



THE LONDON BOROUGH  
www.bromley.gov.uk

BROMLEY CIVIC CENTRE, STOCKWELL CLOSE, BROMLEY BRI 3UH

TELEPHONE: 020 8464 3333

CONTACT: Kerry Nicholls  
*kerry.nicholls@bromley.gov.uk*

DIRECT LINE: 020 8313 4602

FAX: 020 8290 0608

DATE: 29 September 2017

To: Members of the  
**CARE SERVICES POLICY DEVELOPMENT AND SCRUTINY COMMITTEE**

Councillor Mary Cooke (Chairman)  
Councillor Pauline Tunnicliffe (Vice-Chairman)  
Councillors Ruth Bennett, Kevin Brooks, Judi Ellis, Robert Evans, Will Harmer,  
David Jefferys, Terence Nathan and Charles Rideout QPM CVO

Linda Gabriel, Healthwatch Bromley  
Justine Godbeer, Bromley Experts by Experience  
Rosalind Luff, Carers Forum  
Lynn Sellwood, Bromley Safeguarding Adults Board and Voluntary Sector Strategic  
Network

A special meeting of the Care Services Policy Development and Scrutiny Committee  
will be held at Bromley Civic Centre on **MONDAY 9 OCTOBER 2017 AT 7.00 PM**

MARK BOWEN  
Director of Corporate Services

**Paper copies of this agenda will not be provided at the meeting. Copies can be printed off at <http://cds.bromley.gov.uk/>. Any member of the public requiring a paper copy of the agenda may request one in advance of the meeting by contacting the Clerk to the Committee, giving 24 hours notice before the meeting.**

**Items marked for information only will not be debated unless a member of the Committee requests a discussion be held, in which case please inform the Clerk 24 hours in advance indicating the aspects of the information item you wish to discuss**

## A G E N D A

### PART 1 AGENDA

**Note for Members:** Members are reminded that Officer contact details are shown on each report and Members are welcome to raise questions in advance of the meeting.

### STANDARD ITEMS

#### 1 APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTE MEMBERS

**2 DECLARATIONS OF INTEREST**

**3 HOLDING THE PORTFOLIO HOLDER AND EXECUTIVE TO ACCOUNT**

**4 PRE-DECISION SCRUTINY OF EXECUTIVE REPORTS**

**a IMPROVED BETTER CARE FUND (Pages 3 - 14)**

**b INTEGRATED CARE NETWORKS UPDATE (Pages 15 - 20)**

**c DISCHARGE TO ASSESS (D2A) PILOT (Pages 21 - 38)**

.....

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

**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 30<sup>th</sup> 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. RECOMMENDATIONS**

**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: Applicable: Executive decision.
- 

### 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
- 

### 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 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 mental 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



	<p>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).</p> <p>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.</p>	
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	<p>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.</p> <p>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</p>	£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
<b>Total</b>		<b>£597k</b>

#### 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 employ 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.

### **Grant Condition 2 - 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 whilst 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**

- 5.1 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**

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

## **7. PROCUREMENT IMPLICATIONS**

- 7.1 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:

	<u>2017/18</u> <u>£'000</u>	<u>2018/19</u> <u>£'000</u>	<u>2019/20</u> <u>£'000</u>
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	<b>2,349</b>	<b>375</b>	<b>275</b>
 <u>Grant condition 2</u>			
	<u>2017/18</u> <u>£'000</u>	<u>Recurring</u> <u>2018/19</u> <u>£'000</u>	<u>Recurring</u> <u>2019/20</u> <u>£'000</u>
Support for Integrated care Networks	989	989	989
Discharge to assess in Extra Care Housing	400	180	180
Sub total for grant condition 2	<b>1,389</b>	<b>1,169</b>	<b>1,169</b>
 <u>Grant condition 3</u>			
	<u>2017/18</u> <u>£'000</u>	<u>Recurring</u> <u>2018/19</u> <u>£'000</u>	<u>Recurring</u> <u>2019/20</u> <u>£'000</u>
Safeguarding	156	156	156
Direct payments Lead	90	0	0
Market Development and support	200	0	0
Sub total for grant condition 3	<b>446</b>	<b>156</b>	<b>156</b>
<b>Total IBCF expenditure</b>	<b>4,184</b>	<b>1,700</b>	<b>1,600</b>
IBCF Allocation	<b>-4,184</b>	<b>-3,363</b>	<b>-1,677</b>
Unallocated IBCF	<b>0</b>	<b>-1,663</b>	<b>-77</b>

- 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

- 9.1 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

- 10.1 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

<b>Non-Applicable Sections:</b>	
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](mailto: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.
- 

## 2. RECOMMENDATIONS

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; and,
- (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:
•	<ul style="list-style-type: none"> <li>• 27 of these clients received an enhanced care package after their contact with the ICN</li> </ul>

•	• 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	Cost to ASC
	Prior to ICN	After Contact with ICN
	£'000	£'000
<b>Actual Weekly Costs</b>	28	35
<b>Projected Annual Effect</b>	1,460	1,825
<b>Differential</b>		<b>365</b>

- 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:-

<b>Additional ICN Costs</b>	<b>Full year</b>	
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	
<b>Total Costs</b>	<b>779</b>	

- 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 health 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.

<b>Non-Applicable Sections:</b>	
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 9<sup>th</sup> October 2017**

**Date:** 10<sup>th</sup> 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.
- 

## 2. RECOMMENDATIONS

- 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: n/a

### 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

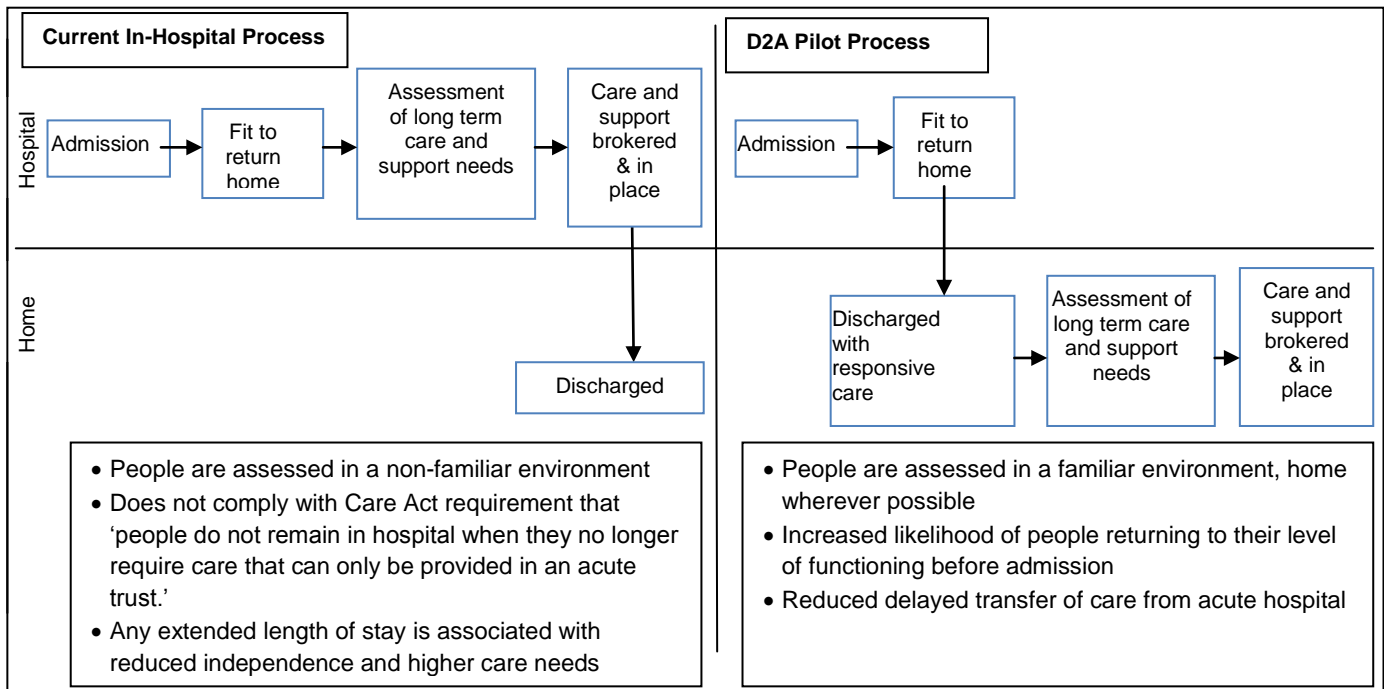
- 3.16. An option appraisal (attached as **Appendix B**) was undertaken to identify how best to achieve the following outcomes.
- Provide additional support throughout the winter when demand on the system, including numbers of assessments and DTtoC, increase significantly
  - Ensuring people are supported 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 DTtoC 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.

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

### 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**

- 6.1 There are no identified procurement implications for LBB as the CCG will undertake the procurement for Recommendations 2, 3 and 4.
- 6.2 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.
- 6.3 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	2017/18	2018/19
	Assumed	6 months	full year
	through		
	D2A		
	Pilot**	£'000	£'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
<b>Cost of pilot</b>	<b>871</b>	<b>316</b>	<b>-112</b>

\*\*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.

<b>Non-Applicable Sections:</b>	
Background Documents: (Access via Contact Officer)	



## 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
<b>Total</b>		<b>372</b>

## 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
<b>LBB Ranking (0=Best; 6=Worst)</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>1</b>	
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
<b>LBB Ranking (0=Best; 6=Worst)</b>	<b>6</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>6</b>	<b>6</b>	<b>5</b>	<b>6</b>	<b>6</b>	<b>6</b>	<b>5</b>	<b>4</b>	
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
<b>LBB Ranking (0=Best; 6=Worst)</b>	<b>1</b>	<b>1</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>1</b>	<b>3</b>	<b>5</b>	<b>5</b>	<b>1</b>	<b>1</b>	<b>1</b>	

## 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
<b>TTL</b>	<b>421</b>	<b>470</b>	<b>465</b>	<b>460</b>	<b>435</b>	<b>565</b>	<b>565</b>	<b>755</b>	<b>1065</b>	<b>508</b>	<b>362</b>	<b>364</b>

Ranking

**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 DTtoC 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 DTtoC 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

**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 within 2 hours.
- Service users are continually reviewed in response to changing 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

**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 were 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 become 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 while 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 DTtoC.