Report No.
ACH19011

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**21 November 2019**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**Better Care Fund (BCF) and Improved Better Care Fund (iBCF) 19/20 Quarter 1 and Quarter 2 Performance Report**
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Ward:	All Wards

1. Summary

This report provides an overview of the performance of both the Better Care Fund and the Improved Better Care Fund 2019/20 on both expenditure and activity for quarter 1 and 2 (period between April 2019 and up to the end of September 2019).

2. Reason for the report going to Health and Wellbeing Board

The purpose of this report is to provide the Health & Wellbeing Board with an overview of the first two quarters performance for the Better Care Fund and the Improved Better Care Fund for 2019/20.

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

That the Health & Wellbeing Board notes the performance and progress of both the BCF and iBCF schemes as well as the latest financial position for quarter 1 and 2 of 2019/20.

Health & Wellbeing Strategy

1. Related priority: Not Applicable

Financial

1. Cost of proposal: BCF: £23,854k for 2019/20; iBCF: £6,313k in 2019/20

2. Ongoing costs: BCF: £23,854k for 2019/20; iBCF: £6,313k in 2019/20

3. Total savings: n/a

4. Budget host organisation: LBB

5. Source of funding: Section 31 Grant, Ministry of Housing, Communities & Local Government (previously DCLG)

6. Beneficiary/beneficiaries of any savings: London Borough of Bromley and Bromley CCG

Supporting Public Health Outcome Indicator(s)

Not Applicable:

4. COMMENTARY

4.1 The Better Care Fund (BCF) grant is ring fenced for the purpose of pooling budgets and integrating services between Bromley Clinical Commissioning Group (BCCG) and the local authority (LA)

4.2 The Improved Better Care Fund (iBCF) was a new funding element added to the Better Care Fund from 2017-18 which is paid to local government as a direct LA grant for spending on adult social care. The 2017 Spring Budget announced additional funding for social care from 2017-18 to 2019-20.

4.3 In order to ensure that local areas are meeting the standard conditions of the Fund it is a requirement to report progress against the agreed plan including expenditure to NHS England on a quarterly basis.

4.4 The purpose of this report is to provide the Health & Wellbeing Board with an overview of the first and second quarter's performance for the Better Care Fund and the Improved Better Care Fund for 19/20.

Better Care Fund - Performance Metrics

4.5 Bromley is responding to the following national metrics with the BCF:
a. Reduction in non-elective admissions
b. Delayed transfers of care (DTOCS) (delayed days)
c. Rate of permanent admissions to residential care per 100,000 population
d.Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.

a. Non-elective admissions (emergency admissions)

	NE Admissions	Actual Quarter Performance#	Quarterly Plan	Variance
Apr-19	2134			
May-19	2249			
Jun-19	2092	6475	6589	-114
Jul-19	2392			
Aug-19	2193			
Sep -19	Published in Nov 19	4585(Jul & Aug)	6659	N/A

#Actual Quarter Performance is derived from Secondary Uses Service health data repository (SUS) activity.

4.6 Quarter 1 saw non-elective admissions into the hospital reported within plan with the first five months of the year showing no clear trend upwards or downwards.

4.7 Work is progressing on a number of schemes as part of the One Bromley programme aimed at reducing the pressure on the non-elective admissions, particularly in the run up to the winter months. This includes the continued evolution of the integrated care network pro-active care

pathway, development of the @home scheme and also the implementation of pathways to support frail patients inside and outside hospital.

4.8 At the time of this report, September figures were not available (due to the reporting schedule). Consequently we do not currently have a complete picture for quarter 2.

b. Delayed Transfers of Care (DToCS)

4.9 For 2019/20 Bromley's target has increased from 10.31 bed days per day to 12.5. This is the overall figure for Bromley which includes DToC's due to both NHS and/or Social Care.

4.10 Quarter 2 data is available for July & August 2019, with September 2019 data due to be published in mid November 2019. However the table below (2019/20 Actuals) illustrates progress:

		19-20 plans			
		Q1 (Apr 19 - Jun 19)	Q2 (Jul 19 - Sep 19)	Q3 (Oct 19 - Dec 19)	Q4 (Jan 20 - Mar 20)
Delayed Transfers of Care (delayed days)	**Number**	**1137**	**1150**	**1150**	**1137**

		19-20 actuals#			
		Q1 (Apr 19 - Jun 19)	Q2 (Jul 19 - Sep 19)	Q3 (Oct 19 - Dec 19)	Q4 (Jan 20 – Mar 20)
Delayed Transfers of Care (delayed days)	**Number**	**633**	**274 (Jul & Aug)**		

Actual performance derived from NHS England Delayed Transfers of Care Data 2019/20
https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

c. Admissions to residential care

		Planned FYE 19/20	Qtr 1 Actual	Qtr 2 Actual	Qtr 3 Actual	Qtr 4 Actual
Long term support of older people (aged 65 and over) met by admission to residential and nursing homes per 100,000 population (57,626 in Bromley)	**Number**	425.0 (245 admsns)	112.5 (65 admsns)	216.3 (125 admsns)		

4.11 As detailed in the table above (c) the admissions to residential care are currently on course to exceed our target of 425.0 per 100,000 of the population. Due to the continuing drive to promote independence by supporting people in their own homes, more people are being admitted to residential placements with enduring, ever increasing and more complex needs. This in turn is resulting in the reduction of the average length of stay, therefore resulting in a higher turnover of admissions.

4.12 One of the LBB primary aims is to support people in their own home for as long as is possible. Where this is no longer feasible the aim is to ensure that the best possible care is delivered within the allocated resources.

4.13 The progress made in delivering more robust Transfer of Care pathways (as detailed within DToC narrative) is complemented through the delivery of temporary bridging reablement, where existing markets cannot pick up this demand. LBB are also working with our voluntary sector to strengthen their service offer and pathways between our statutory and voluntary/charitable sector to maximise early intervention and prevention opportunities. For example via the partnership with Bromley Well.

d. Reablement

		Planned/ Target 19/20	Qtr 1 Actual	Qtr 2 Actual	Qtr 3 Actual	Qtr 4 Actual	Qtr 4 Actual 18/19
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	**Annual %**	90.1%	98.6%				93.1%
	Number	446/495	73/74	Not available until the end of December 19	Not available until the end of March 20	Not available until the end of June 20	(339/364)

4.14 There is a 91 day lag on reablement data. This resulted in the 2018/19 Q4 HWB report not including the 'actuals' which are incorporated in the table above. Due to the same lag, Q1 'number' is a partial indicator.

4.15 Since quarter 4 (18/19) we have maintained current commitments around the delivery of reablement as well as linked this with our early intervention and prevention offer through joint working with our voluntary sector and at the point of discharge from the hospital. Robust plans are in place to maintain performance and ensure early planning, so that Reablement opportunities for local residents can be maximised. We are also strengthening the alignment between Reablement and Bromley Well, in order to maximise opportunities for preventative work that can be done with residents following a period of crisis in the community or following discharge from an acute ward.

4.16 The Take Home and Settle service, delivered by Bromley Well has significantly increased the number of residents accessing early intervention services post discharge from hospital and positively impacted on the number of residents with multiple re-admissions following discharge from an acute setting.

Update on BCF Schemes

i) Self-Management & Early Intervention – Bromley Well

4.17 The Bromley Well service provides a Single Point of Access (SPA) for local people to prevent them from falling into a crisis and improve their health, wellbeing and independence.

4.18 The service is designed to help the residents of Bromley to stay well through a range of early intervention and prevention Interventions (Pathways) and targets those clients who may be at risk of needing long term packages of care or at risk of a hospital admission. This service also seeks to address a number of wider issues that affect an individual's personal outcomes such as housing, debt, health and social issues.

4.19 Bromley Well has 10 pathways which are detailed below:

- Single Point of Access
- Young Carers

- Adults with Long Term Health Conditions
- Elderly Frail
- Employment and Education
- Adults with Learning Disabilities
- Adults with Physical Disabilities
- Carers Support services
- Mental Health services
- Support to the Sector

Adults with Long Term Health Conditions (LTHC)

4.20 Practical Support continues to be one of the main service facets. During quarter 1 and quarter 2 for example, 318 people had support and care plans developed.

4.21 The performance indicator which denotes whether or not people felt more confident, following training, to make positive lifestyle changes to support good health and wellbeing averaged at 97%.

4.22 Work is underway to include the Bromley Healthcare Dental Service within the LTHC support groups to provide talks on oral hygiene and information about dental services that are available within Bromley. The LTHC team in partnership with Blood Pressure UK & Bromley Public Health facilitated its second 'Know Your Numbers' blood pressure awareness event at Bromley Library. Individuals were given information about how to manage / lower their blood pressure as well as information on forthcoming health & wellbeing workshops in Penge & Orpington beginning in September 2019.

4.23 The LTHC team has provided four support groups including people from Darrick Wood, St Andrews Church & Sycamore Lodge as well as Stress Busting Support groups for the Bromley Well Adult Carers service & an ongoing Fibromyalgia Support group which is facilitated by two peer health mentors.

4.24 The Self-Management Groups and Professional Training element of the service has included Health and Well-Being workshops at Newman Court, Sheridan Lodge, Penge and Orpington Village Hall. The team are planning potential future workshops in Stanley Glynn Lodge, Evelyn Rogers Court, Merlin Court & Ralph Perring Court following the Lifestyle Coordinator providing talks with the residents at these sheltered schemes.

Elderly Frail Pathway

4.25 This pathway includes the following services:

- Take Home and Settle
- Sitting Service
- Handyperson
- Hospital After Care (6 - week hospital aftercare)
- Befriending

4.26 The Sitting Service and Take Home and Settle Service are underperforming due to the following issues:

Take Home and Settle

i) The provider organisation has been a member of staff down since the end of May 2019. However the provider has stated that the annual target of 500 will be met by the end of the year. Volunteer illness has also impacting on the service over quarter 1 and 2.

Sitting Service

ii) There has been a drop in referrals due to not having the 'hospital link' post in place, however the new recruit will be addressing this and increasing the number of successful referrals.

4.27 Conversely the befriending service is over performing and has already exceeded its full year target.

Employment and Education

4.28 There has been positive progress in quarter 1 and quarter 2, resulting in employment targets for people with LTHC, mental health issues and learning disabilities being met or exceeded. The targets for physical disabilities are also on track.

4.29 The service worked with the following organisations to help generate outcomes for their clients:

KeyRing / Coventry University / Superhero Series / Jarrett and Lamb / Dream Abstract Design / Ignition Brewery / Food for the Soul / Wimbledon Football club / Tesco / Lush / Penge Green Gym / the Factory Outlet Shop / Mytime Active / Beckenham library / Primark / Crispy Cream / Moss Bros / McDonald's / Coop funeral services / Peabody Trust / TfL.

Learning Disability Pathway

4.30 During quarter 1 and quarter 2 outreach visits were made to Bromley Jobcentre Plus and Disability Training delivered at which the Support Officer attended. The numbers of people with autism being referred to the service has continued to increase.

4.31 Drop-ins are all currently being delivered bi-weekly at Bromley Jobcentre Plus, Mottingham Community Learning Shop and Cotmandene Community Resource Centre.

4.32 Tribunals were attended to challenge DWP benefit decisions; one for Employment and Support Allowance (ESA) and four for Personal Independence Payment (PIP). In one case PIP was reinstated, securing an extra £148.85 per week and a back-payment of £13,992.

4.33 This service has met or exceeded all of the targets.

Physical Disabilities

4.34 The monthly workshops have focussed on the themes of budgeting, dealing with/avoiding falling into debt and awareness of loan sharks. Workshops are popular with the last two oversubscribed.

4.35 Clients have been supported at face to face assessments and medical appointments. This support is necessary for some clients that find these situations stressful and difficult and who may ultimately not attend their appointments and lose financial assistance.

4.36 The telephone support volunteers continue to provide support to people that make contact. Clients have also been supported to complete successful applications for blue badge, taxicard and Dial-a-Ride, reducing isolation.

4.37 The service is meeting the set targets, and exceeding the target for '% of clients who report an improvement in independence through feedback surveys' (92%).

Carers

4.38 There are four strands to this service mental health carers, young carers, mutual carers and adult carers. However the original performance targets were developed merging the activity for all of the strands. In order to get a better picture of what is being delivered by service strand and develop some realistic targets, this will be reviewed as part of the service review.

4.39 49 new Mental Health Carers were seen in Q2, 22 new Mutual Carers with 47 families supported already this year against an annual target of 30.

4.40 The mental health carers services have delivered a range of activities from family-centred sessions to multi-disciplinary meetings with other pathways in Bromley Well, and other agencies e.g. Bromley Community Counselling Service, Oxleas NHS Foundation Trust and Recovery Works.

4.41 The service has developed some tailored projects e.g. Surviving Well which provides support for women who have suffered domestic abuse in the past and have mental health issues related to that.

4.42 The young carers service has delivered leisure activities to meet the high demand of young carers currently accessing the service. Activities are varied to meet a diverse range of needs including emotional support through to peer networking. A trip to the O2 and Oxygen Trampoline Park for the older carers aged 11+ was well attended. There was an activity at Downe Scout Activity Centre for younger aged carers.

4.43 The mutual carers service held workshops, lunches, cookery classes and support groups during quarter 1 and 2.

Mental Health Pathway

4.44 The service has already met the full year targets for contacts along with other targets such as referrals to Recovery Works.

4.45 During the two quarters, Coffee Connection Groups were delivered within the community, as well as a full summer programme of peer support projects including: a walking group, a cultural visit, mindfulness workshops and an introductory course to the Five Ways to Wellbeing. All groups were well attended and clients provided positive feedback.

4.46 The service won the 'Mind Network Excellence Award for Partnerships and Profile', a short video was produced about the service and the award is due to be collected in November 2019

4.47 Production of a Parent's Support Pack was successfully completed and issued via LBB to schools, GPs, Children and Family Centres and local media and services to support parents over the summer holidays.

Support to the Sector

4.48 The Bromley Well Partnership Manager and Chair have met with new CEO of Community Links. The CEO is aware of historical underperformance and is planning to meet other board members to discuss what is needed and will produce a revised action plan once that has been done.

4.49 Commissioners are currently reviewing the service delivery options, which will take into consideration that the service is not providing consistency of service in regards to the improvement plan.

ii) Dementia Universal Service

4.50 The Dementia Universal Support Service (Dementia Hub) was commissioned to establish a clear pathway for people and their carers immediately following diagnosis. The service provides a 'one stop shop' in terms of information, advice, support and planning for people with dementia and their carers immediately following diagnosis.

4.51 The monitoring information, demonstrates that the service is being delivered in accordance with the service specification. When a referral is received, a member of staff makes initial contact within 3 working days to visit clients/carers within 10 working days with a view to assess their needs and provide them with relevant information. NHS Oxleas (Bridgeways) continues to provide on average 65% of initial referrals to the Hub.

4.52 GPs use the Single Point of Entry (SPE) process to make referrals directly to the Hub.

4.53 In quarter 1 and quarter 2 the Hub continued to capture an increased number of people who are re-referred to the service. This is primarily influenced by the fact that individuals health and/or mental condition are deteriorating and therefore, may need to access additional information and/or services as their individual situation changes or they need very light touch support in order to maintain their independence as long as possible.

4.54 The Hub includes:

- General Post Diagnosis Support Service
- Dementia Advice and Navigation Service
- Community Development and Support Service
- Dementia Skills Training.

4.55 The Dementia Advice and Navigation Service caseload has remained high, 120 new clients and 208 cases carried forward from the previous quarters with an average of 66 cases per Dementia advisors.

4.56 During quarter 1 Bromley's first Community Dementia Conference titled "Let's Talk Dementia" was held at the Odeon Cinema. The speakers included the Alzheimer's Society's Head of Research, Development and Evaluation, while several local contributors also addressed the event. Dementia Action Week also took place at the end of quarter 1, resulting in many events taking place around the borough including animal therapy, music and dance.

4.57 During quarter 1 and quarter 2 the dementia café network continued to grow and the cafes are well supported by those with dementia and their carers. They also provide a good vehicle for distributing information and monitoring peoples wellbeing and access to services.

4.58 During quarter 1 and quarter 2 the Hub continued build upon Bromley Borough's 'Working toward a dementia-friendly community status' developing and maintain partnerships with leisure centres, schools, faith groups, GPs and the PRUH and local shops and businesses

4.59 The Befriending/Volunteer element of the service delivered nearly on average 270 volunteer hours in each quarter.

4.60 The Dementia Skills Training continues to deliver to professions (including Extra Care staff) and carers. Carers have also had access to the home coaching service. This evaluation feedback for this service illustrates a high satisfaction rate, for example 100% of participants stated that the information provided in the session would enhance the care and support they were providing.

iii) Update on progress for Integration of Health and Social Care

4.61 During quarter 1 and quarter 2 of 2019/20 both LB Bromley and Bromley Clinical Commissioning Group (BCCG) continued to strengthen joint working arrangements.

4.62 During quarter 1 and 2 the Bromley Health and Care System has:

- Guaranteed that work is underway to take the partnership to its next stage. For example, the Bromley Health and Wellbeing Strategy (2019-2023) sets out our vision for how, through joint working, we will ensure that people in Bromley live independent, healthy and happy lives, and how we will tackle health inequalities.
- Primary care and community care are at the heart of the NHS Long term plan which sets out an ambition for all GP practices to come together with neighbouring and associated practices in “Primary Care Networks” (PCN) to meet the needs of local populations. In Bromley this means our local practices coming together with community services, social care and other providers of health and care services around the needs of local patients.
- Improved DToC performance by continuing to deliver multidisciplinary support and treatment to elderly/frail people through the three Integrated Care Networks and continued to improve hospital discharge arrangements through the Transfer of Care Bureau/ Discharge to Assess initiatives. The Mental Health DToC partnership group across the LA, CCG and Oxleas Foundation Trust has continued its weekly meetings and discussions around current and potential DToCs lead to immediate resolutions with direct support from the Director of Adult Social Care.
- The system continues to promote the validation process, with regular further scrutiny of data shared via SEFT (Secure Electronic File Transfer). This enables a proactive and efficient method of disputing unrecognised DToCs, resulting in the withdrawal of some out-of-borough publications. Whilst managing delays well within the borough, Bromley faces the challenge of managing patients placed out of borough. To reduce these figures a number of Trusted Assessor pilots have begun with our neighbouring boroughs (Croydon, Lewisham, Bexley and Greenwich).
- The joint commissioning strategy for mental health has been approved by LBB and CCG.
- The Better Care Fund Plan 2019/21 has been approved by the CCG and LBB.
- The Joint Ageing Well Strategy has been approved by Executive and Adults PDS.
- The joint Learning Disability Strategy has been significantly progressed and is in draft format

Update on iBCF Schemes

4.63 The iBCF schemes reflect the three grant conditions that the fund 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 providers market is supported.

Assessed and Supported Year in Employment (ASYE) Lead and Placements Coordinator

4.1 The ASYE Lead continues to meet with all newly qualified Social Workers (NQSW) and is working closely with their line managers to ensure all aspects of the programme are adhered to including ensuring that 100% of NQSW's have all learning agreements and probation forms in place. The role involves support, advice and guidance.

4.2 The ASYE lead continues to assess social work staff, completing their Practice Educator Professional (PEPs) qualifications to ensure all students and their practice assessors are supported to meet the standards required. This includes joint assessment with universities.

4.3 In order to ensure that Bromley benefits from best practice, the ASYE attends the Skills for Care Network, Forums and Moderation Panel and ADASS monthly meetings.

Wake up to Care

4.4 The project aims to identify, recruit, induct and train those interested in becoming a carer but do not wish to undertake formal study and provide them with a clear development pathway.

4.5 LBB, via the Head of Workforce Development, operate in a similar way to a recruitment agency. New carers are offered a permanent contract within one of the partner organisations and are supported by Workforce Development while they work (e.g. providing specialist development covering the 15 Care Certificate Standards and access to LBB private, voluntary and independent sector training offer).

4.6 Bromley Workforce Development commission an independent practice educator to oversee the new carers' practice during the first 6-12 months of their employment.

4.7 The offers of employment for quarter 1 and 2 were as follows:

- Glebe Housing Association – 4
- Clairleigh Nursing Home - 7
- Mission Care- 3
- Nellsar Ltd - 2
- LBB Reablement Team – 4

Process and Systems

4.8 The aim of this work stream is to improve social care process and systems. This involves the Project Officer working across the integrated care networks, continuing care and assistive technology.

4.9 These are the current project areas:

- Integrated Care Networks (ICN)

4.10 Performance management systems have been developed and are in place to assist the collection of LBB data.

4.11 There is continued work on developing performance indicators and outcomes with project officer for the ICNs/ Continuing Care/Assistive Technology to produce evidence on the effectiveness of this service and inform future planning.

- Just Checking

4.12 Just Checking is a Home Activity Monitoring Service (Assistive Technology). The aim of this service is to provide lifestyle home monitoring, which can be used to inform and support person-centred planning and promote independence.

4.13 The service is available to adults with a Learning Disability and to Older People and during the one year contract LBB officers will be evaluating if this type of service provision a) makes a difference to determining the levels of need and b) can deliver savings.

4.14 Service continues to develop slowly but officers are taking measures to ensure that the service is promoted across all of the Adult Social Care Teams (crucially at the time of initial assessments).

- Adult Social Care Systems

4.15 During quarter 1 and 2, the workplan has included a review of the Customer Journey with regards to referral and assessment. There has been the introduction of a new referral and assessment format within the Early Intervention Team. The aim is to improve staff efficiency by gathering the right information at the right time; thereby having the ability to make decisions at an earlier stage. This also facilitates signposting to other appropriate interventions

Continuing Health Care (CHC) Lead Social Worker and CHC Care Manager

4.16 The iBCF funded continuing care officers have been proactively engaging and working with colleagues in adult social care, providing training and advice. They have also been challenging assessments and decisions to ensure the right decision is being made in regard to funding.

4.17 Ongoing training sessions were arranged for September 2019 and November 2019. The outcome of the training will be to continue to enhance LBB and CCG working relationships, whilst maximising the understanding of each organisations role and responsibilities in regard to eligibility for continuing care. The training is providing an integrated approach to the assessment of need for continuing care.

4.18 Care management staff are now becoming familiar with the continuing care framework and this should ensure that LBB finance contributions are being appropriately assessed and agreed.

Public Health - Supporting JSNA Priorities

4.19 The project objective is to support clients moving to a position of stability, improved health and well-being employment and positive engagement with the drug treatment service. The funding has supported an interim role (1 year).

4.20 The post holder has:

a) acted as an interface between both the adult and young people substance misuse services and a range of stakeholders, focusing on forging partnerships, developing pathways and building capacity rather than delivering face to face interventions with families.

b) provided a legacy and built skills, knowledge and capacity. It is anticipated that by intervening early, there will be better outcomes for families.

4.21 Key deliverables of the project are:

- Bespoke packages of substance misuse training to key partners
- LBB Guidance for Working with Substance Misusing Families
- Conference on Working with Substance Misusing Families
- Substance Misuse Screening tools for partner agencies
- Substance Misuse pathways for partner agencies into substance misuse treatment

4.22 One of the key deliverables for quarter 1 and quarter 2 was to establish the following workshops:

- Drugs and Alcohol Awareness - 3rd July 2019
- Safeguarding and substance misuse - 2nd October 2019
- Assessment skills and treatment pathways - 8th January 2020
- Treatment Aims; Harm Reduction, Recovery or Abstinence - 1st April 2020

4.23 In addition to the workshops, other achievements include developing a partnership with Job Centre Plus and 'Change Grow Live' (who work with families and friends of people affected by drug or alcohol use to help develop and maintain strong, loving and stable relationships critical to successful recovery); to support substance misusing parents in securing and maintaining employment. The Social Work Assessment Tool has also been revised.

Enhanced Health in Care Homes

4.24 The aim of this project is to review and implement recommendations from the NHS England national vanguard paper Enhanced Health in Care Homes (EHCH). EHCH sets out a number of recommendations, for example progressing Enhanced Primary Care and developing joined-up commissioning and collaboration between health and social care.

4.25 Bromleag Care Practice mobilisation is underway. This will result in eleven homes having registered their patients with the new practice. The care homes pharmacists are due to start with Bromleag in October 2019. The practice manager started on 16 September 2019.

Support for Integrated Care Networks (ICNs)

4.26 Three Care Managers have been seconded to the Integrated Care Networks continue to build on delivering a multi-disciplinary approach and establishing effective partnership working within the three Integrated Care Networks. Considerable benefits have been established since the commencement of the pilots including:

- Effective working relationships between all professionals and learning from each other, as well as sharing of information and a desire and enthusiasm from both health and social care and the voluntary sector to make integration a positive experience for service users.
- A speedier response to referrals, assessment and turnover of cases.
- Early intervention by providing relevant information to service users is assisting in supporting service users to maintain their independence and making informed choices.
- Data continues to demonstrate that a significant amount of referrals are undertaken by Health and Age UK, with input from care managers within the ICN. This is resulting in early intervention and signposting, which in turn is having a positive impact, by avoiding crisis situations but more importantly maintaining independence for the service user at home.

4.27 ICN activity:

LBB Staff commenced in the ICN Hubs from April 2018		Apr-Jun '19	Jul-Sept '19
	Contacts with ICN in Quarters	359	424
	Referred to Adult Social Care	18%	16%
	Referred to Care Navigators (Age UK)	57%	46%
	Referred to Bromley Health Care	56%	41%
	Referred to Oxleas	12%	14%
	Referred to St Christopher's	9%	8%
	Received a care package who had not previously	3%	1%
	Unchanged care package in Quarters	6%	12%
	Increases in care package in Quarters	6%	4%
	Decrease in care package in Quarters	13%	15%
	Independent Carer's Assessments	2	4
	Total contacts with ICN since January 2017	Jan2017 – Jun 2019 3445	3869
	Average age of users	82	83
	are Females	60%	58%
	are Males	40%	42%

Discharge to Assess (D2A) in Extra Care Housing

4.28 There are 14 step-down flats at 3 sites. The project is seeking to reduce the occupancy rate in each stepdown in order to deliver the preferred 6 week period. Step down may be delayed where service users have safeguarding needs or where there have been issues with securing tenancy agreements for those qualifying for permanent ECH residency. However action has been taken to address this via closer working with the housing provider.

4.29 The additional stepdown stock is at full capacity with occupants from the D2A pathway. A flexible approach has been adopted whereby if the additional stock is not available, and an alternative stepdown flat is vacant, then this will be offered to clients from the D2A pathway.

4.30 The hospital D2A & Extra Care Housing teams are working closely together, with the support of the project lead, to maximise on efficiencies wherever possible.

4.31 Performance is being measured via weekly updates and management reports

Safeguarding – South London and Maudsley (SLAM)/Oxleas/Priory

4.32 This project has been commissioned with the aim of having a positive impact on vulnerable people through investment into safeguarding and adult social services. IBCF money was allocated to provide additional resources Oxleas NHS Trust, The Priory and SLAM to ensure the authority is compliant with its safeguarding duties and delegations under the Care Act 2014.

4.33 Additional staff to manage safeguarding casework have now been recruited and the project manager is also in post.

i) LBB and SLAM

4.34 A Project group was formed with SLAM in respect of the Bethlem Hospital site in early October 2017 with membership from the senior team at SLAM and LBB. An established project action plan was created to guide the work of the group.

4.35 Amended safeguarding referral pathways have been successfully implemented to ensure that Bromley has oversight of all safeguarding across the site. LBB/SLAM quality assurance referral and investigation standards for the Bethlem Royal Hospital site has been developed and implemented for the management to follow.

4.36 Regular meetings were held with both SLAM and the police in relation to AWOLS and gathering information as to the risks on the site.

4.37 Given that the aim of this project has been successfully completed, the final project group meeting took place in March 2019.

4.38 Quarterly quality assurance meetings continue with representation from both SLAM and LBB

ii) LBB / Oxleas Safeguarding Project Group

4.39 An LBB/Oxleas safeguarding project group was formed in October 2018 to seek to improve safeguarding process and practice between LBB and Oxleas. The group have been focusing on developing ways in which both parties can work together to improve safeguarding practices.

4.40 A proposal has agreed to utilise the experience and skills of our LBB Adult Mental Health Safeguarding Team (AMHST) to work closely with Oxleas to improve processes and practice in

line with statutory requirements. This proposal was implemented in May 2019 with the agreement of both parties.

4.41 The LBB AMHST now have oversight of all safeguarding activity and referrals, co-ordinating joint working practices and raising awareness of safeguarding process.

4.42 Oxleas staff has been well represented at the LBB safeguarding training courses level 3 and 4 in May 2019. There is a number of Oxleas staff now on a waiting list to attend these courses with further dates being under review.

4.43 The project group has now implemented revised referral pathways to provide LBB with an oversight of safeguarding activity across the Trust and to ensure that we receive regular and accurate data. This is to be implemented with effect from May 2019.

The Direct Payments Lead

4.44 The Operational Direct Payments Lead continues to promote an increase in the number of direct payments actions over quarter 1 and 2 include:

- regular Direct Payment Project Board meetings
- regular in house 'Self-Directed Support' meetings with relevant attendees from Adult Social Care and Liberata to support the design, development and implementation of greater take up of Direct Payments.
- meetings with Direct Payment Champions with representation across social care teams who meet on a regular basis.
- Agreeing team targets for DP numbers and establishing a weekly performance report which is sent to all managers outlining the Direct Payment take up rate.

4.45 LBB has launched its Direct Payments pre-payment card which supports the Government's personalisation agenda: "In order to support the aim of personalisation as an approach which gives the individual receiving care and support choice and control, payments systems need to be inclusively designed".

4.46 The cards also provide benefits for the council, for example a robust process for budget monitoring and management.

Market Development and Support and Care Homes

4.47 The Market development and Support project continues to be coordinated by the joint LBB/CCG care homes project which has the following three work streams:

(a) Strategy development
(b) Health and social care offer to care homes
(c) Quality

4.48 In terms of key milestones, the Residential and Nursing Homes Joint Commissioning Group has overseen progress in relation to:

- The roll out of NHS Mail for care homes – 18 of the homes now have NHS mail addresses
- The implementation of the new GP support service to care homes – 30 homes will be registered with the new practice by the end of October 2019.
- Maximising the use of Red Bags, resulting in 40 or the 43 homes adopting the process – ongoing embedding and retraining taking place.

- Activity Coordinator Forum delivered - 19 homes attended the event and this will now be an ongoing forum
- Care Pulse resource page produced and site is now live. This will enable staff to locate care home vacancies as they arise.
- Co-ordinate My Care (CMC) is being piloted by two homes. This means that patients care plans are patient lead and e-electronically shareable with professions.
- Market Position Statement for Care Homes is in development

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

5.1 All services are designed to avoid people who are vulnerable reaching the point of crisis where they would be seeking support of statutory services and/or requiring unplanned admission.

5.2 The Improved Better Care Fund is for investment into adult services and will have a positive impact on vulnerable people through investment into safeguarding and adult social care.

6. FINANCIAL IMPLICATIONS

6.1 BCF underspends of £806k during 2018/19 have been carried forward into the new 2019/20 financial year to be used against BCF projects.

6.2 The budget and expenditure for both the Better Care Fund and the Improved Better Care Fund are detailed in the tables below:
BCF:

Commissioner	Scheme Name	2019/20 budget £'000	2020/21 budget £'000
LBB	Reablement capacity	870	887
CCG	Winter Pressures Discharge (CCG)	659	672
LBB	Winter Pressures Discharge (LBB)	1,048	1,069
CCG	Integrated care record	385	393
LBB	Integrated care record - staffing contribution	56	57
CCG	Intermediate care cost pressures	638	651
LBB	Community Equipment cost pressures	431	440
LBB	Dementia universal support service	531	542
CCG	Dementia diagnosis	632	645
LBB	Extra Care Housing cost pressures	427	436
CCG	Health support into care homes/ECH	320	326
CCG	PSIS Contract	1,714	1,748
CCG	Risk against acute performance	1,374	1,401
CCG	Transfer of Care Bureau	575	587
LBB	Transfer of Care Bureau - staffing contribution	48	49
LBB	Protecting Social Care	9,155	9,338
LBB	Disabled Facilities Grants - CAPITAL	2,153	2,196
CCG	Carers Funding	538	549
CCG	Reablement Funds	971	990
LBB	Reablement Funds	321	327
LBB	Contract reduction	153	156
LBB	Programmes Team	37	38

CCG	Community Equipment cost pressures	159	162
LBB	Community and Social Care Development Fund	659	672
	Total Recurrent Budget	**23,854**	**24,331**

IBCF	**2019/20 £'000 BUDGET**	**2020/21 £'000 BUDGET**	**2021/22 £'000 BUDGET**
Transformation of Social Care (Adults, Mental Health and LD) / workforce development	60	60	60
CHC Care Manager	55	55	55
Finance Lead to support IBCF and BCF	85	85	85
Assistive Technology	25	25	25
Transitions Programme Lead	50	50	50
Support for Integrated Care Networks (ICNs)	779	779	779
Discharge to assess in Extra Care Housing (ECH)	180	180	180
Safeguarding – SLAM	156	156	156
LD Growth as part of the Medium Term Financial Strategy	1,500	1,500	1,500
New IBCF offsetting growth	3,423	1,710	1,710
Total committed spend	**6,313**	**4,600**	**4,600**
Grant allocation (In Year)	**-6,313**	**-4,600**	**-4,600**

6.3 Any underspends or unallocated amounts on each project can be carried forward into the next financial year if necessary. Quarterly reports are required by Government to show the progress of the BCF/IBCF schemes.

7. LEGAL IMPLICATIONS

7.1 The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It provides the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund. NHS England and the Government allocate the Better Care Fund to local areas based on a framework agreed with Ministers.

7.2 The amended NHS Act 2006 gives NHS England the powers to attach conditions to the payment of the Better Care Fund. For 2017-19 NHS England set the following conditions to access the CCG element of the funding:

- The requirement that the Better Care Fund is transferred into one or more pooled funds established under Section 75 of the NHS Act 2006.
- The requirement that Health & Wellbeing Boards jointly agree plans for how the money will be spent with plans signed off by the relevant local authority and clinical commissioning group(s).

7.3 Under the amended NHS Act 2006, NHS England has the ability to withhold, recover or direct the use of CCG funding where conditions attached to the BCF are not met, except for those amounts paid directly to local government.

7.4 For 2017-19, NHS England require that BCF plans demonstrate how the area will meet the following national conditions:

• Plans to be jointly agreed;
• NHS contribution to adult social care is maintained in line with inflation;

• Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care; and
• Managing Transfers of Care

7.5 The Improved Better Care Fund Grant determination 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.

7.6 The Council is 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 (revised 2019-20)
- Provide quarterly reports as required by the Secretary of State

Non-Applicable Sections:	
Background Documents:	None