graph below sets out DTOC performance since April 2014.



9.5 The average number of delayed days per day has been increasing since 2014/15. In 2015/16 an increase of 21.52% was evident with a significant increase in the number of delayed days attributed to Social Care. In 2016/17 the upward trend continued to an even greater degree with the total number of delayed rising by 62.6%. Unusual spikes in delayed days were recorder in November and December 2016 which heavily affected Bromley's baseline position. Despite an increase in recent months which is being tackled, Bromley has seen a significant overall improvement in performance since January 2017. A number of factors influence performance in this area such as the closure of nursing/care homes, winter pressures and acuity of patients presenting.

9.6 Stronger senior engagement across the system is in place which, in turn, has positively impacted on addressing blockages at system and individual patient level. Bromley is keen

to ensure performance in this area improves over the coming year and has committed to delivering various initiates to support the reduction of DTOCs; further development of the Transfer of Care Bureau (ToCB) and increasing reablement capacity.

9.7 Bromley's DTOC Action Plan, is appended to this document for information.

10. Bromley's BCF Funding Principles

10.1. Local areas are encouraged to place more than the minimum requirement into the fund, but initially Bromley will stay with the minimum allocation. Bromley may however decide to vary and add to the fund in year if there is a good business case to do so and will do this under an amendment to our joint Section 75 agreement. The minimum requirement for Bromley as set out by NHS England stands at £22.125m.

10.2 In summary the fund will continue to be used to create a shift in demand and supply from acute settings into community based services, reducing emergency hospital admissions and moving to a more proactive rather than reactive model of care.

10.3 Bromley have set out some funding principles for administration of the pooled fund between BCCG and LBB. These have been developed over the year and shared with the Health and Social Care Integration Board for their approval:

- ✓ The management of grants that pre-existed BCF and are now subsumed within it, as well as the on-going commitment to protect social care is protected and administered in exactly the same way as 2016/17.

- ✓ Those new additional revenue commitments that have come out of the BCF in 2016/17 are also protected for 2017/18.

- ✓ That any remaining uncommitted funds from 2016/17 are rolled over into the BCF for 2017/18 and used as one-off funds to 'pump prime' the system change required to deliver the local change programmes.

- ✓ That due to Local Authority funding the expectation is clear that although LBB support these local change programmes the LA cannot provide any additional funds to support the programmes. However they endorse the use of part of the BCF for this purpose as long as all existing commitments within the BCF and wider shared Section 75 are maintained.

10.4 The spending plan for the improved Better Care Fund (iBCF) funding for adult social care has been developed on the principle of investing the funding to create a sustainable adult social care system beyond 2020. The funding announced in November 2016 will be invested in core social care services (£0m in 2017/18 and £2.014m in 2018/19). The additional IBCF announced in March 2017 (£4.184m in 2017/18 and £3.363m in 2018/19) will be invested in transformational projects that stabilise the social care market and support the High Impact Changes Model to reduce delayed discharges and reduce pressure on NHS services. It will also be invested in supporting and developing the provider market in the locality.

11. Funding Decisions and Risk Share

11.1 Refer to BCF planning template (tab 3) HWB Expenditure Plan detailing all schemes funded for 2017-19.

Care Act 2014

11.2 Total 2017/18 and 2018/19 funding is £0.6m relating to Support for Carers – New Strategy.

Reablement

11.3 Total 2017/18 funding is £2.118m and £2.161m for 2018/19

Carers breaks

11.4 Total 2017/18 and 2018/19 funding is £0.5m

Social Care

11.5 Total 2017/18 and 2018/19 funding is £9.0m. This consists of social care grant £4.5m and protecting social care £4.5m.

Improved Better Care Fund (iBCF)

11.6. It is confirmed that the IBCF will not be used to offset Minimum CCG contributions to the BCF. The IBCF will be invested in a number of schemes that are transformational and will ensure the sustainability of social care going forward.

11.6.1 In 2017/18 these investments will either be in pump priming revised services, dual running costs during pilots or other one off costs for schemes that support social care or reduce pressures on the NHS. Care has been taken in developing investment schemes for the IBCF that support the High Impact Changes Model. The relationship between the investment schemes and the High Impact Changes Model is summarised in *Table 3* below.

11.6.2 In addition a sum of money will be set aside to invest in an increase in residential nursing care in the Bromley locality.

Table 3. Investment schemes and the High Impact Change Model

IBCF Grant Condition	% of IBCF Invested in Grant Condition in 2017/18	Scheme Name	Supports High Impact Change Model
Meeting Adult Social Care Needs	62% (£2.599m)	Transformation of Social Care and Workforce Development	• 7 Day Services • Trusted Assessors • Focus on Choice
		Resources to Implement BCF and IBCF schemes	• Early Discharge Planning • Multi-disciplinary discharge Teams • Focus on Choice • Home First Discharge to Assess • Seven Day Services • Trusted assessors
		Transitioning from Children's Services to Adult Services	• Focus on Choice
		Public Health and Meeting Requirements of the JSNA	• Focus on Choice
		Investment in Additional Nursing Care facilities	• Enhancing health in Care Homes
Reducing Pressures on the NHS, including supporting more people to be discharged from hospital when ready	28% (£1.189m)	Placing Council Social Workers and Occupational Therapists into the Integrated Care Networks	• Early Discharge Planning • Multi-disciplinary discharge Teams
		Implementing Discharge to Assess in Extra Care Housing	• Home First / Discharge to Assess
Ensuring the Local Social Care Market is Supported	10% (£0.396m)	Investment in Mental Health Safeguarding	• Multi-disciplinary discharge Teams
		Investment in Increasing Uptake of Direct Payments	• Focus on Choice
		Developing and Supporting the wider provider marketplace	• Focus on Choice
		Investment into the 3rd Sector	• Focus on Choice
		Investment to Support Self Funders	• Focus on Choice

Risk Share

11.7 £1.347m has been allocated against risk share as advised in the BCF guidance to ensure some contingency to cover over performance in emergency admissions and not meeting the 1000 reduction to unplanned admissions. This is particularly important in Bromley as the planned reduction in emergency admissions was not delivered in 2016/17.

11.7.1 The contingency has been agreed and signed off by the CCG and the London Borough of Bromley and represents 27% of the risk. The outstanding £3.65m risk will be covered through the CCG's own contingencies and reserves. A key element of the MOU metrics is a performance fund dependant on the delivery of the emergency admissions reduction should the target not be met, this fund will be utilised to offset the risk set out above. The 2017/18 contract has been agreed with Kings College Hospital which includes an agreed activity profile including the QIPP reductions and an element of risk share on the overall targets.

On this basis, we are assured that the contingency level is appropriate and the outstanding risk is covered.

11.7.2 The risks to providers in terms of a shift of acute spend being redirected into community services was explained to the HWB who fully support the direction of travel. It was explained that initial shifts in funding over the next year would be small but through building capacity and investing in the community services that these shifts from reactive to proactive care would accelerate over the next few years.

12. Programme Governance

12.1 The Local plan has now been agreed by both organisations executives and signed off collaboratively through the Health and Wellbeing Board.

12.2 The fund will be held by the Local Authority as in 2016/17 and the BCF will remain a standing item at the Joint Integrated Commissioning Executive (JICE) or equivalent committee, which meets monthly. Each organisation will give delegated powers to JICE to manage and oversee the day to day operations of the fund.

12.3 Each individual project has been agreed with JICE performance reporting, risk management and project mobilisation and all of which will be reported to JICE on a regular basis. Where schemes are identified as underperforming JICE will ensure appropriate management intervention to improve performance and ensure benefits are realised. A full evaluation of all schemes will be reported with a clear view on full benefits realised and impact on local performance metrics. JICE will monitor on a quarterly basis the overall performance impact all BCF schemes are having on key performance metrics as outlined in section 9.

12.4 Each funded scheme will be required to undertake an Equality Impact Assessment (EIA) clearly defining how it will contribute to reducing health inequalities of the population (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics.

12.5 The A&E Delivery Board has been delegated responsibility for monitoring and achieving the DToC target and Action Plan. The Action Plan, agreed across the A&E Delivery Board Partnership area, will be monitored on a monthly basis by the Board.

12.6 Increasingly the services paid for by the fund will be moved across into business as usual and subject to standard business processes and approvals, the only difference being that they continue to be funded through the BCF. The focus for JICE will be where BCF is funding new, redesigned or recommissioned services or projects that are brought in to deliver against the national conditions. Where these services or projects require procurement, reports will be taken back through the usual business processes in order to meet EU regulations and each organisations authorisation requirements.

12.7 Where there are potential synergies across regional and sub-regional schemes, lead officers will ensure alignment and engagement in the appropriate forums. For example projects supporting DToC will be aligned to sub-regional SEL Transfer of Care Board, which is also chaired by the CCG Chief Officer. Bromley will ensure all learning from local evaluation will contribute and support national developments.

13. Additional relevant information

Document or information title	Synopsis and links
Joint Strategic Needs Assessment 2016	https://bromley.mylifeportal.co.uk/media/20397/final-report-jsna-2016.pdf
HWB Strategy	HWB Strategy 2012-2015
Bromley CCG Integrated Commissioning Plan 2014-2019	Bromley Integrated Plan 2014-19.pdf
Bromley's Out of Hospital Strategy 2015 – summary (full report available upon request)	The Bromley Out of Hospital Transformati
Commissioning Intentions feedback 2015	Feedback on our 2016.17 Commissioni
Bromley's Memorandum of Understanding with Providers for ICNs	Bromley Memorandum of Unde
Risk Log ICNs	RIsk Log at 20 April.pptx
Bromley Market Position Statement	Bromley Market Position Statement.pd
ICN operating model	ICN Operating Model - 15 December v1.ppt
High Impact Change Areas	201707 Hospitals to Home Response Deve
Delayed Transfer of Care Action Plan 2017/18	Bromley Delayed Transfer of Care Acti

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Report No.
CS18065

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**EXECUTIVE** **For Pre-decision Scrutiny by the Care Services PDS Committee on 9 October 2017**
Date:	**10 October 2017**
Decision Type:	Non- Urgent Executive Key Non-Key
Title:	**IMPROVED BETTER CARE FUND (IBCF)**
Contact Officer:	Stephen John, Director: Adult Social Care (ECHS) Tel: 0208 313 4754 E-mail: Stephen.John@bromley.gov.uk
Chief Officer:	Ade Adetosoye, Deputy Chief Executive, and Executive Director of Education, Care and Health Services
Ward:	All

1. Reason for report

1.1. This document is an update on the Improved Better Care Fund (IBCF). The report summarises the National Conditions for the use of the IBCF and the spending recommendations to be made from the IBCF grant.

1.2. The Improved Better Care Fund is a time limited grant to local authorities for spending on adult social care that was announced in the Spring Budget in March 2017 and represents an increase on the amount of additional IBCF previously announced in 2016.

1.3. The grant may be used only for the purposes of meeting adult social care needs, reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready and ensuring that the local social care provider market is supported.

1.4. One of the grant conditions is that the IBCF grant can be spent ahead of the final NHS England approval of the Bromley Better Care Fund plan as long as it has been agreed with the Council's health and wellbeing partners. This will be sought at the 30th November Health and Wellbeing Board after it has been considered by Executive.

1.5. The purpose of this report is to gain the agreement of the Council's Executive to utilise the IBCF grant to stabilise and to reduce pressures on the current health and social care market, as well as provide opportunities for 'invest to save' projects across adult social care in the short to medium term. Members are asked to consider the report and agree the proposals for the IBCF.

2. RECOMMENDATION(S)

The Council's Executive is requested to:

2.1. Note the value of this IBCF grant in paragraph 3.3 and the conditions relating to the IBCF grant as identified in para 3.2.

2.2. Approve the principles of the areas identified for investment in adult social care as set out in section 4

2.3. Grant delegated authority to the Deputy Chief Executive & Executive Director for Education, Care and Health Services and the Portfolio Holder for Care Services (including Public Health) to draw down the value of the IBCF Grant for 2017/18 (£4.184m) and to determine detailed expenditure plans for the IBCF Grant proposals within the framework described within this report.

2.4. Subject to the agreement of 2.4 above, Executive are asked to agree the recurring costs of £1.7m in 2018/19 and £1.6m in 2019/20 identified in paragraph 8.2

Impact on Vulnerable Adults and Children

1. Summary of Impact: The IBCF will have a positive impact on vulnerable people through investment into safeguarding and adult social services.

Corporate Policy

1. Policy Status: Existing Policy:
2. BBB Priority: Supporting Independence Healthy Bromley

Financial

1. Cost of proposal: Up to £4,184,109 in 2017/18:
2. Ongoing costs: Recurring Cost Non-Recurring Cost:
3. Budget head/performance centre: IBCF
4. Total current budget for this head: £9,224k over three years
5. Source of funding: IBCF

Personnel

1. Number of staff (current and additional): 23
2. If from existing staff resources, number of staff hours:

Legal

1. Legal Requirement: Non-Statutory - Government Guidance:
2. Call-in:

Procurement

1. Summary of Procurement Implications: The Care Homes Investment procurement implications will be identified in the proposed options appraisal. The proposal for 4 additional Extra Care Housing flats will result in a procurement using normal LBB procurement processes.

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): Not applicable

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Ward Councillor Views

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

3. Background

3.1. The Improved Better Care Fund (IBCF) is a time limited grant to local authorities for spending on adult social care that was announced in the Spring Budget in March 2017 and represents an increase on the amount of additional IBCF previously announced in 2016.

3.2. The government has made it clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. It has also been made clear that where local authorities do not deliver on reducing their delayed transfers of care there could be financial implications to future payments of this grant.

3.3. In the Spring Budget 2017 the London Borough of Bromley was awarded an IBCF Grant of £4.2m in 2017/18, £3.4m in 2018/19 with a further £1.7m for 2019/20. This report describes the proposals for the use of only £4.2m IBCF to be spent within the Bromley Social Care in 2017/18. Some of these costs will however be recurring in future years. There will be further reports to be presented to the Executive for the £3.4m in 2018/19 and the £1.7m in 2019/20. These may include proposals for flexibility to deal with ongoing cost pressures as well as the recurring costs from the 2017/18 proposal.

3.4. As the IBCF is a direct grant to local authorities to spend on adult social care, including services that reduce pressures on the NHS, the final decisions on how the IBCF will be spent rests with the Council. However, a key requirement of the grant conditions is that this is done in conjunction with the wider health and social care partners. The agreement of other partners on the spending plans will be obtained via the Health and Wellbeing Board in order to satisfy this part of the Grant Determination conditions.

3.5. Also, as the grant is a direct grant to local authorities for spending on social care it will not form part of the Better Care Fund Section 75 agreement with Bromley CCG. It is required to be included in the BCF Narrative Plan and BCF Financial Budgets in line with the NHS England BCF Planning Guidelines.

4. IBCF Spending Recommendations

The transformation process within Adult Social Care is already under way and is described in the document “Our Journey to Excellence”. The IBCF spending proposals support this change programme.

The grant conditions for the IBCF require that the IBCF grant paid to local authorities may be used only for the purposes of:

- Meeting adult social care needs;
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready;
- Ensuring that the local social care provider market is supported.

The spending recommendations are therefore grouped under these three grant condition headings.

The IBCF is also expected to be invested in schemes that support the governments High Impact Changes Model - Managing Transfers of Care. The proposed investments in this section support the following aspects of that model:

- Focus on Choice
- Enhancing Health inn Care Homes
- Home First / Discharge to Assess
- Multi-Disciplinary / Multi Agency Teams

Grant Condition 1 - Meeting adult social care needs

4.1. A total of £2.349m (57%) of the IBCF is allocated to this grant condition in 2017/18.

4.1.1. **Transformation of Social Care (Adults, Mental Health and LD) / workforce development.** It is recommended that a proportion of the IBCF (£500k) be set aside to enable these initiatives.

4.1.1.1. Recruitment of appropriately qualified staff within Social Care has been identified as a key concern. Local care providers have also experienced similar problems with the recruitment and retention of domiciliary care staff. The implication of not addressing this situation is that there will be insufficient paid care workers across health and social care within LBB, domiciliary care agencies, care homes and health care assistant roles in the community..

4.1.1.2. It is recommended that some of the IBCF be set aside to help develop initiatives that create closer working relationships with local education providers and to support the wider local health and social care workforce. This will be achieved by offering placements within the LBB social care team (see 4.1.1.3) and work experience with providers to enable those who are interested in a career in the caring profession to understand the context that they would be working. This will broaden their opportunities of moving through a career as a paid care worker, social worker or occupational therapist with LBB or with the local care market. Initiatives include working with local colleges who offer health and social care training which consists of the student having to complete a placement and to provide additional support to those providers that that offer placement schemes and encourage others to take students into their settings. This may include investing in provider's supervision of their placement students. The intention is that following a successful placement and on qualifying from their courses, students will wish to continue to work for local Bromley care providers.

4.1.1.3. Students studying to qualify as social workers are currently offered placements within LBB social care department. Difficulties arise freeing up already busy social workers to mentor and lead these placements. It is recommended that a full time Practice Educator, who is a Senior Practitioner Social Worker, is recruited to manage the placements of around 10 students per year. It is also recommended that for those students who have a satisfactory placement with LBB and who qualify from university at the end of their course, a full time role as a newly qualified social worker can be offered through the normal recruitment processes. The Practise Educator would also be responsible for the supervision of the newly qualified social workers through their first probationary year with LBB. The benefit of this approach is that it ensures successful placements, encourages students to want to work for LBB and provides a steady stream of newly qualified staff coming into Bromley each year. The costs of recruiting and employing a Practice Educator plus the dual running costs associated with developing this role are included in the recommended investment

4.1.1.4. Additional Social Care Packages: There will also be a requirement to invest in a greater number of Care Packages especially as the social care workforce is increased and the current backlog of cases awaiting assessment is reduced. Investment in a 'Discharge to Assess' scheme will improve the current position and facilitate the appropriate discharge for individuals.

4.1.1.5. Carers Services: Investment in carer's services, through the newly commissioned primary and secondary services, is also recommended to support carers, reduce

carer breakdown, and prevent any likely increases in packages of care and hospital admissions.

4.1.1.6. Part of this investment will be set aside to facilitate the retention of mental health social workers and the recruitment of additional metal health social workers.

4.1.2. **Investment in Adult Social Care:** It is recommended that £597k be set aside to invest in the resources described below. The resources will be short term temporary or fixed term appointments to cover the IBCF period only.

Summary of Proposals "Investment in Adult Social Care"		
Role	Purpose	Estimated Cost
CHC Lead Social Worker	The suggested approach is for one full time Social Work CHC Lead who can ensure robust systems are in place to capture patterns, trends and ensure practitioners are reliably knowledgeable and skilled to deliver effective and relevant CHC assessments.	£42k non recurring
CHC Care Manager	A CHC Care Manager to support the CHC Lead Social Worker who will provide additional capacity to the current workforce enabling them time to embed their CHC learning and build their confidence.	£55k recurring
Safeguarding Project Lead (3 days per week)	Project Manager to implement the SLAM Project, approved by Executive 18 July 2017, covering safeguarding at Oxleas and South London & Maudsley NHS trust	£20k non recurring
General project work	Recruitment of an interim Project Mgr. for up to 6 months to manage Discharge to Assess (D2A) in ECH and Social Workers into ICNs	£50k non recurring
IBCF Project Mgr. initial work	It is recommended that the investment already made by LBB in the development of IBCF plans be funded from the IBCF	£110k non recurring
IBCF/BCF programme Mgr. ongoing	Currently there are insufficient resources within Bromley to manage the number of workstreams identified within the BCF and IBCF. In addition, unlike most other localities in England, Bromley does not have dedicated resource in place to manage the overall BCF process and its finances. It is recommended that a proportion of the IBCF is invested in resources to support the workstreams associated with the BCF and IBCF investment plans. A full time BCF Programme Manager to manage the	£110k non recurring

	implementation of BCF / IBCF schemes and the administration of the BCF / IBCF within the locality. (NB. Within Bromley this role is undertaken by several employees in addition to their core duties). Initially, interim rates have been applied to allow for the recruitment of a BCF specialist who can develop the role so that a permanent employee can then take on the role.	
Finance Lead to support IBCF and BCF	The BCF and IBCF within the Bromley health and care system is valued at in excess of £54m over 2017/18 and 2018/19. It is recommended that suitable resource for financial management is made available to oversee the financial controls of both BCF and IBCF on behalf of LBB and BCCG	£85k recurring
Assistive Technology	Revival of the currently lapsed "Just Checking" monitoring licences	£25k recurring
Transitions Programme Lead	A management role that develops the transition process to support young people (and their families) transitioning from children to adult services across education, health and social care, ensuring that the Council meets its statutory duties under the Care Act 2014 and Children and Families Act 2014. The Transitions Lead would develop and manage cross-organisational processes and protocols that ensure young people commencing the transition pathway have their needs met in the most effective and timely manner. The lead would also provide support to ensure young people with both eligible and non-eligible needs transition smoothly from children's to adult services	£50k recurring
OT and Trusted Assessors Resources	Conduct a review of Occupational Therapy services to reduce duplication and maximise staff efficiency. Implement a trusted assessor process where health and social care professionals can refer clients directly into specific services.	£50k non recurring
Total		**£597k**

4.1.3. **Public Health, Supporting JSNA priorities**.

It is recommended that £60k investment is made into a pilot to reduce demands on social care through targeted social work people with drug and alcohol abuse issues.

There is a clear evidence base that substance misuse treatment is effective in reducing harm to individual drug/alcohol misuser's and communities. The aim of the Social Care Support Pilot is to employee a designated social worker with a specialist interest in substance misuse to support clients moving from a position of problematic drugs and/or

alcohol misuse, associated with poor physical health status, chaotic lifestyle and sometimes criminality to a position of stability, improved health and well-being, employment and positive engagement with the drug treatment service and ultimately the community.

4.1.4. **Housing initiatives and research into older peoples housing needs.**

It is proposed that an investment of £100k be made to (a) carry out research into the housing and care needs of older people in Bromley to inform commissioning and service strategies (b) investigate the extent to which existing occupants of social housing with care needs would be appropriate for extra care housing. This will help to better meet individual needs, keep people independent within the community, prevent, reduce or delay long term care placements and also potentially release a social housing unit to meet need in Bromley.

4.1.5. **Care Homes Investment Options Appraisal** –

The Council is facing increased pressures in securing local nursing home placement. Bromley are competing with self-funders as well as other local authorities for placements. A key consideration to overcoming this is to consider an investment in a care home, which the Council would own, but not manage, and have full nomination rights on placements. Officers would like to instruct Cushman and Wakefield, the Councils Property Surveyors to undertake a 2 phased options appraisal on the purchase of suitable accommodation. The first phase would be a high level options appraisal of sites available, while the second phase would deliver a full feasibility study on preferred options identifying capital investment opportunities for the Council. It is recommended that £250k is invested in this work.

It is further recommended that the balance of the 2017/18 IBCF Grant (£842m) be held over for future investment into the Care Homes option that is identified from the work described above or to help secure any identified pressures in long term placements.

<u>Grant Condition 2 -</u> Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready.

4.2. A total of £1.389m (33%) of the IBCF is allocated to this grant condition.

4.2.1. **Support for Integrated Care Networks (ICNs).**

Significant social care cost pressures arise from clients coming to social care from the ICNs. It is recommended that part of the IBCF (£989k) is invested in additional care management resources within the ICNs to manage care and facilitate the collection of data that can be used to determine the correct level of investment in care packages for clients after contact with the ICN. In addition it is recommended that part of the IBCF is used to fund the anticipated cost pressures on ASC resulting from the ICN and a further sum is set aside to cover additional costs should they be evidenced once better data can be obtained and analysed.

A separate and more detailed paper is being presented to Executive for their consideration of this proposal.

4.2.2. **Discharge to assess in Extra Care Housing (ECH)**.

Bromley currently has 12 Step Down flats in Extra Care Housing and these are often occupied over a long period of time by individual service users. It is recommended that part of the IBCF (£400k) be invested to review the current processes within ECH so that individuals are discharged from hospital into an ECH flat and have their longer term care needs assessed and a care package arranged within 4 to 6 weeks. In addition, an investment of up to 4 additional floating Step Down beds to be made for the purpose of providing accommodation for those that are unable to find suitable accommodation and are at risk of becoming long term ECH tenants.

The benefits of this approach is that the 12 existing flats would be occupied only for up to 6 weeks whist reablement, rehabilitation and further assessments take place leading to more appropriate longer term care packages being put in place. It is anticipated that those care packages will be at a lower cost than ongoing residential costs.

The additional costs include the piloting of this approach to prove the benefits and the additional 4 ECH flats to provide accommodation for those who are unable to be offered long term residency by landlords

This investment will help support the discharge to assess initiative, details of which are being reported to Executive on 10 October 2017 in a separate report.

Grant Condition 3 - Ensuring that the local social care provider market is supported

4.3. A total of £0.446m (10%) of the IBCF is allocated to this grant condition. The market includes all providers and not just Care Homes and is intended to support the market so that people can exercise choice and control, including with regards to Direct Payments.

4.3.1. **Safeguarding – SLAM.**

This proposal has already been approved by Executive (£156k) and is included for completeness. It covers the effective management of safeguarding investigations within the community and hospitals relating to mental health.

4.3.2. **Direct Payments Lead.**

It is recommended that an investment of £40k is made for a lead to develop and increase the uptake of Direct Payments. In addition a further £50k is recommended to resource the systems for Direct Payments, including pre-Payment cards, and to develop an interactive guide for Direct Payments.
Currently in excess of 40% of all Direct Payments offered to service users are declined for reasons relating to it being too difficult for the service user to manage their own care packages (689 cases in 2016/17). A dedicated Direct Payments lead will help to significantly reduce this number. An increase in the uptake of Direct Payments will drive demand for the Personal Assistant market and the Direct Payments Lead will work closely with Vibrance, who are a registered charity that offer advice and assistance to Service Users for all aspects of Direct Payments, to help develop the market.

4.3.3. **Market development and support** It is recommended that £200k be invested in this initiative.

4.3.3.1. Bromley providers are rated to be in the bottom 20% in England according to the CQC. Investment is recommended to help raise the sustainability and performance of care homes, assist in the training of their staff and provide emergency care funding for those providers in danger of failing financially. Due to the current lack of

availability locally, this will also include investing in growing the PA market through the contract with Vibrance and through the local education providers.

4.3.3.2. Bromley Third Sector Enterprise and integrated care networks (ICN): Working in conjunction with the social workers in the ICNs, social workers will train the 3rd sector enterprise to identify service users earlier who might need only a small package of care.

4.3.3.3. Support for Self-Funders: Care Home Select (CHS) are currently commissioned to provide advice, guidance and brokerage of placements for individuals leaving the PRUH who are self-funding their care. CHS have a good relationship with the local market and continually support them to ensure they are able to meet presenting needs. Support will be given to CHS to build the self-funded domiciliary care market and ensure self-funders are offered the appropriate level of care aiding the prevention and independence of self-funders.

5. IMPACT ON VULNERABLE ADULTS AND CHILDREN

The IBCF will have a positive impact on vulnerable people through investment into safeguarding and adult social services. As the IBCF is for investment into adult services only there will be no impact on children, with the exception of those transitioning to adulthood that will be positively impacted by the proposed Transitions Lead post.

6. POLICY IMPLICATIONS

The Improved Better Care Fund supports the Building a Better Bromley and Supporting Independence priorities.

7. PROCUREMENT IMPLICATIONS

Procurement will be engaged as appropriate on the proposals in this report.

8. FINANCIAL IMPLICATIONS

8.1. The value of the IBCF Grant for the next three years is £4.184m in 2017/18, £3.363m in 2018/19 and £1.677m in 2019/20

8.2. The IBCF is a direct grant to local authorities which they are required to spend on social care. It will therefore not form part of the Better Care Fund Section 75 agreement with Bromley CCG. It will, however, form part of the BCF Narrative Plan and BCF Financial Budgets in line with the NHS England BCF Planning Guidelines.

The proposed spend on the IBCF is detailed in the table below:

	2017/18 £'000	2018/19 £'000	2019/20 £'000
Transformation of social care/workforce development	500	60	60
Investment in ASC	597	215	215
Supporting JSNA priorities	60	0	0
Housing Initiatives	100	100	0
Care Home option appraisal	1,092	0	0
Sub total for grant condition 1	**2,349**	**375**	**275**

Grant condition 2	2017/18 £'000	Recurring 2018/19 £'000	Recurring 2019/20 £'000
Support for Integrated care Networks	989	989	989
Discharge to assess in Extra Care Housing	400	180	180
Sub total for grant condition 2	**1,389**	**1,169**	**1,169**

Grant condition 3	2017/18 £'000	Recurring 2018/19 £'000	Recurring 2019/20 £'000
Safeguarding	156	156	156
Direct payments Lead	90	0	0
Market Development and support	200	0	0
Sub total for grant condition 3	**446**	**156**	**156**

Total IBCF expenditure	**4,184**	**1,700**	**1,600**
IBCF Allocation	-4,184	-3,363	-1,677
Unallocated IBCF	**0**	**-1,663**	**-77**

8.3. By agreeing to the expenditure for 2017/18, this will lead to recurring expenditure in future years. The expectation is that this will also be funded from IBCF and will be the first call on the additional funding.

8.4. Any underspend on the grant allocation can be carried forward and used to support future years expenditure

8.5. It should be noted that IBCF is a finite resource and is only available for three years. Once the funding ceases this will potentially be a pressure on the service moving forward with recurring spend and therefore this will need to be closely monitored and reported on

accordingly.

9. PERSONNEL IMPLICATIONS

The majority of personnel implications are as set out in this report. In the event that the recommendations are agreed consultation with staff and their representatives will be required for those issues affecting the workforce, the outcome of which would be subject to a separate report at that time.

10. LEGAL IMPLICATIONS

The Improved Better Care Fund Grant Determination (2017/18): No 31/3064 is made by the Secretary of State under section 31 of the Local Government Act 2003. The grant may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.

The Council is also required to:

- Pool the grant funding into the local Better Care Fund, unless the authority has written ministerial exemption

- Work with the relevant clinical commissioning group and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and

- Provide quarterly reports as required by the Secretary of State

Non-Applicable Sections:	
Background Documents: (Access via Contact Officer)	

Report No.

CS18067

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**EXECUTIVE** **For Pre-Decision Scrutiny by the Care Services PDS Committee on 9 October 2017**
Date:	**10 October 2017**
Decision Type:	Non-Urgent Executive Key
Title:	**INTEGRATED CARE NETWORKS UPDATE**
Contact Officer:	Alicia Munday , Head of Programme Design (Commissioning) Tel: 020 8313 4559 E-mail: alicia.munday@bromley.gov.uk
Chief Officer:	Ade Adetosoye, Deputy Chief Executive and Executive Director of Education, Care and Health Services
Ward:	(All Wards);

1. Reason for report

1.1 This document is an update on the Integrated Care Networks (ICNs). The report summaries the function and the impact of the ICNs on Adult Social Care. The report also makes recommendations to the Council's future involvement in the ICNs.

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2. RECOMMENDATION(S)

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

(1) Approve the Council formerly signing and joining the Integrated Care Network (ICNs) Alliance Agreement as set out in para 4.8
(2) Agree to the drawdown from the Improved Better Care Fund (IBCF) of £365k in year, increasing to £629k in a full year, for the next 3 years, as a result of additional care packages costs as set out in para 6.1-6.7
(3) Agree the drawdown of £150k per annum from the IBCF, for 3 years, of iBCF funding for resourcing the Council's involvement in the ICNs.

Corporate Policy

1. Policy Status: Existing Policy: Commissioning Programme
2. BBB Priority: Excellent Council Supporting Independence:

Financial

1. Cost of proposal: Up to a £989k per annum for three years
2. Ongoing costs: Up to £989k per annum for three years
3. Budget head/performance centre: iBCF
4. Total current budget for this head: £9,224k over three years
5. Source of funding: iBCF

Staff

1. Number of staff (current and additional): 3
2. If from existing staff resources, number of staff hours:

Legal

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

Customer Impact

1. Estimated number of users/beneficiaries (current and projected):

   Circa 300

Ward Councillor Views

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

3. BACKGROUND

3.1 In October 2016, 3 Integrated Care Networks (ICNS) began operating across Bromley, these are designated to the 3 principle regions, East, Central and West. Each ICN operates a Multi-Disciplinary Team (MDT) approach to ensure the most appropriate care and support is made available to those residents with the most complex care needs in our community.

3.2 The ICNs consist of 6 signatories to a memorandum of understanding (MOU) which sets out the objectives of the ICNs, the expected deliverables and the operational framework for the partners to work together. The signatories are:

- Bromley Health Care
- Oxleas NHS Foundation Trust
- King's College Hospitals NHS Foundation Trust
- Bromley GP Alliance
- St Christopher's Hospice
- Bromley Third Sector Enterprise (Community Links Bromley, Age UK Bromley and Greenwich, Bromley Mencap, Bromley and Lewisham Mind, Carers Bromley, Bromley Citizens Advice Bureau

3.3 The Council did not initially sign up to the MOU, but does participate in the MDT discussions where there is a patient who receives or might require social care support.

3.4 Through the MOU the ICNs are financially incentivised to deliver improvements to the performance of the health system in Bromley, mainly in respect of reduced admissions to hospital and fewer delayed discharges.

3.5 The ICNs operate through weekly multi-disciplinary team meetings. Patients are identified by GPs and for the first phase are predominantly frail elderly people who are frequent users of GP, community and acute services. Patients are tracked before and after the involvement of the ICN to establish the impact of the intervention.

3.6 This report gives a summary of the impact of the ICN work, particularly in relation to Social Care and makes recommendations for the Council's future involvement in the ICN.

4. Summary of Outputs from the ICNs

4.1 To date (9 months to the end of June 2017) the ICNs have received approximately 550 referrals. The Council have been able to' track' 58% of these clients, as the Council's systems holds their NHS number. This is important as the remaining 42% may also be social clients, but the Council has not obtained their NHS number. The Council attempts to collect all clients NHS number wherever possible.

4.2 Of the 58% (322) of the clients we have been able to track the information below indicates the outputs in terms of social care:

4.3

1	180 (56%) of clients did not receive a acer package before or after their contact with the ICN.	
2	121 (38%) of these clients were already in receipt of social care services. Of these 121:	
•	• 27 of these clients received an enhanced care package	

	after their contact with the ICN	
•	• 4 clients received a lower care package	
3	Of the 201 (62%) clients that were not in receipt of social care,	
•	• 31 of them (15%) following their contact with the IC received a care package from the Council.	

4.3.1 The average age of people going through the ICNs is 82 – so it is targeting our oldest and most vulnerable residents. The oldest person was 103 and the youngest was 38.

4.3.2 Of the clients not previously in receipt of social care, following their contact with the ICN 10% (31) of them received a care package from the Council –

4.3.3 Of clients in receipt of social care, 22% of clients received a higher care package after their contact with the ICN.

4.3.4 Of Clients in receipt of social care, 4 people were recorded as receiving a lower care package following their contact with the ICN.

4.3.5 Of the 322 clients that we have been able to identify through the ICN, 180 (56%) did not receive a social care package, before or after their contact with the ICN.

4.4 It is important to note that all Social Care assessment and associated approved care packages are still completed under the Care Act, and as such whilst there is an identified pressure on ASC budgets, it is noted that this is still in line with meeting the Council's statutory duties, and assisting the Council in ensuring any wrap around support for an individual is provided by the partners within the ICN.

4.5 There is no exact science to demonstrating the cost benefit analysis of the ICN to Social Care, as it is not possible to ever identify what the cost of a social care package would have been without an intervention, however, currently the evidence suggests that the ICN is identifying a greater demand for Social Care. A summary of this is evidenced below.

4.6 It should be noted, that the weekly costs will always be variable depending upon individual needs, the fully yearly affect is projected as a multiplier of the snapshot in time, but could significantly change if clients change, or individual needs change. This does not take into account any assessed client contributions.

4.7 The costs identified below, relate solely to the care packages, and do not include overheads of additional assessment, or care management resource for attending ICN meetings

	Cost To ASC Prior to ICN	Cost to ASC After Contact with ICN
	£'000	£'000
Actual Weekly Costs	28	35
Projected Annual Effect	1,460	1,825
Differential		**365**

4.8 Officers are concerned that because there is no formal social care presence within the ICN, the Council is incurring additional cost pressures without being able to influence the process. It is therefore recommended that the Council formerly sign the Alliance Agreement.

4.9 It is recommended that the Council formerly signs the MOU in relation to the Care Homes, with the understanding that this is under a former review by the programmes team within ECHS, to monitor and evaluate the impact on ASC together with partners involved in the ICN; and,

4.10 It is recommended, that the Council identify £515K per annum from the iBCf fund for the next 3 years, £365k pa for the anticipated cost pressures on ASC, and £150k for resourcing care management involvement in the ICNs;

4.11 Not all of the costs have been identified as only 58% of the data could be analysed. If the costs are extrapolated to include all of the cohort there will be an additional £264k per annum required. It is recommended that the council identify these costs from iBCF for the next three years and,

4.12 During the 3 year programme, officers will monitor the impact of being involved in the ICNs on ASC. As indicated in para 4.4, all packages of care approved through the ICN are still are under the Care Act and in line with meeting ng the Council's statutory duties. A crucial mechanism for driving down costs pressures will be to consider trusted assessor status within the ICN. Officers will review this as an option and any recommendations in relation to this will be bought back in a monitoring update to Members,

4.13 Note, that monthly updates will be provided to the Portfolio Holder on the ICN, and that members will be updated in a full report every 6 months.

5. POLICY IMPLICATIONS

5.1 The Integrated Care Networks support people to remain as independents as possible, a key Building a Better Bromley priority. Eligibility for Social Care remains under the Care Act.

6. FINANCIAL IMPLICATIONS

6.1 It is clear that as a result of the ICNs, additional costs have been incurred by the Council due to increased packages of care being identified.

6.2 The Performance management team, together with the Programme design team have analysed the ICN data as far as possible, and have attempted to calculate what the financial impact of the ICN has been

6.3 Some costs have been identified but only 58% of the data could be accurately analysed, By extrapolating the data set to include all of the cohort the costs could rise further as seen in the table below:-

Additional ICN Costs		
	Full year	
Cost identified arising from ICN's as per paragraph 4.7	365	
Figure based on only 58% of data accurately analysed		
Extrapolate this for remaining 42%	264	
Staffing	150	
Total Costs	**779**	

6.4 Additional care management and data analysis resource is required to support the Councils involvement in the ICS. It is recommended that £150k is set aside for this. Any new posts created for this work, will be fixed term for 3 years in line with the availability of the iBCF

6.5 Additional care packages have been identified and increased within the ICNs, it is therefore recommended that £515k per annum (£365k of care costs and £150k staffing) be drawn down from iBCF for three years.

6.6 It is also recommended that £264k per annum for three years be set aside to meet additional costs should they be evidenced once better data can be obtained and analysed.

6.7 The total drawdown will be a maximum of £779k per annum

6.8 It should be noted that iBCF is a finite resource and is only available for three years. Once the funding ceases this will potentially be a pressure on the service moving forward, and this will need to be closely monitored and reported on accordingly..

7. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

7.1 The ICNs are designed to support the most vulnerable adults in our community.

8. LEGAL IMPLICATIONS

8.1 This report seeks the approval of the Executive to (1) enter into an Alliance Agreement (MoU), no specified period to facilitate the delivery of integrated , high quality, affordable and sustainable heath and care services in the most appropriate way to the GP registered population of the London Borough of Bromley.

8.2 Regulation 12 of the Contract Procedure Rules 2015 provides an exemption from the rules for such agreements whereby where a number of contracting authorities genuinely co-operate with each other to meet public service obligations that each is entrusted to perform and each authority need not necessarily have the same obligations.

8.3 These services are required pursuant to obligations placed up on the Council by the Health and Social Care Act 2012. The requirement to provide these services is mandatory however the decision to enter into the alliance agreement is discretionary.

8.4 Under the Council's Constitution a Portfolio Holder may delegate to the Chief Executive in consultation with the Portfolio Holder provided that the Contract Procedure Rules are also complied with.

8.5 The report author will need to consult with the Legal Department regarding the execution of the contract.

9. PERSONNEL IMPLICATIONS

9.1 As included within the recommendations, there is a £150k resource allocated for a period of 3 years to support care management and performance data analysis, in the attendance and participation of ICNs as well as performance monitoring. This will be delegated to the Head of Care Management and Assessment to determine the most appropriate use of.

Non-Applicable Sections:	
Background Documents: (Access via Contact Officer)	IMPROVED BETTER CARE FUNDING REPORT

Report No.
CS18068

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**EXECUTIVE** **For Pre-Decision Scrutiny by the Care Services PDS Committee on 9th October 2017**
Date:	**10th October 2017**
Decision Type:	Non Urgent Executive Non Key
Title:	**Discharge to Assess (D2A) Pilot**
Contact Officer:	Jodie Adkin, Head of Discharge Commissioning Tel: 07803 496492 E-mail: Jodie.Adkin@bromley.gov.uk
Chief Officer:	Stephen John, Director of Adult Social Care Education, Care and Health Services, London Borough of Bromley Tel: 020 8313 4754 E-mail Stephen.John@bromley.gov.uk
Ward:	All Wards

1. Reason for report

1.1 The purpose of the report is to obtain approval for a pilot to implement the Discharge to Assess model in Bromley Adult Social Care, utilising £818k of the Better Care Fund.

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2. RECOMMENDATION(S)

2.1. Care Services PDS Committee Members are asked to note and comment on the contents on this report.

2.2. Executive is asked to:

2.2.1. Agree the drawdown of £818k from the Better Care Fund (BCF) to support the implementation of a Discharge to Assess pilot in adult social care.

2.2.2. Note that an evaluation of the D2A will be reported back to Members in May 2018

Corporate Policy

1. Policy Status: Not Applicable Existing Policy New Policy:

2. BBB Priority: Supporting Independence Healthy Bromley:

Financial

1. Cost of proposal: £818k

2. On-going costs:n/a

3. Budget head/performance centre: n/a

4. Total current budget for this head: £zero

5. Source of funding: BCF

Personnel

1. Number of staff (current and additional): 11

2. If from existing staff resources, number of staff hours: 0

Legal

1. Legal Requirement: Statutory Requirement Non-Statutory - Government Guidance:

2. Call-in: Applicable:

Procurement

1. Summary of Procurement Implications:

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): current 0, proposed 871

Ward Councillor Views

1. Have Ward Councillors been asked for comments? No

2. Summary of Ward Councillors comments:

3. COMMENTARY

Summary

3.1. This report recommends the funding of a pilot "Discharge to Assess" model in Bromley. This model, following a number of successful national pilots, enables people to leave hospital without delay as soon as they are medically ready to be assessed for their long term care and support needs. Assessment takes place outside of the hospital setting in a more familiar, community based setting, with a focus on enabling people to return home wherever possible. The model aims to reduce the amount of time people remain in a hospital bed unnecessarily where levels of functioning, independence and wellbeing decline and the cost to the whole system is significant.

3.2. The pilot will create a temporary, community based joint team of health and social care officers to enable prompt hospital discharge. The team will provide a multidisciplinary enablement and assessment function to run alongside the existing hospital-based Care Management Team and test a different approach to hospital discharge for people with ongoing care and support needs including access to immediate wrap around care and support. Should the pilot be successful, existing resources would be transformed to adopt a Discharge to Assess model locally.

3.3. In summary, the pilot will fund a team to:

- reduce delayed transfers of care
- pump-prime the transformation of existing resources to reduce pressures on the system
- improve outcomes for service users
- potentially identify efficiencies (including cashable) in on-going care and support costs
- Enable Bromley to achieve the challenging delayed transfer of care targets which have been set by NHS England.

Background – delayed transfers of care

3.4. The Care Act requires local authorities and partners to ensure 'people do not remain in hospital when they no longer require care that can only be provided in an acute trust'. Where people who are ready to be discharged but remain in hospital, awaiting further care and support in the community, this is referred to as Delayed Transfers of Care (DToC). DToCs are reported to NHS England (NHSE) on a weekly basis measuring delays that are attributed to either the NHS or to the local authority.

3.5. During 2016/17 there were a total of 6,435 delayed transfer of care days reported in Bromley, an increase of 63% on the previous year.

- 65.45% of these were deemed "social care" (local authority) associated delays (4,212).
- 77% of social care delays were caused by pressures on the availability of packages of care and placements.
- Social care associated delays have increased year on year. Delays are often caused by delays in finding suitable nursing placements and the availability of costly double handed packages of care.

3.6. A comparison of Bromley's performance on DToC with our nearest local authority neighbours shows that local social care delays were consistently amongst the highest in the region throughout 2016/17. (Attached as **Appendix A1**)

3.7. Delays in discharging people from hospital have an evidenced impact upon their health and wellbeing. A wait of more than 2 days reduces the potential of a person being re-abled or rehabilitated to regain independence, while a wait of 10 days in a hospital bed can lead to the equivalent of 10 years aging in muscles of people over 80, significantly reducing the possibility

of ongoing independence and increasing the levels of care required. [Research from 2014 National Audit of Intermediary Care, Professor John Young.]

3.8. The cost to the overall system is high. The National Audit Office reports that unnecessary hospital bed days due to delayed transfers of care costs the NHS in the region of £820m per year.

3.9. Hospital Trusts are able to charge organisations for delayed discharge days at a rate of £155 per day. Although not currently practiced by Kings College Hospital Trust, the potential penalty equates to a £652,860 charge to London Borough of Bromley during 2016/17.

3.10. However, from September 2017, as part of the requirements of the Better Care Fund/Improved Better Care Fund, Bromley has a target to reduce DToC in order to achieve the national target of no more than 3.5% of total beds delayed nationally. This means a local reduction in DToC from 4,184 total delayed days from September 2016 - March 2017 to 2,310 delayed days for the same period during 2017/2018, a 45% reduction. Not achieving the target could result in financial penalties against the iBCF.

3.11. In addition, Integration and Better Care Fund Planning Guidance 2017-2019 includes a specific grant condition for local authorities to manage transfers of care. The condition states that all areas should implement the “High Impact Change Model” to support system-wide improvements in transfers of care. Discharge to Assess is a significant part of the High Impact Changes required. It is expected that the BCF will fund local transformation in line with this model to support the shift of resources away from hospital care and towards care in the community and at home.

Background – responding to delayed transfers of care

3.12. In Bromley, the Transfer of Care Bureau (ToCB) was established (October 2015) to tackle the ongoing delayed transfers of care. The ToCB brings together local authority care managers, discharge co-ordinators, community health and therapy providers and the voluntary/community sector to facilitate hospital discharge for people requiring on-going care and support

3.13. Despite the success of this model, people’s on-going care and support needs are assessed in hospital, while health and social care funding processes run parallel to one another. The current infrastructure can be time consuming and undertaken under significant pressure, resulting potentially in costly packages of care or long term placements being arranged in order to enable people to leave hospital.

3.14. Levels of demand continue to rise, with an increase in levels of frailty and complexity of need being seen. In 2016/17 there were approximately 1,500 social care assessments (125 per month) undertaken by the ToCB staff based at the hospital. Year to date performance is showing a 33% increase in assessments during quarter 1 against the same period last year - a trajectory of approximately 2,000 assessments forecast for 2017/18.

3.15. The current infrastructure is under increasing pressure and requires modernisation in order to function effectively within existing resources. The pilot recommended in this report will provide an additional resource to support demand throughout the winter months (when pressure in the system increase considerably), while also testing new ways of working that can be used to transform existing resources.

Options Appraisal

3.16. An option appraisal (attached as **Appendix B**) was undertaken to identify how best to achieve the following outcomes.

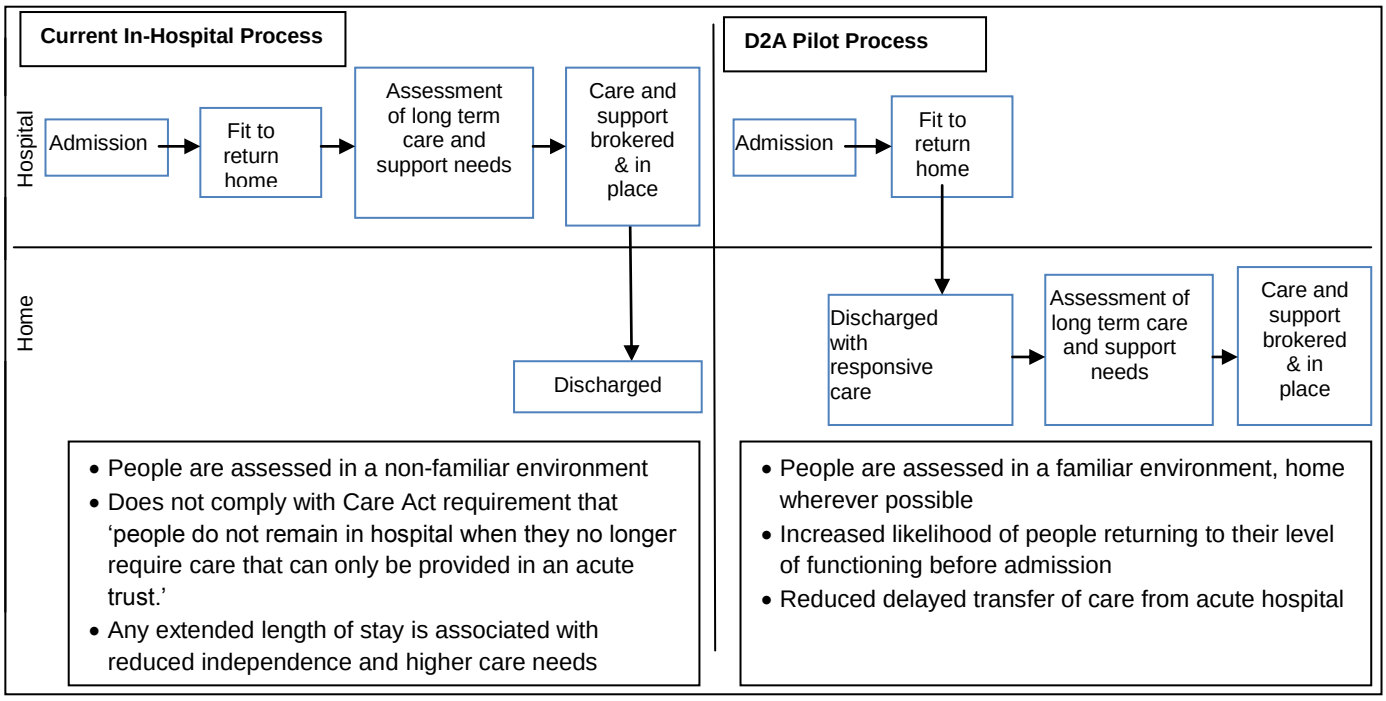
- Provide additional support throughout the winter when demand on the system, including numbers of assessments and DToC, increase significantly
- Ensuring people are supported in the right place, at the right time, to meet their needs to recover and maintain independence in the community reducing the pressure on adult social care services
- Maximise iBCF funding by reducing delayed transfers of care associated with social care
- Enable Bromley to deliver a fit for purpose Better Care Fund by supporting implementation of the required High Impact Change Model

The appraisal recommends the piloting of the Discharge to Assess model in Bromley.

The Discharge to Assess Model

3.17. The Discharge to Assess model (or D2A as it has become known nationally) provides short-term care and reablement/rehabilitation in people's homes or uses 'step-down' beds to bridge the gap between hospital and home. In either scenario, people no longer need to wait unnecessarily for assessments or community resources to become available in hospital. The model changes the way current services are provided by moving reactive services out of hospitals and into the community providing responsive, proactive wrap-around care that can support people immediately.

3.18. The diagram below compares an "in hospital" assessment process against the D2A model.



3.19. Several examples of D2A are available nationally (attached as **Appendix C**):

3.20. In Bexley, a single pathway has been developed to support people to return home from hospital. Social care related DToC have reduced from 26 in June 2015 to 2 in June 2017.

3.21. South Warwickshire have developed three pathways:

- Pathway 1: Home providing care and support at home to maintain people's independence
- Pathway 2: Step down beds for individuals requiring additional, non-hospital support that cannot be met safely at home
- Pathway 3: Long-term placement including residential and nursing

South Warwickshire have reported a reduction in on-going social care costs from £442pw for non D2A service users, against a cost of £224pw for D2A service users.

3.22. Findings from D2A models around the country including Bexley, Medway and Sheffield have reported:

- a reduction in length of stay in hospital
- an increase in people leaving hospital supported to regain independence
- reduction in costly packages of care, and
- less people being admitted to long term nursing homes following admission.

All D2A services nationally have reported positive feedback from service users and staff. Case studies can be found in **Appendix D**.

3.23. In addition to these positive examples, local learning has shown:

- When assessed post discharge and at home the cost of care packages can reduce by 60% from £398pw to £227pw.
- 65% of service users assessed for their long term care and support needs following a period of reablement at home no longer require an adult social care service
- Continuing Health Care Reviews undertaken 2/4 weeks following admission to nursing homes result in a reduction of on-going cost due to a period of settling and recovery.

All of these examples provide a period of recovery/stabilising before assessing for long term care and support needs in a familiar community based setting. The D2A pilot aims to build upon this for all people leaving acute care with ongoing care and support needs.

The Discharge to Assess Pilot in Bromley

3.24. The recommendation in this report is to fund the piloting of D2A locally to test whether the benefits gained in other local authorities can be achieved in Bromley. In line with the model described above, the pilot would enable people to be discharged from hospital as soon as they are able to be supported in the community with immediate wrap-around care and support as required. People are able to achieve maximum recovery and functioning before they are assessed for their long term care and support needs.

3.25. In line with national best practice, three D2A pathways are proposed in Bromley.

- Pathway 1 – Home: As many people as possible will be supported through this pathway. The pilot will help people to achieve their maximum potential before transferring them to any on-going care and support requirements. For some this may be as short as 3-5 days. For others, where further recovery is possible, individuals may remain in the pathway for up to 6 weeks (in line with the council's reablement policy) to maximise their potential. Any time spent by people on the D2A pathway will form part of their maximum 6 week free service (e.g. if someone receives 2 weeks support in D2A and then moves onto the existing reablement service, they will receive up to a maximum of 4 weeks in reablement).

- Pathway 2 – Step down: This pathway involves using interim placements for those that require a short period of intense recovery to maximise their independence or for those who cannot return home for safety reasons. The majority of people will return home following an interim placement, based on the experience of the current bed based rehabilitation model where 75% of patients return home.

- Pathway 3 – Long term placement: This provides for those requiring a long term nursing home placement. It will replace the current process of initial assessment, funding agreement and nursing home assessment that takes place in hospital and which takes on average 10 days to complete. Within D2A, health and social care assessments will be completed when the service user is settled outside of hospital, providing a more informed view of the levels of care required. A core objective of this pathway will be to remove this lengthy process and allow a period of settling before the assessment of long term care and support needs is undertaken.

3.26. Success criteria for the pilot therefore includes the following:

- All pathways: Improved outcomes for service users including increased independence and improved experience of the discharge process
- Pathway 1 – Ongoing care and support needs are reduced with a subsequent impact upon cost.
- Pathway 2 – Majority of service users return home following interim placement
- Pathway 3 - Care and support needs are reduced and less complex placements are required above the council's nursing home ceiling rate.

3.27. The pilot will run for 6 months from October 2017 with fortnightly budget and performance reviews. Despite the success other local authorities have had in implementing a D2A model, it is imperative that Bromley is able to evaluate the approach as a pilot in order to determine the configuration of the service model going forward. A full evaluation report including an evaluation of the pilot and recommendations for the future will be provided to Members at the end of the 6 month pilot.

The Pilot D2A - Staffing Resources

3.28. Delivering the pilot's objectives will require a temporary multidisciplinary team to provide intervention and assessments for those discharged through D2A.

3.29. The D2A team will run alongside the existing hospital based team for the period of the pilot, the temporary infrastructure preventing the risk of destabilising the existing workforce and reducing capacity for social work at the hospital during the challenging winter months. If the pilot is successful as planned, it will be possible to review and realign existing resources into a new single function.

3.30. In line with national best practice, the temporary D2A team will be composed of

- 1 FTE Team Manager
- 7 Care Managers/Care Manager Assistants
- A dedicated GP
- 2 FTE Occupational Therapy Assistants/moving and handling risk assessors

A breakdown of the interim staffing costs are included in **Appendix A.** The longer term impact upon staffing is difficult to determine at this stage, although (a) the dual running of the two teams will not be required once the pilot has been completed and (b) the resource to implement

D2A after the pilot will be determined as a result of the learning from the pilot and all costs will be contained within existing staffing budgets.

The D2A Pilot - Financial Assumptions

The model consists of the following:

3.31. Discharge to Assess Team: £372k is required to implement a temporary multidisciplinary team filled by interim staff to provide intervention and assessments for those discharged through D2A. Provision is included for training and development of the existing workforce to support D2A.

3.32. Domiciliary care packages: up to an estimated £156k is required for domiciliary care to be provided under the D2A pilot. This will provide responsive care as required by the needs of the service user, procured through the existing CCG infrastructure available at the hospital. There has been a considerable amount of engagement with the local market to provide responsive care for people leaving hospital. Providers have also fed back via market engagement that a more sustainable way to procure care to meet the level and variation in demand is on a day rate with carers integrated into the D2A team, able to be deployed as required. This is also a more cost effective way to procure care.

3.33. Administrative and Tracking: £50k will provide for an administrative and tracking staffing resource for the whole of D2A infrastructure to ensure that resources are maximised, that demand is matched to capacity and that the D2A has a robust performance and evaluation framework for future learning. Performance will be regularly reported to the Departmental Management Team within ECHS.

3.34 Long term placements: Up to £240k enables the procurement of immediate nursing home beds so that service users can be discharged from hospital quickly. Placements will be brokered through existing CCG arrangements which provides additional support to families. Engagement with providers has shown that they would be more likely to accept patients straight from hospital and in a more responsive way with support from the D2A team. Initial mobilisation of the additional nursing beds procured by the council recently for use in reducing DToCs has demonstrated the willingness of providers to work in more efficient ways including taking over the phone assessments and admitting at weekends which has not been possible in our standard spot purchased beds.

		£'000
1	Discharge to Assess Team	372
2	Domiciliary Care packages	156
3	Infrastructure, tracking and evaluation	50
4	Long term Placements	240
	Total	**818**

The D2A Pilot - Demand and Outcome Assumptions

3.35. Demand modelling suggests that the D2A pilot should expect 870 service users requiring assessment for their long term care and support needs in the community. This has been developed based on the number of people that could be safely supported in the proposed pilot figures. Indicative numbers of people within each pathway are Pathway 1 – 650; Pathway 2 – 155; Pathway 3 – 65.

3.36. Currently self-funders are supported via Care Home Select (CHS) within the ToCB to identify and commission their own support at home or in a placement. Where someone can benefit from support to achieve independence they will be offered the service regardless of self-funding status. This helps to protect statutory services in the long term as self-funders will become the responsibility of the local authority in the event of funds being depleted (by, for example, the unnecessary provision of expensive residential care).

3.37. The D2A pilot is aligned to the existing Charging Policy and would result in no change to income received through partial funders. Individuals supported through D2A would be charged as appropriate following the assessment of their long term care and support needs, reflective of the current process.

3.38. As stated earlier in the report (3.19 – 3.22), other authorities have been successful in achieving significant reductions in on-going social care costs by using a D2A model. This report does not assume that these will be mirrored in Bromley – there are different demographic pressures in each location, each authority is using a version of a D2A model with variations in pathways and staffing, and each local care market is different. This report has more prudently assumed a 15% reduction in on going social care costs as detailed in the Financial Implications section.

Risks

3.39. The potential impact of not implementing the D2A model may be significant. Sign off of the Better Care Fund is dependent on clear plans to implement the HIC model. Failure to achieve the DToC target set by NHSE could result in a financial penalty applied against the Improved Better Care Fund (iBCF). More immediately, the current hospital based model is unlikely to cope with additional pressures throughout the coming winter.

3.40. Due to the challenges in exact modelling of potential social care demand there is a risk that the financial envelope will not be sufficient to support demand. To mitigate against this, however, modelling has been undertaken against the previous year's activity and tested against live tracked patients at the hospital throughout the busiest months of the year to date. In addition, the funding of administration and tracking capacity will allow a robust daily oversight of activity and financial position which will be reviewed regularly.

3.41. Pathway 3 relies upon availability of care homes which may not be responsive or sufficient enough to meet the demand of the D2A model. However, the proposed numbers of people are within existing demand and therefore no 'new' placements are being sourced. The use of Care Home Select to source placements as well as dedicated support from the D2A team is an additional offer to providers locally and which has been received positively. Providers have confirmed they are more likely to engage and take additional patients from the hospital with this additional support in place addressing some of the barriers in accessing placements locally.

3.42. The recruitment of staff is a local and national challenge. The innovative nature of the D2A model is an attractive opportunity for professionals and therefore likely to support recruitment. Officers will use a range of recruitment approaches including interim and agency staff to reduce the risk of vacancies in the service. In the event that the level of demand on the hospital care management team begins to decrease through more people being supported through Discharge to Assess, interested hospital based personnel will be enabled to move into the community based D2A.

4. IMPACT ON VULNERABLE ADULTS AND CHILDREN

4.1. The implementation of the D2A model will ensure vulnerable adults that have been acutely unwell and have on-going care and support needs are appropriately assessed and supported in the right place at the right time to maximise recovery, independence and staying well in the community for longer. The D2A model will also reduce the risk of infection and physical deterioration associated with prolonged unnecessary hospital stays.

5. POLICY IMPLICATIONS

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

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

- Invest in NHS commissioned out-of-hospital services;
- Support implementation of the High Impact Change Model for Managing Transfers of Care
- High Impact Change 4: Discharge to Assess is described as *'Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home'*

5.3 The Joint Integrated Commissioning Executive has discussed and approved this project, prior to Executive consideration of this report, on 10 August 2017

6. PROCUREMENT IMPLICATIONS

There are no identified procurement implications for LBB as the CCG will undertake the procurement for Recommendations 2, 3 and 4.

Summary of Procurement Implications: The health and social services Light Touch regime of the Public Procurement Contracts Regulations 2015 and the cumulative value is above the threshold (£589,000) requiring competitive tender.

If all the services are to be procured as a group of services the Light Touch regime should be followed, this would equally apply if some of the services are grouped together and the estimated value for them combined exceeds the threshold.

7. FINANCIAL IMPLICATIONS

7.1. The table below outlines the cost and benefits of carrying out this pilot. The pilot is funded from the Better Care Fund (BCF).

	Numbers Assumed through D2A Pilot**	2017/18 6 months £'000	2018/19 full year £'000
Discharge to Assess Team		372	0
Domiciliary Care Packages		156	312
Infrastructure, tracking and evaluation		50	100
Long Term Placements		240	480
Savings from Dom Care (Step 1)	650	-475	-951
Savings from Step Down (Step 2)	156	0	0
Savings from Placements (Step 3)	65	-27	-53
Cost of pilot	**871**	**316**	**-112**

**The pilot will run for six months and then be evaluated.

7.2. As set out in the body of the report shows that considerable savings have been made in pilots in other authorities. A prudent approach has assumed on the savings that may accrue from the pilot in this model based on 15% (other Local Authorities have seen higher savings figures up to 50%). A 15% assumption is reflected in the table above.

7.3. The model assumes that due to the running of the pilot there will be a saving on the level of domiciliary care and residential packages. Assumptions have been made of a 15% reduction in domiciliary care packages and a reduction of placements above the ceiling rate of 70%.

7.4. The assumption is that staffing will double run for six months. During this period the current staffing cohort will be reorganised to enable them to operate under the pilot model. Therefore there will be no additional staffing costs going forward after the six month pilot period.

7.5. It is not possible to accurately calculate the full cost/benefit implications of the pilot. However a report will come back to the executive after six months with a full evaluation and recommended way forward. During the six month period performance and financial information will be captured by the service and reported into the management team.

7.6. From the body of the report it can be seen that there is a risk of a penalty being charged in a form of a reduction in the IBCF if our delayed discharge remains high. In addition, there is a risk to the council of a fine of £155 per day for each DTOC attributable to Social Care and this would equate to a total of £653k penalty charge using 2016/17 figures. It must be noted that although this remains a risk, no financial penalties have been imposed so far. The evaluation of the pilot must evidence the reduction of DTOC in order to mitigate these risks.

7.7. It is assumed that clients going through the D2A pathways will be charged for social care once their assessment has been completed in line with the council's charging policy. Failure to do this will result in a negative impact on the income stream for adult social care.

7.8. Although this is a demand led service the budget available for care packages is capped as per paragraph 3.34.

7.9. It is recognised that any reduction in delayed discharge could result in cost pressures on social care. However, a more effective discharge arrangement could enable more cost effective packages of care following discharge.

8. PERSONNEL IMPLICATIONS

8.1 It will not be possible to create the temporary care management team from existing resources due to pressures on the current workforce. Given the short term nature of the proposed pilot scheme, the team will be sourced using suitably qualified agency workers.

9. LEGAL IMPLICATIONS

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

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

Non-Applicable Sections:	
Background Documents: (Access via Contact Officer)	

Appendix A

Cost for the 6 month pilot

		6 month cost £'000
1 FTE GP	£100ph	96
1 FTE Team Manager	£40ph	38
2 FTE SCM	£35ph	67
2 FTE OT	£20ph	38
2 FTE Care managers	£25ph	48
3 FTE CM assistant	£19ph	55
Training and development		30
Total		372

Appendix A1

Total Delayed Days Local Authority

NHS	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	AVERAGE
Bexley	316	589	420	284	234	100	103	266	91	113	205	189	243
Bromley	137	193	136	165	121	258	203	188	264	160	97	98	168
Croydon	430	342	458	714	797	822	806	580	375	416	459	670	572
Greenwich	108	107	117	309	252	255	372	383	275	191	61	130	213
Lambeth	432	317	375	392	525	432	430	283	429	262	235	391	375
Lewisham	285	371	366	284	336	388	392	432	321	285	207	288	330
LBB Ranking (0=Best; 6=Worst)	2	2	2	1	1	3	2	1	2	2	2	1	
Social Care	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	AVERAGE
Bexley	255	374	361	388	176	166	152	86	192	272	217	364	250
Bromley	284	277	305	264	251	307	341	525	779	348	265	266	351
Croydon	23	12	88	164	201	194	227	221	188	327	354	289	191
Greenwich	221	182	58	175	231	229	473	213	231	111	161	97	199
Lambeth	243	163	162	181	174	245	247	186	134	182	89	168	181
Lewisham	73	141	81	82	67	138	131	86	77	114	110	144	104
LBB Ranking (0=Best; 6=Worst)	6	5	5	5	6	6	5	6	6	6	5	4	
Both	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	AVERAGE
Bexley	30	31	30	65	44	32	29	52	31	31	20	0	33
Bromley	0	0	24	31	63	0	21	42	22	0	0	0	17
Croydon	8	0	0	0	31	34	30	0	0	0	28	31	14
Greenwich	0	0	30	25	31	29	31	0	0	0	0	0	12
Lambeth	49	9	10	6	38	0	17	0	0	0	28	31	16
Lewisham	166	204	123	146	212	50	0	15	0	0	17	16	79
LBB Ranking (0=Best; 6=Worst)	1	1	3	4	5	1	3	5	5	1	1	1	

Bromley												
NHS	137	193	136	165	121	258	203	188	264	160	97	98
Social Care	284	277	305	264	251	307	341	525	779	348	265	266
Both	0	0	24	31	63	0	21	42	22	0	0	0
TTL	421	470	465	460	435	565	565	755	1065	508	362	364
Ranking												

Appendix B

Options Appraisal: reducing Delayed Transfer of Care

Objectives

1. To reduce the numbers of Delayed Transfer of Care associated with social care delays therefore achieving maximum iBCF funding and fulfilling statutory responsibilities
2. Support implementation of the eight High Impact Changes suggested to enable BCF sign off and achieve maximum impact on reducing DToC
3. Ensuring people are supported in the right place, at the right time, to meet their needs to recover and maintain independence in the community reducing the pressure on adult social care services
4. Provide additional support throughout the winter when DToC increase significantly

Options

Option 1: Do nothing
No additional cost
Continue to provide the existing care management service within the Transfer of Care Bureau (ToCB) assessing for the long term care and support needs in an acute setting.

This option would have no impact on the above objectives and delayed transfer of care would likely continue on the upward trajectory.

Option 2: Step-down beds in dedicated, non-acute ward
Unable to cost due to no current resource available
A dedicated ward in the acute/sub-acute hospital to support those who are medically safe for transfer but are awaiting social care support to be discharged safely

This model, used in neighbouring boroughs (including Foxbury ward at St Mary's, Sidcup), provides non-acute care for people no longer requiring consultant led care and support. The ward supported those who have on-going social care needs awaiting assessment and community support.

This option would initially have a significant impact on DToC however the evaluation of the Foxbury unit, and local experience of 'temporary' beds show they quickly become full and the level of impact reduces.

Although there may be scope in the future, the high demand being placed on the PRUH and Orpington means the physical space is not currently available to provide such a service at either of these sites. Consideration to a community-based ward has been made, however currently this resource does not exist in Bromley and therefore the only options would be out of borough.

Option 3: Discharge 2 Assess/Home First
£800k for a 6 month pilot
Discharging patients who are clinically optimised for the assessment of their long term care and support to take place in the community, and wherever possible home.

In line with the agreed nationally prescribed High Impact Changes the Discharge to Assess model moves assessments from an acute setting to the community, and wherever possible home. The model reduces delays in transfer of care by ensuring people are transferred once they are clinically optimised and no longer need a hospital bed ensuring individuals are supported in the most appropriate setting to meet their needs. The D2A model supports the likelihood of regained independence and reduced level of need in the medium to long-term through shorter length of stay.

The model is in line with the Eight High Impact Changes namely High Impact Change 4 Discharge to Assess/Home First. It also supports the Building a Better Bromley priority of Supporting Independence and achieving a Healthy Bromley.

This model would require a period of double running of the hospital Care Management team for a period of 6 months, therefore requiring additional temporary pump-prime funding, while the assessments from the acute hospital are transferred into the community, increasing over a period of time. The double running of the service however provides time to fully explore all options of the model and pilot a range of different approaches to support varying levels of need and complexity, maximise the learning potential of the pilot. For example, supporting those with dementia and/or challenging behaviour at home rather than nursing care, utilising different types of care to maximise recover potential and developing the most appropriate procurement methodology to support on-going commissioning of services in this model.

There is a level of uncertainty associated with this option as it will always be impossible to predict the exact nature of presentations and need at the hospital, however a pilot period, building on neighbouring and national approaches, would

allow the development of a local infrastructure and a proof of concept to be realised to influence activity going forward. Modelled against previous years DToC performance and building on existing local resources would provide a sound basis for undertaking a pilot.

Option 4a: Increased Care Management Capacity at the Hospital
Circa £150k
Increasing care management capacity at the hospital to undertake assessments and broker long term care and support

By increasing the number of care managers at the hospital it is expected assessments will be done quicker and planning for discharge commence earlier due to reduced workload of existing staff. This will likely reduce delayed transfers of care support some delayed transfer of care. This model however does not support the Eight High Impact Changes and will continue to deliver assessment of long-term care and support needs in an acute setting. There is evidence to suggest in some instances assessing need in an unfamiliar environment and when someone is acutely unwell is likely to result in the need for increased levels of care and support, higher than the medium to long-term need. For example elderly patients recovering from a common urinary tract infection (UTI) who have suffered from an associated episode of temporary delirium are likely to require higher levels of support when assessed while still in hospital as appose to when they have returned home to settle and further recover.

Option 4b: Increased Care Management Capacity at the Hospital and reviewing officers
Circa £350k
To ensure on-going care and support is in line with medium to long term functioning, an addition review in the community post discharge

This option would achieve a similar outcome to the Discharge2Assess Model in ensuring on-going care and support is in line with medium to long term functioning. This would increase the steps in the process and place a potential additional pressure on adult social care services.

Option 4a&b would not support longer-term transformation or the Eight High Impact Changes. In addition this is unlikely to have less of an impact on DToC then Option 3.

Option/Impact Matrix

	Objective 1: Impact on DToC (max=5)	Objective 2: 8 HIC (Y=5, N=0)	Objective 3: Right place right time (Order)	Objective 4: Additional support throughout the winter	Total
Option *1*	0	N	1	0	1
Option *2*	2	Y (5)	2	0	9
Option *3*	4	Y (5)	5	5	19
Option *4a*	3	N	3	3	9
Option *4b*	3	N	4	4	11

Recommendation
Option 3, Discharge to Assess/Home First is recommended as the most likely to address all four objectives

Appendix C

Additional Information From Other Local Authority D2A Schemes

1. South Warwickshire

Model

- Assessment for care and therapy needs at home, not in hospital
- Three pathways for three distinct cohorts of patients – but no patient is excluded
- Multidisciplinary team assessing and providing patient care
- Patients referred on within four to six weeks
- Discharge care co-ordinators facilitating patient journey
- 7 day per week service, 8.30am - midnight

Outcome

- Approximately 40 patients per week discharged through pathway 1 (home), 23 through pathway 2 and 5 for pathway 3 per week.
- Admission to residential care has decreased slightly over the past 12 months
- On-going cost of care and support for pathway 2 £226 against non D2A patient at £442 per week
- Positive patient and staff feedback

2. Bexley

Model

- Service users are provided with short term, funded support to be discharged to their own home for assessment for longer-term care and support needs to be undertaken.
- The Bexley model focuses on more complex cases on a single, home based pathway. The model provides significant packages of care at home to support people to return home and prevent admission to long term placement.
- D2A in Queen Elizabeth Hospital commenced as a pilot with one ward in September 2016, with the expansion across the hospital taking place in November 2016
- The Social Care Assistant visits patients at home within 48 hours to undertake the Care Act 2014 needs assessment and Continuing Health Care checklist (to determine if the patient is entitled to a full CHC assessment.)

Outcomes

- 25 patients per week are supported via D2A
- Social Care related DToCs have reduced from 26 in June 2015 to 2 in June 2017

3. Medway

Model

- Service users are assessed by an allied professional within 2 hours of returning home.
- Personalised enablement goals are agreed to maximise recovery.
- Equipment is available at home wihtin 2 hours.
- Service users are continually reviewed in response ot changin needs and transitioned from D2A once maximum potential has been achieved.
- Market development has resulted in a number of agencies with varying specialisms being in place to support D2A pathways.

Outcome

- Supported over 650 discharges from Medway hospital Since April 2016 and November 2016
- Reduction in DToC of 25% in first 3 months
- An average of 32 service users per week are supported through D2A

Appendix D

Case Study (Tower Hamlets) Pathway 1

72-year old woman, Ms T had been in hospital for 5 months due to an infected hip joint, she was not engaging with therapists on ward, it was recommended by the hospital, based on her presentations on the ward for a costly double handed package of care 4 times per day to facilitate discharge. Instead Ms T was referred for D2A. A Physiotherapist and social worker met the patient at home and set up an immediate package of care of 2 carers 4 x day, a hospital bed was provided and continence issues managed. Enablement goals where agreed together with the patient. The OT visited 2 days post discharge – the hospital bed was no longer needed, 6 days later client was walking around her home. Further goals were set to further encourage this. 8 days post discharge the Social worker reduced package of care to 1 carer 3 times per week

Non-D2A

Had this person not been supported on D2A she would have gone home with a large package of care which she would have quickly became dependent on due to decreased functioning therefore likely needing it on an on-going basis. The hospital bed would have also remained at the property impacting on the availability of equipment.

Case Study, Pathway 3

Mr Jones was in hospital for 3 weeks following a urinary tract infection (UTI) which had caused temporary delirium. Mr Jones has Parkinson's and following his recent admission now requires supervision for his mobility and transfers. Mr Jones wife, who was his carer has increasing health conditions and can no longer provide care for Mr Jones at home. It was agreed Mr Jones could no longer be supported safely at home and therefore a placement was required. The D2A team met Mr Jones and created a plan with the provider to support Mr Jones to settle. 2 weeks later Mr Jones was doing extremely well and was settled in his placement. A joint health and social care assessment took place at the same time in the placement with funding being agreed by social care for on-going care and support in line with ceiling rate.

Non-D2A

Had Mr Jones not have been supported through D2A a Continuing Health Care and Social Care Assessment would have been undertaken in hospital assessing his presenting challenging behaviour due to the temporary delirium. Funding would have been agreed then a nursing home sourced. Finding a provider that will support challenging behaviour is extremely difficult and can often take some time. All the whole Mr Jones would have remained in hospital where the risk of infection is high and he is becoming more distressed. His average length of stay would have likely doubled therefore presenting a significant DToC.

Report No.
DRR17/048

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**DEVELOPMENT CONTROL COMMITTEE** **EXECUTIVE**
Date:	**Wednesday 4 October 2017** **Tuesday 10th October 2017**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**LOCAL DEVELOPMENT SCHEME 2017-2019**
Contact Officer:	Mary Manuel, Head of Planning Strategy and Projects Tel: 020 8313 4303 E-mail: mary.manuel@bromley.gov.uk
Chief Officer:	Chief Planner
Ward:	(All Wards);

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1. Reason for report

This report seeks Members' agreement to the amended Local Development Scheme (LDS) for 2017-19 (forming Appendix 1) setting out the revised timescale for the preparation of the Local Plan for the Borough. The current legislative requirements for the LDS are to only include the development plan documents (DPD) which are subject to independent examination. For Bromley this includes the borough-wide Local Plan, submitted in August to the Secretary of State for examination and the Bromley Town Centre Area Action Plan to be reviewed following the Local Plan adoption by the Council. The LDS also shows an indicative timescale for the preparation of a local Community Infrastructure Levy and a new Planning Obligations Supplementary Planning Document (SPD).

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2. RECOMMENDATION(S)

Development Control Committee

2.1 Members are asked to recommend to the Executive that the revised Local Development Scheme for 2017-2019 as set out in Appendix 1 be approved as the formal management document for the production of the Bromley Local Plan and the review of the Bromley Town Centre Area Action Plan.

Executive

2.2 Members are asked to agree the Local Development Scheme for 2017-2019 as set out in Appendix 1 as the formal management document for the production of the Bromley Local Plan.

Impact on Vulnerable Adults and Children

1. Summary of Impact:

Corporate Policy

1. Policy Status: Not Applicable
2. BBB Priority Excellent Council Quality Environment Vibrant, Thriving Town Centres

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Financial

1. Cost of proposal: Estimated Cost £50k - £60k
2. Ongoing costs: Non-Recurring Cost:
3. Budget head/performance centre: Planning Strategy and Projects
4. Total current budget for this head: £32k and £37k
5. Source of funding: Existing revenue budget for 2017/18 and a carry forward sum of £37k

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Personnel

1. Number of staff (current and additional): 6FTEs
2. If from existing staff resources, number of staff hours:

Legal

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

Procurement

1. Summary of Procurement Implications:

Customer Impact

1. Estimated number of users/beneficiaries (current and projected):

Ward Councillor Views

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

3. COMMENTARY

3.1 The Council is required to publish an up to date Local Development Scheme (LDS), setting out the timescale for the preparation of local development plan documents (DPDs). There is no longer a requirement for the LDS to be submitted to Secretary of State. The last LDS approved by the Council was prepared in November 2016.

3.2 The November 2016 LDS showed the submission of the Draft Local Plan in April 2017 following consultation in November/ December 2016. However, the response to the consultation was significant and representations were reported to Development Control Committee and the Executive in June 2017 seeking agreement from Full Council to approve submission to the Secretary of State for examination. Following approval from Full Council the Draft Local Plan was submitted in August 2017. An update to the LDS showing the submission in August 2017 forms one of the supporting documents to the Submission. However, this is the first opportunity to report a revised LDS to Development Control Committee and the Executive and provides an opportunity to also update the timescale for the introduction of a local Community Infrastructure Levy and CIL Charging Schedule.

3.4 The new LDS included as Appendix 1 to this report seeks to reflect the anticipated timescale following submission, the Council's resources and lessons from other authorities and Inspectors' reports regarding timescales. The revised timescale in Appendix 2 to the LDS shows the submission to the Secretary of State in August 2017 and adoption of the Local Plan in June 2018. The Local Plan needs to be in conformity with the London Plan which forms part of the Development Plan for the Borough.

3.5 The introduction of the Community Infrastructure Levy (CIL) will follow the adoption of the Local Plan. The consultation period for each of the two consultation stages of the preparation of the CIL charging schedule is six weeks. On this basis the LDS shows the CIL Examination in Summer 2018 and introduction by the end of the calendar year. The intention is to report to Members in November 2017 seeking approval to undertake consultation on the Preliminary Draft Charging Schedule over Winter 2017/18.

3.6 At this stage it is difficult to estimate the impact of further Government's reforms, and the resources required to incorporate changes as appropriate within the plan making process and associated documents. The Local Development Framework Advisory Panel (LDFAP) has, and will continue to meet regularly to provide guidance and advice with regard to the Local Plan and Bromley Town Centre Area Action Plan review.

3.7 The Local Plan sets the vision and objectives for the Borough, planning policies and site allocations. The number of supplementary planning documents will be kept to a minimum but will include a revised S106 supplementary planning document (SPD) alongside the introduction of a local Community Infrastructure Levy.

3.10 The Local Plan and CIL work is led by the Planning Strategy team which provides the majority of the resources. However, as well as contributions from other Council services, consultants are required to undertaken specialist work and this is included in the Local Plan budget. The Council is responsible for paying the cost of the Examinations of the Local Plan and the Community Infrastructure Levy Charging Schedule which are estimated to be in the region of £40-60k and £25k respectively and includes the Inspector and the Programme Officer's costs.

3.11 The LDS shows the Bromley Town Centre Area Action Plan (BTCAAP) being reviewed following the adoption of the Borough-wide Local Plan. It will part of the Local Plan as a whole, and if there is a need for an early partial review of the Local Plan on the basis of the emerging new London Plan this could be integrated into the BTCAAP review.

4. POLICY IMPLICATIONS

The Local Plan when' Adopted' together with the London Plan and the Bromley Town Centre Area Action Plan, will form the Development Plan for the Borough and will set out the policies against which to consider planning applications . The LDS is a procedural document regarding the preparation of the Local Plan. However, the Local Plan is one of the key strategic documents guiding the development of the Borough and helping deliver the 'Building a Better Bromley' priorities.

5. FINANCIAL IMPLICATIONS

5.1 The cost of the examination of the plan in public is expected to be between £50k and £60k. These costs can be met from a budget of £69k which includes the Local Plan budget of £32k and the carry forward sum of £37k.

5.2 It should be noted that the precise timing of the examination in public is determined by the Planning Inspectorate and is therefore outside of the Council's control.

5.3 The timetable included in Appendix 1 to this report indicates that the Bromley CIL charging schedule should be effective from the end of 2018. With a similar scale of development as in 2015/16, it is anticipated that between £2m and £4m per annum could be generated by Bromley's CIL towards infrastructure.

5.4 There will be a cost for the examination of the CIL charging schedule, which is estimated to be up to £25k. Should the charging schedule be approved and the Council adopt a local CIL, then the costs incurred can be set against future CIL income.

5.5 Once the local CIL is in place, S106 contributions will mainly be for affordable housing, unless specifically negotiated.

6. LEGAL IMPLICATIONS

The Council has a duty to publish an up to date Local Development Scheme.

Non-Applicable Sections:	Impact on Vulnerable Children and Adults, Personnel and Procurement
Background Documents: (Access via Contact Officer)	Report Local Development Scheme 2016-18 Development Control Committee 24.11.16 and Executive 30.11.16

London Borough of

BROMLEY

LOCAL DEVELOPMENT SCHEME

September 2017

Introduction

1.1 The Planning and Compulsory Purchase Act 2004 (The Act) requires the Council to prepare and maintain a Local Development Scheme. This document is the revised Local Development Scheme for Bromley, (also referred to as the LDS). It replaces the November 2016 version. This version has been prepared with regard to the Act and its associated Regulations which set out what is required of an LDS.

1.2 This LDS takes into account the changes in legislation and policy at a national and regional level and the resources available to the Council. It reflects the impact of continued planning reforms, and the London Plan, (as amended in 2016) with which the Local Plan will be required to be in general conformity. The Mayor has publicised his intentions to complete a full review of the London Plan during 2017-2019, with a view to publishing the revised London Plan in Autumn 2019.

1.3 The primary purpose of the LDS is to inform the public about local development plan documents for Bromley and the timescale for their preparation. Planning Practice Guidance (2014) states that local authorities should publish the timescale on its website and keep this up to date.

1.4 Bromley adopted its UDP in 2006, and 'saved' many of its policies in 2009. The Council subsequently worked on its Local Development Framework, and under this system adopted the Bromley Town Centre Area Action Plan and Supplementary Planning Documents for Affordable Housing, and for Planning Obligations. The Council is now preparing Bromley's borough-wide 'Local Plan'.

1.5 There are six different types of planning documents that could potentially be prepared. Their content varies from policies for the use of land, policies for involving the public in planning, guidance and information to procedural documents.

- Development Plan Documents (DPDs)
- Neighbourhood Plans
- Supplementary Planning Documents (SPDs)
- Community Infrastructure Levy (CIL) Charging Schedule
- Statement of Community Involvement (SCI)
- Authority Monitoring Report (AMR)

Development Plan Documents (DPDs) form the Local Plan for the Borough.

1.6 The Bromley Local Plan will be the borough-wide DPD which sets out the overarching strategy for the future development of the Borough to 2030 and detailed policies to manage new developments and incorporates strategic site allocations supporting its delivery. The Bromley Town Centre Area Action Plan (BTCAAP) is an existing adopted DPD (2010) covering a specific part of the Borough, and will therefore be reviewed once the Local Plan is adopted. When reviewed it will form part of the Borough's Local Plan.

1.7 The statutory **Development Plan** for Bromley currently comprises the London Plan (2016), the 'saved' policies of the 2006 UDP, and the Bromley Town Centre Area Action Plan, and is set out in Diagram 1.

1.8 Local Development Documents must be in 'general conformity' with the London Plan, (the Mayor's Spatial Development Strategy).

Neighbourhood Plans

1.9 The Localism Act 2011 makes provision for Neighbourhood Plans to be prepared. Neighbourhood Plans are community-led documents which would be initiated through a Neighbourhood Forum and ultimately adopted by the Council as part of its development plan. Neighbourhood Plans have to be in 'general conformity' with strategic policies in the Local Plan for an area, and are subject to independent examination and a referendum.

1.10 There are currently no Neighbourhood Forums within the Borough and no proposals for Neighbourhood Plans.

Supplementary Planning Documents

1.11 Supplementary Planning Documents are used to amplify planning policy within development plan documents. There is no legal requirement for these to be included within the LDS, and this enables local planning authorities to respond as circumstances change. They do not form part of the 'Development Plan' for the Borough. However, they are 'material considerations' and provide additional detail to existing policy in the development plan or national policy.

1.12 DPDs and SPDs are subject to public consultation. In addition, DPDs are subject to Sustainability Appraisals in their preparation to assess the economic, social and environmental effects of the plans. DPDs are submitted to the Secretary of State for an Independent Examination by a Planning Inspector.

1.13 The Town and Country Planning (Local Planning) England 2012 Regulations sets out the revised procedure for the preparation and review of Local Plans.

Community Infrastructure Levy (CIL) Charging Schedule

1.14 The Community Infrastructure Levy is a charge that local planning authorities may choose to levy on new development to fund infrastructure required to support growth and the delivery of the Development Plan for the area. To date, LB Bromley has used S106 agreements negotiated with developers to secure funding where needed as appropriate. However, restrictions to the pooling of S106 agreements

came into effect from April 2015 to avoid the use of S106 and CIL monies to pay for the same piece of infrastructure. No more than five S106 contributions can be pooled to fund the same type of infrastructure. The CIL Charging Schedule will set out the rates at which CIL will be charged for specific types of development.

Bromley's Current Position

2.1 The Council decided to move to preparing a Local Plan in line with the National Planning Policy Framework rather than a Local Development Framework which it started to prepare and adopted some documents.

2.2 The current Development Plan for the Borough comprises:

- 'saved' policies from the 2006 UDP
- Bromley Town Centre Area Action Plan (2010)
- Affordable Housing SPD (2010)
- Planning Obligations SPD (2010)
- Supplementary Planning Guidance linked to the saved UDP policies
- The London Plan (2016)

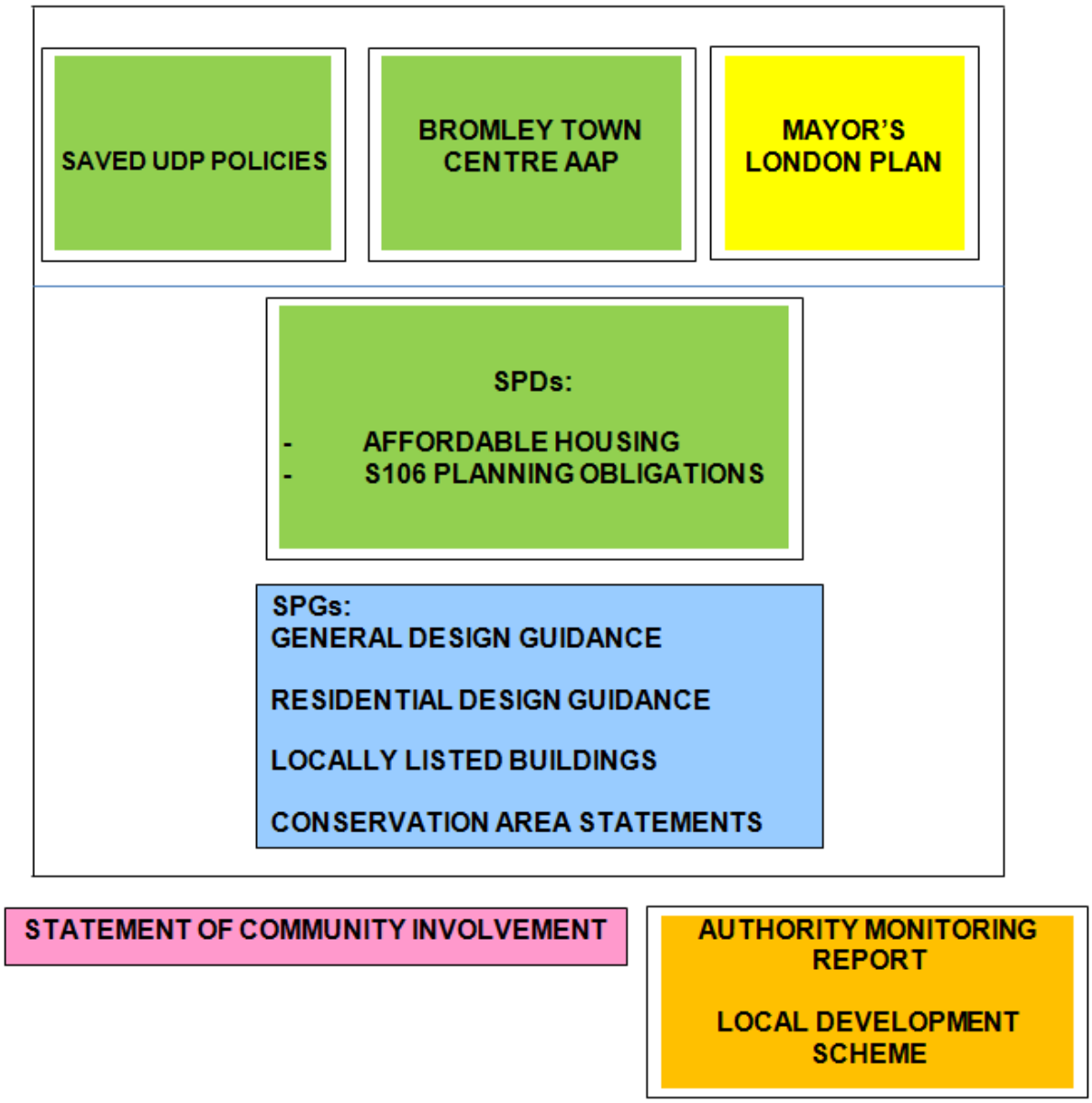
2.3 Diagram 1 illustrates this position.

Saved Policies

2.4 The Unitary Development Plan (UDP) 2006 was saved for three years after adoption by virtue of the Planning and Compulsory Purchase Act 2004. In 2009 the Council successfully sought a Direction from the Secretary of State to retain specific policies beyond this period. Appendix 1 lists the policies 'saved'.

Diagram 1

BROMLEY'S DEVELOPMENT PLAN (CURRENT)



Supplementary Planning Documents

The Council has two adopted Supplementary Planning Documents: 'Affordable Housing', and S106 Obligations'.

Supplementary Planning Guidance

The Council's existing supplementary planning guidance (SPG) can only remain in force while the relevant UDP policies are operational. All are currently linked to 'saved' policies and have been retained as a material

consideration in the determination of planning applications. Table 1 shows the current SPG linkages to 'saved' policies.

Table 1 - Supplementary Planning Guidance

Supplementary Planning Guidance/ Information Leaflets (IL)	Links to saved Unitary Development Plan Policies
General Development Principles	BE1/BE3
Residential Design Extending your homes (IL)	H7/ H8/ H9/ H11
Conservation Area Character appraisals and Guidance	BE9
Shop fronts and security Shutters (IL)	S1/S2/S4/S5/BE9
Archaeology (Fact Sheet)	BE16
Advertisements	BE21

Preparation of the Local Plan

3.1 The Council signalled it would move to a Local Plan with the National Planning Policy Framework (2012) and incorporate the work undertaken so far to progress the Local Development Framework. This included the evidence base which continues to be updated as appropriate, and the Core Strategy Issues Document consultation from 2011. With the Bromley Town Centre Area Action (BTCAAP) adopted in 2010 it was agreed that it would be reviewed after the adoption of the Borough-wide Local Plan. The Borough-wide Local Plan would therefore only include those elements which required updating, for instance, the Bromley North site (former Opportunity Site A); originally included in the Bromley Town Centre Area Action Plan, Policy OSA Bromley North was quashed following a judicial review.

3.2 In 2012 the Council undertook consultation on its Local Plan 'Options and Preferred Strategy' in 2014 its 'Draft Policies and Designations' Document. The issuing of the Draft Policies and Designations Document overlapped with the Mayor of London consulting on the Further Alterations to the London Plan in early 2014. The FALP were consolidated into the London Plan in March 2015. Following the 2015 London Plan, the Council consulted on its Draft Allocations, Further Policies and Designations. The Mayor's minor alternative to the 2015 Plan were incorporated into the London Plan in March 2016. The Council commenced consultation on its Proposed Submission Draft Local Plan in line with Regulation 19 of the Town Planning Regulations 2012 as amended formally, in November 2016.

3.3 There is a period of transition between the old and new systems. The old system is represented by the 'saved policies of the 2006 adopted Bromley Unitary Development Plan (UDP) and currently these together with the Bromley Town Centre Area Action Plan form the Development Plan for the Borough together with the London Plan. Appendix 1 sets out the 'saved' UDP policies. The Government is starting to prepare a new London Plan with the intention to publish in 2019. This will have implications for the Borough and may require a partial review of the Local Plan in 2019/2020 beyond the timescale of this LDS.

Development Plan Documents

3.4 Bromley Borough Local Plan – this will set out the spatial vision and strategic objectives, policies for managing development in the Borough, identify the main sites where development or change is anticipated and the proposals map identifying areas designated for protection or where areas where specific policies will apply. It will incorporate some revised site allocations from the Bromley Town Centre Area Action Plan 2010.

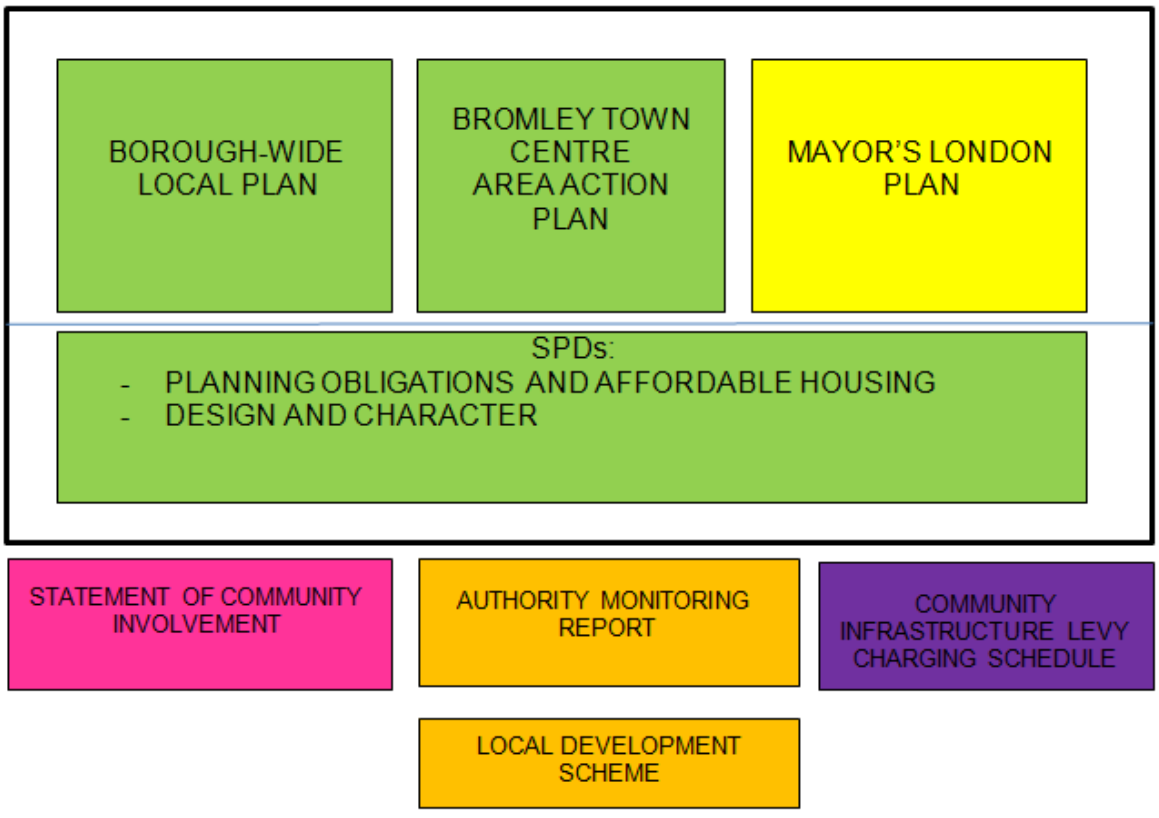
3.5 While the Bromley Town Centre Area Action Plan forms part of the broader Development Plan, it will be reviewed following the adoption of the Borough-wide Local Plan, and will if required include an appropriate early partial review of the Borough-wide Local Plan.

3.6 In addition there will be a Community Infrastructure Levy (CIL) Charging Schedule.

3.7 The timetable for the production of these three documents is detailed in Tables 2, 3 and 4 and shown in summary in Appendix 2. Diagram 2 shows the other documents involved as well.

Diagram 2

BROMLEY'S DEVELOPMENT PLAN (PLANNED)



Supplementary Planning Documents

3.8 The LDS is only required to set out the timetable for Development Plan Documents which have to be subject to an Examination in Public. However, the Council considers it useful to indicate the programme for the S106 Planning Obligations Supplementary Planning Documents which will be prepared alongside the introduction of a Bromley Community Infrastructure Levy.

Planning Obligations – The existing SPD will be reviewed in line with the Borough Local Plan and the introduction of the Borough's Community Infrastructure Levy (CIL).

Affordable Housing – It is anticipated that the existing SPD will be reviewed and updated in light of the Borough Local Plan following its adoption.

Character and Design – This would be a new SPD covering in the main the topics covered by the current SPGs regarding General Design and Residential Design and follow on from the Local Plan.

Other Documents

3.9 Local Development Scheme This document will be kept under review and progress monitored as part of the Authority Monitoring Report.

Statement of Community Involvement (SCI) Bromley's Statement of Community Involvement (SCI) was reviewed in 2016 following public consultation and agreed by the Council's Executive in July 2016. This reflects the greater public access to, and use of information technology.

Neighbourhood Plans There are no current proposals for Neighbourhood Plans within the borough.

Authority Monitoring Report An annual AMR is reported to Development Control Committee and in addition monitoring information is made available on the Council's website and updated throughout the year.

Local Development Document Profiles

3.10 The following tables outline each document proposed to form part of the Bromley Local Plan.

TABLE 2

TITLE	**Borough-Wide Local Plan**	
Development Plan Document	YES	
ROLE & CONTENT	The Local Plan will establish the Vision, Key Objectives and Spatial Strategy for the Borough, reflect the spatial aspirations of the Community Strategy and contain a number of core policies and a monitoring and implementation framework. It will address levels of growth and the strategic distribution of development and will include policies addressing key issues and policies to aid the development management process including a clear strategy for the delivery of its objectives. The Local Plan will include a key diagram identifying the spatial elements of the strategy.	
GEOGRAPHICAL COVERAGE	Borough-wide	
Responsibility for Production	Lead	Planning Strategy Team
	Resources	Planning Strategy Team with input from other services as required
	Stakeholder & Community Involvement	Consultation and engagement in line with the SCI
KEY MILESTONES	▪ Consultation on sites assessed as part of the site allocation process. ▪ Consultation on new Local Green Space Designations, ▪ Consultation on revised Statement of Community Involvement ▪ Draft Local Plan Proposed Submission Consultation ▪ Submission to the Secretary of State and then Examination ▪ Receipt of Inspector's Report ▪ Adoption of the Local Plan by Full Council	Sept/Oct 2015 February/March February/March 2016 November/December 2016 August 2017 Spring 2018 Spring/Summer 2018
REVIEW	The document will be monitored on an annual basis through the Authority Monitoring Report.	

TABLE 3

TITLE	**Community Infrastructure Levy Charging Schedule**
Development Plan Document	NO
ROLE & CONTENT	The document will set out the charges to be levied on new development within the Borough.
GEOGRAPHICAL COVERAGE	Borough-wide

UDP REPLACEMENT	N/A		
Responsibility for Production	Lead	Planning Strategy Team	
	Resources	Planning Strategy Team with input from other services as required	
	Stakeholder & Community Involvement	Consultation and engagement as required by the CIL Regulations 2010 (as amended) and in line with the SCI	
TIMETABLE & KEY MILESTONES	▪ Preliminary Draft Charging Schedule consultation ▪ Publish draft schedule and consults ▪ Submit for examination ▪ Receipt of Inspector's Report ▪ Adopt Charging Schedule		Winter 2017 Spring 2018 Summer 2018 Autumn 2018
REVIEW	The document will be monitored on an annual basis and will then be the subject of review if the monitoring highlights such a need.		

Table 4

TITLE	**Review of Bromley Town Centre Area Action Plan**		
Development Plan Document	YES – part of the Local Plan		
ROLE & CONTENT	The revised BTCAAP will form part of the Development Plan, and set out the ambitions and objectives for Bromley Town Centre within the adopted Local Plan vision and spatial strategy. It will set out the future role of the town centre as an Opportunity Area as defined in the 2016 London Plan and Draft Local Plan. It will address levels of growth of retail, office and residential floorspace, while contributing to an enhancement of the character of the town centre. It will revisit and update site allocations within the town centre, and specific policies to aid the development management process.		
GEOGRAPHICAL COVERAGE	Bromley Town Centre		
Responsibility for Production	Lead	Planning Strategy Team	
	Resources	Planning Strategy Team with input from other services as required	
	Stakeholder & Community Involvement	Consultation and engagement in line with the SCI	
KEY MILESTONES	• Commence review of the BTCAAP. • Issues and Options report • Proposed Submission Town Centre AAP		Summer 2018Winter 2018/19 Summer 2019
REVIEW	The document will be monitored on an annual basis through the Authority Monitoring Report.		

Risk Assessment

4.1 The Council is required in the LDS to set out a clear timetable for the delivery of the local development documents. Therefore it is important to identify the risks that could affect the work programme shown and to consider how these can be minimised and mitigated. The main issue is the impact the risks could have on the programme, although it is important that the plan progresses in compliance with legislation and regulations and is found 'sound' at its Examination to ensure a robust up to date Local Plan at the end of the process.

Table 4 - Risk Assessment

Risk Identified	Likelihood/Impact	Management Action
New policy guidance being published part way through the plan preparation	**Medium/high** Conservative Government has continued the extensive reform of the planning system undertaken by the Coalition Government. Further changes are anticipated.	• High level policy change is monitored. • Plan has to be progressed on the best information available at the time. • Seek advice from the GLA, DCLG and Planning Inspectorate as appropriate.
Loss of staff/reduction in staff resources/competing work priorities. Reduced ability of other departments and partners to contribute effectively and in a timely manner.	**Medium/high** The Council is going through a period of transformation. Loss of experienced staff will impact on the production of local development documents and ability to keep to the timescale. Many partner agencies are also experiencing substantial change and a reduction in resources which may impact on their ability to contribute as planned.	• Staff input from other departments secured at Chief Officer level • Recognition of the importance of the Local Plan and its priority over other work. • Focus resources on the Local Plan and minimise non statutory work • Use work experience, other planning colleagues to contribute • Use consultants for specialist work subject to available funding • If necessary and other alternatives exhausted timetable will need to be reviewed.
Need to meet Duty to Co-operate and undertake joint working with other authorities/partners	**Medium/medium** Other authorities and partners have their own priorities and timetables for development plans which	• Regular Duty to Co-operate meetings with sub-region • Liaison with other authorities and bodies through partnership

	will differ. Inspectors' Reports have highlighted the importance and the extent to which co-operation is expected under this Duty.	groups e.g. Borough Officers Group, Partnership Officer Group ,South London Partnership, London Councils as well as co-operating with individual authorities/partners
Insufficient budget for preparation of plans or evidence base work and consultation	**Low/high** sufficient financial resources are required to prepare local development documents including for consultancy, consultation and the examination process	• Budget required for known studies and consultation already built in to Council budget, however, Examination Costs can only be estimated at this time. • CIL costs can be set against future CIL income • Ways to add value to work, e.g through joint commissioning as with South East London Housing Partnership • Ensure future likely examination and associated costs are considered within the Council budgeting process and set aside as far as possible.
Capacity of the Planning Inspectorate and other agencies to support the process	**Low/high** Decisions taken nationally to change the resources of statutory agencies and their capacity to deal with consultations or the programme Examination process could cause delays	• Liaise with Planning Inspectorate in revising the LDS and keep PINS up to date if the timetable changes. • Maintain contact with key agencies to minimise prospect of slippage
Consultation fatigue amongst the public	**Medium/high** Other parts of the Council and other partner agencies undertake consultation and communities can get 'fatigued' of being consulted.	• Evidence to suggest good level of involvement, especially for future stages involving site allocations and planning policies • Keep the public informed of the process. • Link with other Council and partner consultation where possible
Delay due to scale of public response	**Medium/high** Public Interest particularly in site allocations and detailed policies can be high.	• Continue to encourage the public to respond on line to enable easier and effective analysis of responses.
A requirement to carry out further studies in light of the	**Medium/High** New national, regional policy or guidance, change	• Review of progress, changing policies, 'needs' assessment , and land availability

site assessment work or changes in national/regional policy or guidance to ensure that Draft Plan is 'sound'.	in market conditions for instance may mean the Council has to undertake new/additional research or evidence.	
Demand on staff and other resources to inform the preparation of a new London Plan and advance Bromley's position or update the Local Plan and supporting documents in light of the London Plan review.	**High** The GLA have started preparing evidence for a new London Plan, and are requiring information and contributions from Boroughs.	• Early and ongoing discussions with the GLA • Scheduling local evidence gathering and research where possible use London wide data and GLA resources where possible

Local Plan Evidence Base

5.1 Local Development Documents are required to be underpinned by up to date evidence. The Council has undertaken, and where necessary commissioned research to support the preparation of the plan and this is available via the 'bromley.gov.uk' website. However, the Council has an obligation to keep its' evidence up to date and will undertake new studies as necessary and review existing evidence in a timely manner. The GLA is commencing the preparation of a new London Plan, and officers will seek to draw on London evidence where possible, and ensure local evidence is used to state and advance the Borough's position within any new London Plan.

Duty to Co-operate

6.1 The Duty to Co-operate was created in the Localism Act 2011, and amends the Planning and Compulsory Purchase Act 2004. It places a legal duty on local planning authorities, county councils in England and public bodies to engage constructively, actively and on an ongoing basis. The Council has set out its collaborations and outputs required to comply with the Duty in its "Statement of Compliance with the Duty to Cooperate" which accompanies the Local Plan submission.

6.2 The strategic priorities the Government expects joint working includes where appropriate:

- The homes and jobs needed in the area; and
- The provision of retail, leisure and other commercial development.

- The provision of infrastructure for transport, telecommunications, waste management, water supply, wastewater, flood risk, and coastal change management, and the provision of mineral and energy (including heat);
- The provision of health, security, community and cultural infrastructure and other local facilities,; and
- Climate change mitigation and adaptation, conservation and enhancement of the natural and historic environment, including landscape.)

6.3 The Duty to Co-operate covers a number of public bodies in addition to councils. These bodies are set out in Part 2 of the Town and Country Planning (Local Planning) (England) Regulations 2012 and comprise:

6.4

Environment Agency
Historic Buildings and Monuments Commission for England (English Heritage)
Natural England
Mayor of London
Civil Aviation Authority
Homes and Community Agency
Clinical Commissioning Groups
National Health Service Commissioning Board
Office of the Rail Regulator
Highways Agency
Transport for London
Integrated Transport Authorities
Highway Authorities
Marine Management Organizations

6.5 These bodies are required to co-operate with councils on issues of common concern to developing sound local plans. Local Enterprise Partnerships and Local Nature Partnerships are not covered by the Duty but local planning authorities have to co-operate with LEPs and LNPs having regard to their activities as they relate to Local Plans.

6.6 The Council has, and continues to undertake a range of work to ensure the Duty to Co-operate is met. This includes one to one meetings with neighbouring authorities on specific issues, and specific stages in the preparation of respective development plan documents, meeting with groups of authorities, for instance South East London boroughs, boroughs adjoining Crystal Palace, participating in London wide initiatives and Bromley's non-London neighbouring authorities,. These include adjoining parishes, Dartford, Sevenoaks and Tandridge Councils, and Kent and Surrey County Councils.

6.7 Specific work is undertaken on a cross borough basis, for instance, the joint Strategic Housing Market Assessment undertaken jointly with Bexley, Southwark, Greenwich and Lewisham, as the five boroughs that make up the established South East London Housing Market Area. Working with authorities and other partners through Biggin Hill Consultative Committee and the Locate Initiative are also examples of the Duty to Co-operate.

Appendix 1

‘Saved’ policies from the 2006 UDP

Housing policies
H1 Housing Supply
H2 Affordable Housing
H3 Affordable Housing – payment in lieu
H4 Supported Housing
H6 Gypsies and Travelling Show People
H7 Housing Density and Design
H8 Residential Extensions
H9 Side Space
H10 Areas of Special Residential Character
H11 Residential Conversions
H12 Conversion of Non-Residential Buildings to Residential Use
H13 Parking of Commercial Vehicles

Transport policies
T1 Transport Demand
T2 Assessment of Transport Effects
T3 Parking
T4 Park and Ride
T5 Access for People with Restricted Mobility
T6 Pedestrians
T7 Cyclists
T8 Other Road Users
T9 Public Transport
T10 Public Transport
T11 New Accesses
T12 Residential Roads
T13 Unmade Roads
T14 Unadopted Highways
T15 Traffic Management
T16 Traffic Management and Sensitive Environments
T17 Servicing of Premises
T18 Road Safety

Conservation and the Built Environment
BE1 Design of New Development
BE2 Mixed Use Development
BE3 Buildings in Rural Areas
BE4 Public Realm
BE5 Public Art
BE7 Railings, Boundary Walls and Other Means of Enclosure
BE8 Statutory Listed Buildings
BE9 Demolition of a listed building
BE10 Locally Listed Buildings
BE11 Conservation Areas
BE12 Demolition in conservation areas
BE13 Development adjacent to a conservation area
BE14 Trees in Conservation Areas
BE15 Historic Parks and Gardens
BE16 Ancient Monuments and Archaeology
BE17 High Buildings
BE18 The Skyline
BE19 Shopfronts
BE20 Security Shutters

BE21 Control of Advertisements, Hoardings and Signs
BE22 Telecommunications Apparatus
BE23 Satellite Dishes

The Natural Environment
NE1 Development and SSSIs
NE2 Development and Nature Conservation Sites
NE3 Nature Conservation and Development
NE4 Additional Nature Conservation Sites
NE5 Protected Species
NE6 World Heritage Site
NE7 Development and Trees
NE8 Conservation and Management of Trees and Woodlands
NE9 Hedgerows and Development
NE11 Kent North Downs Area of Outstanding Natural Beauty
NE12 Landscape Quality and Character

Green Belt and Open Space
G1 The Green Belt
G2 Metropolitan Open Land
G3 National Sports Centre Major Developed Site
G4 Extensions/Alterations to Dwellings in the Green Belt or on Metropolitan Open Land
G5 Replacement Dwellings in the Green Belt or on Metropolitan Open Land
G6 Land Adjoining Green Belt or Metropolitan Open Land
G7 South East London Green Chain
G8 Urban Open Space
G9 Future Re-Use of Agricultural Land
G10 Development Related to Farm Diversification
G11 Agricultural Dwellings
G12 Temporary Agricultural Dwellings
G13 Removal of Occupancy Conditions
G14 Minerals Workings
G15 Mineral Workings – Associated Development

Recreation, Leisure and Tourism
L1 Outdoor Recreation and Leisure
L2 Public Rights of Way and Other Recreational Routes
L3 Horses, Stabling and Riding Facilities
L4 Horses, Stabling and Riding Facilities – joint applications
L5 War Games and Similar Uses
L6 Playing Fields
L7 Leisure Gardens and Allotments
L8 Playing Open
L9 Indoor Recreation and Leisure
L10 Tourist-Related Development – New Development
L11 Tourist-Related Development – Changes of Use

Business and Regeneration
EMP1 Large Scale Office Development
EMP2 Office Development
EMP3 Conversion or redevelopment of Offices
EMP4 Business Areas
EMP5 Development Outside Business Areas
EMP6 Development Outside Business Areas – non conforming uses
EMP7 Business Support
EMP8 Use of Dwellings for Business Purposes
EMP9 Vacant Commercial Sites and Premises

Town Centres and Shopping
S1 Primary Frontages
S2 Secondary Frontages
S3 The Glades
S4 Local Centres
S5 Local Neighbourhood Centres, Parades and Individual Shops
S6 Retail and Leisure Development – existing centres
S7 Retail and Leisure Development – outside existing centres
S8 Petrol Filling Stations
S9 Food and Drink Premises
S10 Non-Retail Uses in Shopping Areas
S11 Residential Accommodation
S12 Markets
S13 Mini Cab and Taxi Offices

Biggin Hill
BH1 Local Environment
BH2 New Development
BH3 South Camp
BH4 Passenger Terminal/Control Tower/West Camp (Area 1)
BH5 Former RAF Married Quarters (Area 2)
BH6 East Camp
BH7 Safety
BH8 Noise Sensitive Development

Community Services
C1 Community Facilities
C2 Communities Facilities and Development
C4 Health facilities
C5 Facilities for Vulnerable Groups
C6 Residential Proposals for People with Particular Accommodation
C7 Educational and Pre-School Facilities
C8 Dual Community Use of Educational Facilities

Environmental Resources
ER2 Waste Management Facilities
ER9 Ventilation
ER10 Light Pollution
ER11 Hazardous Substances
ER16 The Water Environment
ER17 Development and the Water Environment

Implementation
IMP1 Planning Obligation

Appendix 2

Revised Provisional Table for the Preparation of the Local Plan and Community Infrastructure Levy

	2016												2017												2018												2019						
	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July
Borough-wide local plan including spatial, strategic, and detailed development policies and site allocations		LG Space Consultation									Formal Pre-Submission Consultation Draft Local Plan								S											A														
Review of Bromley Town Centre Area Action Plan																														Commence Review BTCAAP						Issues and Options Consultation						Proposed Submission BTCAAP	
Bromley Preparation of Community Infrastructure Levy Charging Schedule																								Preliminary Draft Charging Schedule				Draft Charging Schedule				S			A							
SPD Planning Obligations & Affordable Housing																										Draft SPD Consultation							A										

Notes

S' refers to Submission to the S/S for examination.
'A' refers to Adoption by the Council.

The GLA is preparing a new London Plan with anticipated formal consultation in 2017, Examination in 2018 and publication in Autumn 2019