Cambridge Local Health Partnership ITEM 7

27 March 2014

Update on Better Care Fund Proposals

1 Introduction

1.1 This paper summarises the 100+ proposals received by the Better Care Fund during January 2014.

2 Categorisation of Proposals

2.1 We asked for proposals in January 2014. We received more than 100 proposals from the County Council, the CCG, district councils, service providers and the voluntary sector.

2.2 A team from the CCG and the County Council sorted the proposals into 14 themes. These themes have then been grouped into four areas:

Area	Themes
Support that is provided for people at home (i.e. primary prevention / tertiary prevention)	• Carers • Homes / healthy lifestyles / primary prevention • Isolation • Community medicine • End of life
Support that is provided when people need help (i.e. secondary prevention / crisis prevention)	• Secondary prevention • Chronic illness management • Dementia • Mental health / chaotic lives • Response to Care Bill • Crisis prevention / recovery • Multi-agency working
Support that is provided to help people when they are ready to leave hospital (i.e. discharge pathways)	• Discharge planning
Investment in infrastructure to support integration	• Capacity to work between organisations

2.3 Many of these proposals could fit into more than one category – the intention here is to group ideas that are most similar so their implications for commissioning under BCF can be considered together; not to provide a comprehensive or perfectly accurate categorisation.

2.4 The proposals are detailed in Appendix 1. Particularly large-scale proposals, in terms of client group numbers or amount of transformative change, have been marked with **.

3 Comments on Proposals

3.1 These proposals represent a broad scale of interventions in terms of the target group, some relate to a group of villages, some to districts, and some to the whole county. They also have a broad scope in terms of amount of change implied by the proposal – some are extensions of business-as-usual, e.g. establishing a brokerage unit for residential / nursing care placements, others are fundamental changes, e.g. commissioning a comprehensive and exhaustive carer support service. Most fall somewhere in the middle, and will imply different amounts of change depending how they are implemented.

3.2 Broadly speaking, the proposals have been grouped according to the focus of their impact. The proposals that provide support to people at home tend to be focused on primary prevention. As such, their impact on health and wellbeing and subsequent impact on demand for acute and social care services is likely to be felt in the longer-term. However, the impact of the support provided to people when they need help is likely to be felt more rapidly by the acute and social care services, as admission avoidance and intensive return-to-independence services could start diverting people away from acute or social care services as soon as they are operational (similarly with the hospital discharge proposals).

3.3 Some proposals can be ‘traditionally’ commissioned, in the sense that there is a clear target group and service area, a clear mandate for change, and (relatively) clear funding arrangements (e.g. carers’ services, discharge support). However, many proposals in the second group, around multi-disciplinary working especially, do not have a well-defined and agreed target group, and services must be very flexible to have a positive aggregate impact (because the people the services will be supporting will have different and specific personal circumstances and issues).

3.4 A common risk stratification tool which triangulates between the main health and social care issues identified in the JSNA and the demographics and patterns in demand for acute and social care services would allow the development and commissioning of more generic services and an assessment of their impact. This would also avoid doing an explicit trade-off exercise between the different groups identified in the proposals (e.g. should funding support women who have experienced sexual violence or older people with cardiac health problems?).

4. The Proposals in Relation to the National Conditions

4.1 BCF work is also required to address national conditions. These are:

a) Plans to be jointly agreed – Plans are being discussed and developed by CCC and CCG, and will be subject to agreement by CCC, CCG governing bodies and the Health and Wellbeing Board.
b) Protection for social care services – No proposals currently suggest reducing social care services *per se*, although a number imply transformation so that services are focused on re-ablement / return to independence / avoidance of long-term admission. The definition of 'protecting social care services' should be locally agreed, which may require further discussion.
c) 7 day working – The proposals received so far suggest the development of 7 day services in rapid response intermediate care and discharge from hospital. This seems to meet the national requirement to 'support patients being discharged and prevent unnecessary admissions at weekends'.
d) Data sharing – work is progressing on using NHS number as part of business-as-usual, and understanding plans for open APIs and appropriate Information Governance.
e) Joint approach to care planning – the multi-disciplinary teams proposal is specific about the development of joint assessment and care plans for the groups targeted by MDTs. The risk stratification tool described above needs to be developed in order to specify the proportion of the population who would receive joint assessments and care plans via MDT / intermediate care / discharge from hospital arrangements.
f) Agreement of impact upon acute services - This is a matter for discussion by the Executive Group.

4.2 BCF includes approximately £500k capital and £1.3m revenue for meeting the statutory duties set out in the Care and Support Bill. Until the final Care Bill and associated regulations are passed it is difficult to be exact on whether the outlined proposals will meet the new statutory duties. Broadly speaking, the main changes will be:

- More people eligible for carers' support through new eligibility criteria for carers. There are proposals in the area of carers' services which would be likely to support delivery of the new responsibilities
- More people eligible for social care through potentially more generous eligibility criteria. Discussion is continuing on this at a national level and the final criteria are not yet available
- More duties on the provision of information and advice to self-funders - the proposals include community-based information and advice which is likely to support delivery of this work.
- A large increase in assessments as any individual wishing to qualify for the £72,500 cap on individual contributions will require a local authority social

care assessment. The proposal to expand the social worker team for assessment will be likely to support delivery of this responsibility.

- Maintenance of 'care accounts' for self-funders and administration of the £72,500 cap on individual contributions to social care. This is likely to require both revenue funding and capital funding in ensuring our systems can cope with the care account
- A significant expansion in 'deferred payments' - allowing people to put off selling their house to pay for their care until after their death. Whilst we do offer some deferred payments at present, each one carries a significant administrative and legal cost. It is not yet known how many more deferred payments we are likely to see under the new arrangements.

5 Suggested Key Areas for Change

5.1 The BCF form requires an explanation of key changes that will be made. It is suggested that the following is included on the form. This shows the areas of changes and highlights the most commonly proposed work or services in each area. Further development is needed to commission any of the proposals mentioned here. Furthermore, this list is not exclusive and does not imply that any proposals not mentioned here will not continue to be developed as part of the next round of discussions.

(A) Support for people at home – *to help people to live independently at home, either preventing them needing acute or long-term health and social care or minimising their needs*

- Integrating carers' services and meeting the requirements of the Care & Support Bill, so carer breakdown is avoided
- Integrating Disabled Facilities Grant, occupational therapy, home improvement, advice and guidance to provide comprehensive housing service for vulnerable groups, possibly countywide, so housing is safe
- Community-based services providing relatively informal support for people with low-level conditions or who are coping with changes in circumstances, for example peer coaching for people with disabilities, so low-level conditions do not deteriorate
- Extending community medicine, for example supporting community pharmacies to do more medication management, developing occupational therapy and physiotherapy to be more accessible and support people to be more independent, so long-term support services are minimised
- Develop a small grants pot to provide broader primary prevention activities or other patient-group specific interventions, so people are more resilient and can cope independently

(B) Support for people in need of help – *to help people who have had a crisis (or who are at the most risk of crisis) to get back to living independently so they don't need long-term or acute health and social care services*

- Development of support or recovery programmes for people with long-term conditions, at a variety of levels of need – for example a support service for people with mental health issues who are very vulnerable and a further crisis that would result in breakdown, or telehealth remote monitoring for people at risk of hospital admission, so long-term support services are minimised
- Develop a common risk stratification tool, scale up multi-disciplinary teams across the county to respond to the results, develop a shared health and social care database, so we can identify people most at risk of crisis and respond with a joined-up proactive package of support to prevent crisis
- Develop and extend integrated intermediate care and rapid response services across the county for hospital and social care admission avoidance, including developing community step-up beds for use by GPs / MDTs and for hospital discharge, so we can avoid someone in crisis being admitted to hospital wherever possible

(C) Support for people to leave hospital – *to help people be discharged from hospital as quickly as is safe so they can recover at home (or another appropriate place)*

- Expand teams to do 7 day discharge planning and discharge, so people don't have to wait for staff to be available at weekends to be discharged
- Develop 'return home' package (could be voluntary or private sector provider(s)), to help people be discharged from hospital safely and speedily, with support to help them back to independence

(D) Investment in infrastructure to support integration – *to work between organisations to develop common approaches to assessment, treatment and support*

- Establish joint team to oversee integration activity, so there is capacity to do the development work necessary to common assessments, joint services, and joined-up packages of care and support

5.2 The organisation of proposals into areas (A), (B), (C) allows them to be aligned with the implied strategic changes that emerge from the Health and Wellbeing Strategy, the CCG OP Programme, and the development of a joint CCC-CCG OP Strategy. (C) is particularly aligned with the aims of the BCF to ensure slick discharge from hospital.

5.3 The detail under (A),(B),(C),(D) above is not a final statement of services that will be funded by the BCF. The process of calling for ideas has yielded a wide variety of proposals, from across the whole system, and the themes outlined above were some of the most commonly proposed areas. The number of responses and the relative similarity of the themes suggests that there is a significant amount of agreement about strategy and commitment to contribute to change amongst commissioners and providers in Cambridgeshire, which is very positive given the scale of the strategic ambition to transform the system. There will be further discussion with respondents to the first call for ideas and other contributors following submission of the outline plan to Government on 14 February ahead of the second submission in April, and further development throughout 2014-15 ahead of the transfer of funding to the BCF in April 2015.

5.4 In Cambridgeshire, it was already recognised that changes are necessary to meet the financial and demand challenges the health and social care system is facing when the BCF was announced, and the fund was welcomed in the *Vision and Principles* document as an opportunity to speed up the pace of change to meet these challenges. The decision of local agencies to face these challenges meant that some work was already underway to pilot integrated and flexible working to support independence, such as the multi-disciplinary team pilots in GP practices and the introduction of reablement into the hospital discharge pathway. Many of the proposals received as part of the call for ideas respond to the experience of these pilots and suggest going further faster – for example, extending multi-disciplinary teams across the county. It is the expectation of the local system that the degree of change implied by these proposals is not limited by the specification of the pilot but is as ambitious as the scale of the challenge facing the system as a whole. This may mean expanding the scale of a proposal (for example the number of GP surgeries with a multi-disciplinary team), the pace of service delivery (for example designing a service that responds within an hour, 24 hours a day, rather than within 3 hours in the working week), or the expectation of service efficacy (for example designing a service where the intervention is specifically time-limited to ensure that it maintains throughput and can support as many people as it was designed to support).

5.5 The key risk of the current strategy is that there is not a reduction in demand for acute services, and since they are paid for according to demand, other services that are key to the delivery of the strategy are unexpectedly financially restrained and the system lurches to a focus on emergency and acute services. Payment-by-results for the BCF funded activity may mitigate some of these risks but Health and Wellbeing Board, CCC and CCG decision-makers should be satisfied that they understand the impact of failure; specifically, the loss of the performance related element of the BCF (which is

already committed and spent on services in Cambridgeshire, so this would be a net loss) and the failure to address the short and longer term pressures of demand and financial restraint.

Paper prepared by:

Tom Barden, CCC 4 February 2014 (Final Version for HWB Board)

Appendix 1

Summary of proposals

Support that is provided for people at home

- Carers

Proposals for carers came from two potential bidders. The Care & Support Bill gives increased rights to family/informal carers, including the right to an assessment and a more personalised service through personal budgets. The Government requires that local plans set out how much money is used for carer-specific services, taking into into the NHS funding previously used for carers' breaks.

One bidder proposed developing a family assessment methodology for social care assessment**, which would encompass the new statutory responsibilities for assessment of carers contained in the Care & Support Bill. A bidder also proposed developing a new system of supporting carers at different levels, reaching out to the 60,000 with advice and information and providing more intensive personalised services for the smaller numbers of people within the 60,000 who provide more significant levels of care.

The second bidder proposed developing an integrated carer support service** outside any individual statutory agency that would meet these responsibilities.

There were also two specific proposals: reviewing the system of respite beds for carers of people with dementia, as it appears that the stock of these beds has reduced drastically recently, and expanding the emergency respite support provided for carers.

- Homes / healthy lifestyles / primary prevention

This theme linked housing / homes and activity and exercise. Disabled Facilities Grant (DFG) proposals were also included here.

DFG is ring-fenced so should be considered as a proposal under this theme.

Two providers proposed the development of a comprehensive range of accommodation solutions that support people to stay independent for as long as possible and reduce or delay the need for higher cost health and/or social care services**. This would involve a capital development strategy and a re-development of sheltered housing strategies.

Home improvement

Three proposals were received for an integrated home improvement service, primarily focused at older and disabled people who might receive support from DFG.

The first proposal was for a new countywide 'Home For Life' service**, that would co-ordinate occupational therapy, home adaptations under DFG, small DIY jobs and advice and guidance. Supportive proposals were received in relation to this proposal from three local district councils, and the bid also claimed support from a fourth local district: the fifth district in Cambridgeshire has not yet committed to this bid. Impact on key metrics was not specified. Roughly £500k revenue and £2m capital per year was requested (not including the potential cost should the fifth district become involved, or the handyperson scheme).

One district council proposed a separate integrated and extended DFG service offering occupational therapy, grant processing and home improvement services, which they have been discussing with other local authorities in the East of England.

One bidder proposed scaling up Home Improvement Agency activity as part of a falls prevention strategy.

Activity / exercise for falls prevention

Activity / exercise classes were proposed by district councils and health partners. Three district councils proposed expanding and refreshing activity classes to primarily reduce falls and build better overall health amongst older people. Another district council proposed expanding community activities more generally, including social isolation issues, but using evidence from physical activity programmes. One bidder also proposed with evidence from Public Health exercise classes as a falls prevention measure in older people.

Sheltered / extra care housing

Two proposals were received in the area of sheltered / extra care housing.

One bidder proposed introducing health screening in sheltered / care home housing it manages.

One district council (on behalf of a local Strategy Group) proposed using BCF to commit to funding the revenue costs of extra care schemes which will be developed over the next few years, based on the hypothesis that Extra Care is more cost effective than residential / nursing or home-care.

Other

A bidder proposed a comprehensive primary prevention service involving active case management and regular telephone support for people with long-term conditions or who are isolated**, with the aim of signposting to activities for supporting wellbeing, provision of low level support and referrals on to GP or community rapid response teams.

Another bidder proposed expanding information and advice services to include health, social care, housing, debt, financial advice, in order to prevent breakdown in

people living independently to reduce likelihood of hospital or social care admissions. The same bidder proposed a programme to find out older people's priorities based on the Age Concern work in Warwickshire. It also proposed the development of partnership boards in adult social care and health more widely, to integrate user experience and feedback mechanisms as other elements of the system are integrated, and implement a quality assurance system.

A provider proposed a peer coaching project to support people over 50 with disabilities to adapt their lives to their condition, so that they are more resilient and less likely to experience a crisis.

One organisation proposed extending its service to support people at high risk of having a stroke.

Another organisation proposed establishing a set of self-referred programmes to support people who may have a low-level mental health problem or who are having trouble regulating their behaviour to prevent deterioration.

A bidder raised a proposal to address fuel poverty as a means to preventing ill health.

A proposal for the development of a small grants pot to respond to the demand from VCS for a range of projects that could support specific or small client groups.

- Isolation

All projects were aimed at older people.

One provider proposed a project to develop 'virtual communities' of care home residents, possibly by using tools like video conferencing or Skype.

Two proposals were received to expand day centre / mobile warden provision from two separate providers.

One provider proposed extending its community transport scheme in East Cambs and Fenland.

Another organisation proposed expanding befriending and timebanking schemes to reduce isolation amongst older people.

A local district council proposed extending its older people's services brand across the county, using fair events to promote activities that older people could take part in.

- Community medicine

All proposals related to frail or vulnerable older people.

Two proposals were received relating to parish nursing for small groups of villages. These proposals could be examined further to see if the concept could be applied across the county for all rural areas with vulnerable older people living there.

The administering of medication was also an issue for two proposals. The first bidder proposed training care staff to deliver a wider variety of medications, which could support the rationalisation of visits by different agencies. The second proposed developing the role of community pharmacies in medication management, particularly in care homes.

The second provider also proposed developing and extending the occupational therapy and physiotherapy service to reduce demand for home care (e.g. by rationalising the need for 'double-up' carers) but also to provide more support in the community to maximise rehabilitation. Accord Health proposed reviewing people with non-complex social care packages to make sure packages were using all community resources and making the best use of the statutory support of different agencies. Similarly, one bidder proposed developing the Assistive Technology service to make equipment more widely available.

- End of life

End of life care was identified as a source of avoidable hospital admissions by a bidder, which proposed extending home based end of life care to reduce admissions.

A bereavement counselling service proposed extending its remit, arguing that this would reduce visits to the GP by bereaved people.

Support that is provided for people when they need help

- Secondary prevention

Secondary prevention for specific conditions

Some submissions proposed support for people suffering from specific conditions. One provider suggested cardiac and respiratory rehabilitation services in the community to reduce re-admission rates for people with these conditions, based upon evidence suggested by Public Health. Another proposed an integrated low vision service to reduce falls, depression, hospital admissions amongst older people with low vision.

Telehealth

Three bidders all proposed an expansion of telehealth remote monitoring. Evidence suggests that this is effective in reducing hospital admissions for people with chronic heart failure – two of the bidders proposed extending this service to older / vulnerable people and people living in sheltered housing more frequently than currently.

Other

A local hospital submitted a proposal containing a range of ideas for specialist services for older people that came from their older people's strategy**.

A provider proposed a change the threshold at which home care is no longer deemed cost effective from the provision of 22 hours per week to 33 hours per week, which would enable more people to continue to live at home and fewer people moving into residential / nursing care because their need for support had gone above 22 hours per week.

Another bidder proposed establishing an integrated health and social care transitions team for children and young people with a disability and support from health or social care who are finishing their formal education, with the aim of smoothing the change from children's services to adult services.

- Chronic illness management

Proposals under this theme are targeted at particular groups, and are aimed at reducing avoidable hospital / residential / nursing care admissions by effective management of illness in the community at home.

One bidder proposed piloting a Wellness Centre in Cambridge to support people with long-term conditions by co-locating different services. The centre would be in Brookfields Hospital.

A provider proposed expanding services for people with dual sensory loss. Another bidder also proposed expanding services for people over 65 who have a hearing or visual impairment.

One bidder proposed establishing a support service for people with Acquired Brain Injury in Fenland. Another bidder also proposed generally developing new housing and support services for people with Acquired Brain Injury.

Two organisations proposed developing a comprehensive recovery programme for people with long term health conditions (mental health and physical health) or those who meet the social care threshold (critical/substantial)**. The bid would build on the successful existing recovery college model operated by one of the bidders.

- Dementia

The number of people with dementia is predicted to rise and these patients use a lot of health and social care services.

One provider proposed expanding case management of dementia patients via the Dementia Support Team, which is associated with delayed institutional care.

A local hospital trust proposed developing a transition unit to support people with Learning Disabilities to move to specialist dementia care placements, providing appropriate care away outside acute hospitals.

- Mental health / chaotic lives

Proposals in this theme are aimed at supporting adults who have mental health issues or who are chronically excluded from society. Chronically excluded people may have a range of mental health, substance abuse, alcohol abuse, housing issues; and are frequent users of health and community services as a result.

Two bidders jointly proposed developing a service available for people who have a low level mental health problem associated with another crisis in their lives and who could deteriorate without a short-term intervention, ending up using more services than they had to.

A district council proposed piloting a multi-disciplinary team to work with people with persistent anti-social behaviour to co-ordinate different agencies' support for them with the aim of reducing disproportionate statutory service use. Another provider also proposed continuing the successful project to work with chronically excluded adults leading chaotic lives in Cambridge City.

One organisation proposed expanding a particular method of treatment for alcoholics, currently established in Huntingdonshire.

A bidder proposed developing new services for people with autism and Aspergers Syndrome, as required by the Autism Act.

Another organisation proposed that a service supporting older homeless people to live independently should continue to be funded.

A provider proposed extending the counselling services available to women who have experienced sexual violence, with the intention of reducing use of health and social care services in the longer-term.

- Response to Care Bill

Any changes to services as a result of the Care and Support Bill must be funded by BCF. Changes around carers' services are covered in 'carers' above, but the Bill also implies a need to do more assessments as a result of the changes in the social care funding system.

One organisation proposed establishing a peripatetic team of social workers to help with existing peaks in demand for assessments, e.g. winter pressures, implementation of new assessment procedures. This will help with reducing hospital and residential / nursing care admissions because people who are not assessed but are in need must manage independently or by relying on other services that do not have an assessment, e.g. A&E / emergency hospital.

However, the proposal of expanding the social worker team for assessments is also relevant in the response to the Care & Support Bill.

- Crisis prevention / recovery

Short term response services

There were four proposals in the area of short-term response services, designed to try to avoid admission to hospital for older people living in the community.

The first proposed strengthening intermediate care**, e.g. night care, nursing, end of life care, sitting services, emergency personal care, reablement, with the intention of supporting people to live independently for longer. A rapid response team was also proposed, available within one hour of referral. Another provider also proposed a rapid response team, called a 'Joint Emergency Team' (JET)**, able to link together ambulance, health and social care staff (and offer similar services to the intermediate care expansion above).

The same organisation proposed developing a joint falls prevention pathway that encompasses health and social care services.

The third bid came from a district council, and proposed extending its falls assistance service to be able to sign more people up.

Several providers jointly proposed a crisis support service led by VCS to provide support to GPs and hospitals in the winter to support early discharge of older

patients and do case-finding of GP patient lists to try to prevent crises and deterioration leading to hospital admission.

Alternatives to hospital / residential / nursing admission

Two organisations both proposed an alternative to hospital admission using places in the community. A third organisation proposed an increase in 'step-up' beds available as a short-term alternative to hospital admission.

One bidder proposed using VCS to support patients in community rather than admit to hospital.

Another bidder proposed establishing an overnight personal care team, as difficulty finding that particular service is often a key consideration in admitting someone to residential / nursing care.

A provider proposed establishing 'hospital at home', additional home care support to prevent admission to hospital.

- Multi-agency working

Proposals in this theme focus on the ways in which services can work together to support vulnerable groups, e.g. older people, to live independently. They mainly focus on groups of people who would be identified by a risk stratification tool developed using health and social care criteria, who would usually be older or disabled

Multi-disciplinary teams and databases

One provider** proposed multi-disciplinary 'team around the person' working, which would include single assessment, rapid response and crisis prevention and joint working. This should be seen in the context of their bid as part of the OP Procurement Programme.

Two organisations both proposed expanding the multi-disciplinary teams in GP practices to include health and social workers**. This would enable the development of a multi-agency system of early identification of risk, joint assessment (using a common assessment framework) and action planning. Increasing spending on social care / community services like this is expected to reduce the costs associated with hospital, particularly for end of life care. It is also expected to reduce the rate of delayed discharge from hospital. (See Public Health evidence, and evidence provided by Kirsteen Watson re OP procurement).

A provider proposed developing a multi-disciplinary approach using Care Co-ordinators**, and developing a culture of integration amongst the MDTs using specific cultural change methodology.

An organisation proposed the development of a predictive modelling tool that would support multi-disciplinary working, which should be seen in the context of their overall bid under the OP Procurement Programme**.

Three bidders also suggested including the VCS in the multi-disciplinary teams and ensuring good co-ordination of such services. Two similar bids from separate providers were also received.

Another group of three bidders also proposed a database for patients with health and social care information that would also be accessible to VCS agencies. Relatedly, a provider proposed a single patient portal to promote information sharing between health and social care.

Activities to ensure that NHS number is used as primary identifier by all agencies, a 'national condition' of BCF, would also be included under this theme.

Other proposals

A provider proposed a care home review team, composed of a geriatrician, social worker, paramedic and pharmacist, to review people living in care homes to prevent crises developing. Another bidder made a similar proposal, to establish teams to train care homes in falls, pressure ulcers, end of life care and UTIs to reduce hospital admissions.

Another provider explained a number of ways they would integrate care and work together with other agencies should they be successful in the OP Programme Procurement**.

One organisation proposed developing a joint commissioning 'Brokerage Unit' that commissions residential / nursing placements for older people. This would mean quicker and slicker discharge from hospital.

The same organisation also proposed piloting integrated health and social care personal budgets.

The third bid from this organisation proposed putting key health and social care information on a special type of bus pass so that these can be read by emergency response team if necessary.

Support that is provided to help people when they are ready to leave hospital

Improved discharge planning capacity

One provider proposed an expansion of discharge planning pathways, including an early supported discharge pathway for stokes. Two other organisations proposed the development of a 7-day discharge planning service, which would include specialist mental health workers to ensure that all adults and older people – including those with dementia and other mental health issues – do not experience a discharge delays. This would all be underpinned by a provider's proposal to expand the complex discharge team. Another organisation proposed establishing 'community discharge teams' to support each acute trust with discharge.

Pathway development

An organisation proposed expanding the re-ablement service to reduce discharge delays and to increase admission avoidance. Another provider proposed allowing homecare agencies provide "return home" packages. A separate bidder proposed the establishment of an A&E discharge support service. A fourth bidder proposed using BCF funding to support a complex care pathway which would allow the paying of higher unit costs to reduce discharge delays. A fifth bidder proposed allowing care agencies to set their own care grids. This would reduce the volume of tasks undertaken by staff involved in the discharge planning process.

Increased capacity

A district council proposed the development of a sheltered housing scheme specifically aimed at supporting the hospital discharge process. Another district council made a similar proposal, advocating the establishment of specific temporary accommodation units within the area to facilitate the hospital discharge process. A provider proposed reviewing the utilisation and effectiveness of interim beds, and using BCF funding to stimulate the domiciliary care market to increase capacity; another provider also made this proposal. Another bidder proposed the creation of a fast transport service which would be supported by dedicated carers in order to reduce discharge delays.

Other proposals

A proposal for support to develop the health economics and impact analysis of BCF-funded interventions.

A proposal to establish an Integration Team to oversee the development and implementation of projects to integrate health, social care and other services, which would project manage and act as a 'doing' resource for pathway development and business process change activity.