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

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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. 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.

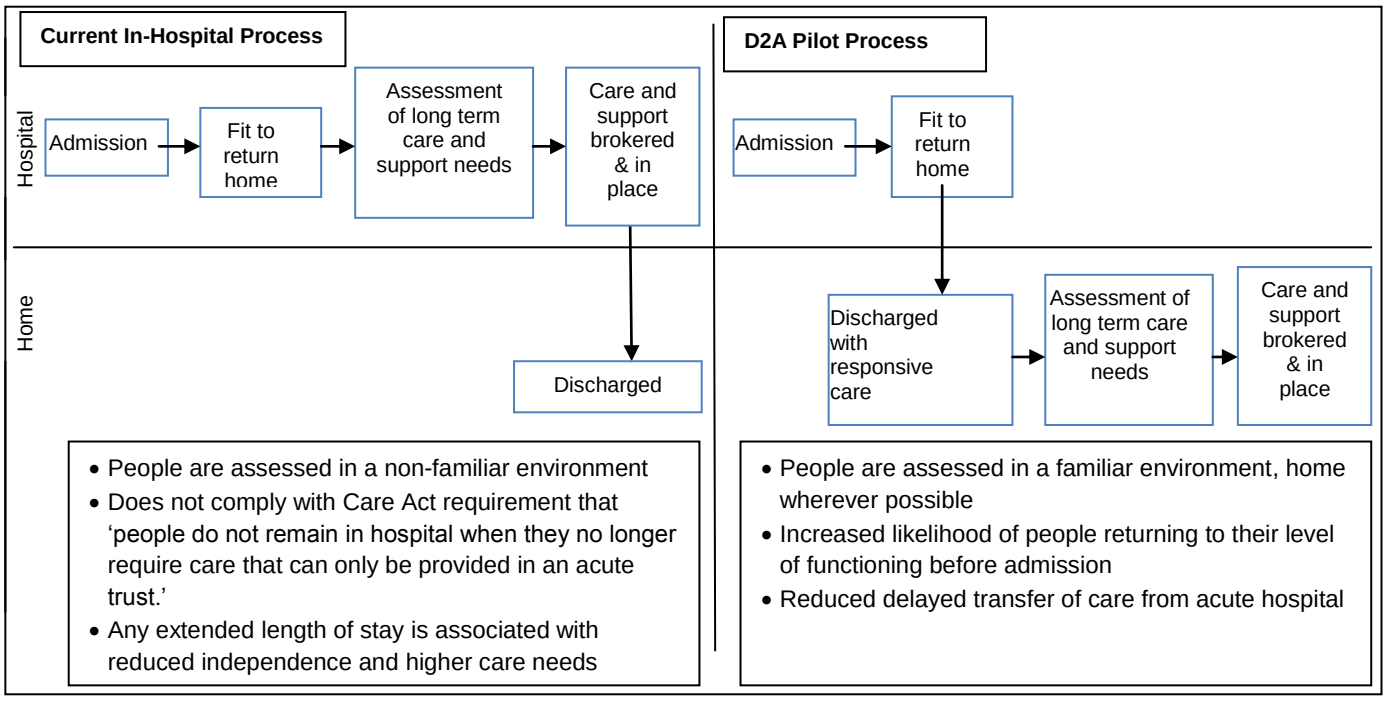
- Provide additional support throughout the winter when demand on the system, including numbers of assessments and DToC, increase significantly
- Ensuring people are supported in the right place, at the right time, to meet their needs to recover and maintain independence in the community reducing the 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

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 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.