Small Grants for Local Systems – Criteria and application process

Summary

This document sets out the criteria and application process for local systems[1] to access small grants they can use to support implementation and/or accelerated progress in relation to effective prevention and/or discharge to assess. Small grant applications are invited from local system leads who are involved in shaping and delivering activities relating to their Better Care Fund plan.

Overview

In August 2020, the Government published the Hospital Discharge Service: Policy and Operating Model. This policy, while building on earlier guidance released at the start of the COVID pandemic, marks a significant departure from previous guidance, including that around delayed discharges. The policy embeds the Home First ethos and Discharge to Assess approach and includes provision of additional funding to support implementation of recovery support following hospital discharge. The policy sits within broader ambitions to support people to live at home independently for longer, a key ambition of the BCF.

This small grants programme is intended to support local systems to implement initiatives in relation to prevention and/or discharge, in line with national policy.

Programme scope and criteria

A grant up to £15,000 is available to support implementation of projects in relation to prevention or Home First discharge to assess model. Where required, this may include gaining access to external expertise and capacity, and accessing this can be supported by the LGA if required.

Successful applications will be expected to demonstrate how the small grant will help to improve outcomes and system performance, e.g. linked to key metrics, a person-centred experience and/or demonstrating value for money.

[1] 'System' in this context refers to single local authority / CCG footprint. Grant funding can be used for projects spanning more than one 'system' if appropriate

Examples of the types of projects that the grant could cover include:

- Actions to increase the proportion of discharges on pathways 0 and 1, embedding Home First, or reducing delay after a person is assessed as ready to be discharged
- Expanding community services to support Home First, for example home-based reablement
- Initiatives including pilots aimed at improving outcomes and experience for one or more of the following:
    - Those with mental health needs
    - Those experiencing the aftereffects of COVID-19 who require sometimes complex multidisciplinary ongoing home care
    - Working age adults
- Initiatives linked to early intervention that directly support prevention outcomes including avoiding or delaying unplanned admission to hospital or long-term care
- Improving data collection and reporting, and developing shared understanding of pathways, including those linked to early intervention and prevention
- Meeting workforce training and transformation needs
- Supporting roll-out of short-term crisis support to help an individual go home and so prevent a care home admission, or as step-up care to prevent an emergency admission
- Accelerating development of integrated discharge hubs and multi-disciplinary working
- Reducing mental health assessment of individuals delayed or with long lengths of stay

<u>Funding and Support offer</u>

Successful systems will have access to:

A. Funding of £10,000 to £15,000 to enable systems to demonstrate measurable progress with implementation. Please note that initial payment of small grant funds can be made only to councils, for use on a local system-wide basis.

B. Where local systems feel they would benefit from external support, the support for each system will be agreed by BCFT, the LGA support team and the local system before implementation begins, and could draw on the following:

- BCFT /LGA support including peer advice, critical friend and challenge support, and project oversight; this will include joint work with ECIST as appropriate
- Peer-to-peer support and learning (across selected systems)

Application criteria and process

Applications will be selected on the strength of their ask and anticipated impact by a panel of BCF national partner representatives.

Applications must meet the following criteria:

- The application must be supported by all local system partners
- Use of the small grant must result in measurable progress in performance and policy implementation
- The system must agree to support the collation and sharing of learning
- The system must agree to oversight and input by the LGA on behalf of the BCFT
- Should the cost of the proposed project exceed £15,000, the application must specify the alternative funding source(s) that will augment the small grant
- Small grant funding cannot be used to cover or contribute towards capital expenses
- Where delivery is not feasible by end of March 2021, for those systems requiring greater flexibility the project must be completed within 6 months from grant award

Applicants should complete the application form below.

Applicants are encouraged to discuss their application with their Better Care Manager.

Completed application forms must be submitted by email to england.bettercarefundteam@nhs.net and copying in the Better Care Manager, no later than **5pm on Friday 12th February 2021**.

BCFT Small Grant Programme – application form

Small grant applications are invited from local system leads who are involved in shaping and delivering activities relating to their Better Care Fund plan.

System name	York
Name of organisations involved	Care Rooms Ltd, CYC, VOYCCG, YTHFT, (NYCC) (cc2i)
Do all these organisations support the application?	Yes
Contact details (for progressing application)	pippa.corner@york.gov.uk
Local authority to receive grant on behalf of system	City of York Council

1. Please outline the objectives of the proposed project(s); How the objectives align with your local BCF plan and outline why is it needed? *(Please outline in no more than 300 words)*

We wish to partner with Care Rooms Ltd and NYCC to establish a pilot of the Care Rooms model for York and North Yorkshire, as initially proposed by the innovation partner CC2i, prior to the emergence of the pandemic. (CC2i have postponed their engagement in further extending the pilots as many interested councils were obliged to reprioritise in 2020).

The pilot requires an upfront investment of £15k from each local authority in order to establish the service in a new area. York has been unable to resource this sum due to significant financial pressures in 2020-21, which are expected to continue in 2021-22. We have explored the model in some detail with Care Rooms, developed the contract documentation and approvals needed, and agreed in principle that this programme would work well in the city of York, and for NYCC it is expected to be suitable in the Selby District.

The overview of the model is attached with this proposal.

It uses local, screened 'Hosts' with spare rooms, to provide a range of 1:1 safeguarded personal and Nursing care services for step up, step down and respite, discharge to assess and home IV nursing services for accelerated discharge.

Suitable for a range of patients:

- Post day surgery patients (particularly those who live alone) & addressing
  patient backlogs and Pathway 1 of D2A
- Patients at risk of falls & medically fit people who may be waiting for house
  modifications
- Self-funding patients waiting for residential care
- Admission Avoidance

CQC accreditation has been achieved (enabling CareRooms to support IV services in host rooms)

2. What difference will the project make, and how will this be evidenced? *(Please outline in no more than 300 words)*

We are committed to providing alternatives to short term placements into long term care settings. York and NYCC as a system are opposed to making permanent placements from a hospital bed, which has been validated and affirmed by the COVID-19 Hospital Discharge Policy. We have developed a range of alternatives, and significantly increased our investment in a range of domiciliary services, technology and asset based community development to enable people to return and to remain at home. However, there are some people who do need care and support temporarily away from their own home. This model recreates a homely environment with a skilled, registered and trained care giver, backed up by technology. It also operates in local communities, supporting the cared for person to rebuild their network and to become part of the solution to their self-care needs as they recover.

- Giving patients the best chance of supported recovery
- Mental health benefits plus reduction in isolation & loneliness
- D2A Home First alignment & Step Up benefits
- Identification of early UTI and & minor infection signs
- Nutrition, hydration & exercise monitoring - plus physiotherapy where necessary
- Ongoing support once back at home - community integration, monitoring and more

Our response to COVID-19 and the HDP has resulted in an increase in people entering care for the first time, after a sustained period where the system trend has been downwards. We believe this model offers

an opportunity to halt this increase by offering a better alternative for the right people. As NHS services enter the recovery period, and elective admissions resume, many patients will need a short period of rehabilitation, convalescence, and confidence building. We will monitor activity, delivery milestones, quality, outcomes for individuals, LoS, DTOC etc. The pilot will be captured in our whole system overview of capacity and discharge pathways through the command centre.
3. How much funding is required, and (in outline) how will it be allocated?
£30,000 fixed contribution per partner (we have agreed this can be shared between NYCC and CYC 15k each) which delivers • Six month project • Subject matter expertise to help shape the development of the required dashboards • £13,500 worth of CareRooms credit for each co-funding partner, which is equal to 100 nights of step up/step down, respite, reablement care or discharge to assess care (alternatively for those rooms where IV services are provided, this will cover up to 38 nights of care)
4. If the costs of the proposed project exceed £15,000, please specify the alternative funding source(s) that will augment the small grant
The cost of establishing the pilot for the council is £15k to participate, and this will deliver 100 nights of step up or step down care, to enable proof of concept to be tested. If the council wishes to continue as a partner the costs would be on a spot purchased basis. People can also choose to book in as self-funders for respite.
5. What is the timeframe for delivery?
Immediate mobilisation as all the due diligence has been carried out, and the model has been shared with system partners as an innovative and creative option within our overall Home First ethos. Care Rooms have already started to network in our areas and begun the soft market testing to recruit interested carer hosts. The technology platform and equipment is already available.
6. What will happen when the project ends?
If the project has been a successful element within our D2A and prevention pathways we will continue to pay for short term care

provided by the hosts. Expansion of the scheme may follow, but initially we have agreed a baseline of 5 care rooms in each area, (10 in total across York and North Yorkshire).	
Do you agree to sharing learning from the project?	Yes
Please confirm that you have discussed this bid with your Better Care Manager	Yes – Jenny Sleight