Appendix 4a

Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Medway Council**
Clinical Commissioning Groups	**NHS Medway Clinical Commissioning Group**
Boundary Differences	**Co-terminus**
Date agreed at Health and Well-Being Board:	9 September 2014
Date submitted:	19 September 2014
Minimum required value of BCF pooled budget: 2014/15	**£832,000**
2015/16	**£17,632,000**
Total agreed value of pooled budget: 2014/15	**£832,000**
2015/16	**£17,853,600**

b) Authorisation and signoff

Signed on behalf of the NHS Medway Clinical Commissioning Group	

By	Dr Peter Green
Position	Chief Clinical Officer
Date	

Signed on behalf of Medway Council	
By	Barbara Peacock
Position	Director of Children and Adults Services
Date	

Signed on behalf of the Medway Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Andrew Mackness
Date	

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Medway's Joint Strategic Needs Assessment	Joint Council and CCG assessment of the health needs of the Medway local population in order to improve the physical, mental health and wellbeing of individuals and the community. http://www.medwayjsna.info/ua/
Joint Health and Wellbeing Strategy for Medway 2012-2017	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out between 2012 and 2017. http://www.medway.gov.uk/pdf/health%20and%20Well-being%20StrategyFINAL.pdf
Medway CCG 5 Year Strategy	CCG 5 Year Commissioning Strate
Medway CCG 2 Year Operational Plan	Commissioning Strategy and Ops Pla
Update from NHS England (Kent and Medway) and Medway Clinical Commissioning Group on the NHS Belongs to the People; A Call to Action	Medway CCG's response and actions from Call to Action. http://democracy.medway.gov.uk/mgconvert2pdf.aspx?id=22218
Medway Carers Strategy Action Plan 2009-2014	Outlines Medway Council's commitment to supporting carers. http://www.medway.gov.uk/pdf/12%2010%2004%20Medway%20Carers%20Strategy%20Action%20Plan%20September%202012%20final%20for%20publication.pdf
The Council Plan 2013-2015	Outlines Medway Council's core values and

	key priorities for 2013/15 http://www.medway.gov.uk/pdf/Council%20Plan%20Medway.pdf
Sustainable Community Strategy 2010-16	Outlines Medway Council's commitment to supporting growth and a vibrant local voluntary and community sector. http://www.medway.gov.uk/pdf/sustainable_com_strategy_web.pdf
Home Truths Report	Summary report highlighting commissioning recommendations to address gaps across health and social care. Available on request
Report to Medway Health and Wellbeing Board (Public Meeting) – 9 January 2014 and 2 April 2014	Report for board members outlining requirements of Better Care Fund and agreeing direction of travel. http://democracy.medway.gov.uk/mgconvert2pdf.aspx?id=22218
Medway Council Cabinet report regarding Better Care Fund – 14 January 2014 and Addendum Report	Report for Cabinet members outlining requirements of Better Care Fund and seeking approval to delegate responsibility for developing plan to Director of Children and Adults Services and Portfolio Holder for Adults Services. http://democracy.medway.gov.uk/mgconvert2pdf.aspx?id=22249
Medway CCG Governing Body report regarding Better Care Fund – 22 January 14 and 26 March 2014	Report for Governing Body members outlining requirements of Better Care Fund and seeking approval to delegate responsibility for developing plan to Chief Clinical Officer, Chief Operating Officer and Chief Finance Officer. http://www.medwayccg.nhs.uk/about-us/meetings-held-in-public/
Medway Better Care - Right care, right time, right place (Draft Communications and Engagement strategy February 2014)	Outline plan of on-going communication and engagement with providers, public and carers.  14.02.06 Medway Better Care Comms a
Better Care Fund – Annexe 1	Description of projects to be funded via Better Care Fund.  9 Sept 14 Appendix 1 summary of project
Public Health Programmes and Alignment to Better Care Fund Plan	The Better Care Fund Plan's integrated approach, with a focus on prevention and early intervention, align directly with the

	principles highlighted in Medway's Joint Health And Wellbeing Strategy (JHWS). Key Public Health led programmes and activities which align to the BCF plan themes are shown in the table attached. Public Health programmes and aligr
Medway BCF Report (Institute of Public Care)	Review of planned activity in Medway BCF plan against national evidence base Medway BCF Report March 2014 (1).doc
Medway CCG Informal Governing Body report regarding Better Care Fund – 27 August 2014	14.08.19 IGB report.doc
Medway Council Cabinet report regarding Better Care Fund – 2 September 2014	14.08.20 FINAL Cabinet report.doc
Report to Medway Health and Wellbeing Board - 9 September 2014	FINAL HWB report.doc
Risk Scoring Matrix used to determine risk levels for Section 5.	Guidance - Calculating Risk Score
Carers Support Service Specification	Carers Support Services Specification

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

We will foster a healthy and flourishing Medway through an integrated health and social care service that provides the right care, in the right place and at the right time.

Medway's resident population is around 263,900, with a registered population of around 283,000. People over 65 make up 14.1 per cent of the population. Projections from 2010 to 2020 suggest that the number of people 65 years of age or over will increase by 29 per cent to 46,900 and the number over 85 years will grow by 34 per cent to 5,500. This will result in increased pressures on the Medway health and social care economy without significant investment in preventative activities which enable people to live longer, healthier lives independently in their own homes. This requires a shift from a reactive to a more proactive preventative focused health and social care system. More information about the health of people in Medway can be found in Medway's Joint Health and Wellbeing Strategy (2012-2017) and the Medway JSNA.

The vision for health and social care services across Medway for 2018/19 outlined in this Plan reflects the underlying principles identified in Medway's Joint Health and Wellbeing

Strategy and is reflected in the wider CCG Strategic Plans and 2 year and 5 year plans. These are a commitment to an integrated systems approach and partnership working; a focus on prevention and early intervention in all areas; on-going and effective stakeholder communication and engagement and a commitment to sustainability. It is recognised that the challenges facing the health and social care system, in part through an ageing population, cannot be met in isolation, but must be addressed through greater integration of health and social care funding and systems and a whole system transformational approach.

Similar to other areas in the country, Medway is experiencing increased demand on its services with increasingly limited resources in both health and social care. Whilst we strive for continued better value for money from our services we recognise that this is not just a financial issue. Our vision for the next 5 years is a fundamental transformation of the quality and experience of health and social care across all elements of commissioning and provision, which will result in improved individual outcomes as well as a demonstrable greater experience of our health and social system.

We are committed to enabling people in Medway to live more independent and healthier lives by giving them greater choice and control, maximising their social support systems, through building resilient communities. We will engage with the people who use our services to understand and map their experiences, capabilities and needs in order to put people at the centre of what we do. We will put the people who use our services at the centre of what we do, doing this with them rather than to them. This is about a real commitment to understanding the challenges people face in their day-to-day lives and how these challenges can be addressed so people have more positive experiences and outcomes in the future.

All partners recognise that there is much more work to do, and this will mean putting in place a new and transformational service model based on integrated multi-disciplinary teams working closely with primary care and specialist services. It also means that we will place a strong focus on wellbeing, speed of response, striving for maximum independence, reablement, maximising self-management, prevention, providing services in people's own homes.

b) What difference will this make to patient and service user outcomes?

As a result of the changes proposed, by 2018/19 Medway anticipates that these changes will have come into effect:

- More resilient communities and a new relationship between urgent care and community services
- More people living independently in their homes for longer
- Improved satisfaction of people's experiences of the health and social care system
- Reduction in long term dependency on statutory services through a healthier population and improved community and neighbourhood responses
- Less people, including children, using A&E inappropriately
- Reduction in non-elective acute admissions and inappropriate use of A&E

This will be achieved by:

- Improved care co-ordination, including GPs at the centre of people's care
- Improved access to reablement, rehabilitation and intermediate care
- Improving integrated care pathways, including for people with dementia
- Greater and smarter use of assistive technologies including social media, allowing vulnerable people to continue to live independently and/or receive care at home
- Use of risk stratification tools to target initiatives at those in most need
- Integrated commissioning of services
- Data sharing across health and social care (including mental health)
- Providers of care and support being incentivised to reduce reliance on care and support services with a greater focus on reablement
- A new relationship between urgent care and community services
- Integrated commissioning and developing integrated services
- Ensuring that people have access to the right services, 7 days a week (including out of hours) where it is needed

We are aware that a number of uncertainties still exist in relation to proposed investments and outcomes. This plan is still in its developmental stages and will be further progressed and built upon throughout 2014/15. The figures and information we are sharing are our best estimates based on work-to-date and these will invariably evolve and change as our knowledge and understanding grows. Some of this understanding will be gathered through beginning some of the schemes early in 2014/15 allowing the partnership to gather evidence of what is working and begin the shift away from acute care as early as possible.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

In order to secure improved outcomes in health and social care in Medway the following key strategic aims have been identified for the Better Care Fund Plan:

- Co-ordinated care around individuals using a proactive and joined up case management approach
- Improved outcomes for the people who use our services and the local community
- Improved experience of care for people who use our services and their carers
- Maximise independence, avoiding hospital admissions and use of nursing and care homes
- Preventative services support people to stay well and healthy for longer

The success of the Better Care Fund will be monitored through the delivery of these 5 key strategic aims and through regular reporting to the Joint Commissioning Management Group, the Health and Well Being Board and where necessary to Medway Council's Cabinet and the Medway CCG Governing Body.

In order to achieve our vision and the five strategic aims, we recognise that this will require building on identified areas of good practice and, where necessary, significant change across the whole of the health and social care economy in Medway. In order to

achieve a significant shift away from the use of acute services, all providers of health and social care services will need to change how they work. The changes proposed will help drive reductions in emergency admissions to hospital, reduce lengths of stay in hospital and reduce the demand for nursing and residential home care. In order to monitor the impact of integration, the following will be used to show success of the schemes:

- Less people, including children, using A&E inappropriately
- More people living independently in their own homes, avoiding or delaying the use of nursing and care homes
- Demonstrable improvements in people's personal experiences of the health and social care system
- GPs at the centre of organising and co-ordinating people's care, specifically those over 75 and/or with complex needs
- Stronger community resources which prevent people entering into high cost, long-term care packages
- Carers feeling better supported and their own needs better met
- Reduced demand on the acute sector through a shift in resources from bed-based to community-based care
- A local social care system equipped and resourced to meet its duties set out in the Care Act

Our key success factors will be to:

- reduce length of stays in hospital;
- reduce number of permanent admissions to nursing and residential care homes;
- reduce attendance at A&E (including repeat visits);
- reduce readmission to hospital;
- reduction in A&E visits following a fall in over 75 year olds;
- reduction in hospital admission/A&E from nursing and residential homes;
- reduce use of nursing and residential care homes;
- reduce home care packages following a period of reablement;
- increase number of carers' assessments, including via GP surgeries
- Increase percentage of people with a long term condition with a care plan
- Improved levels and quality of mental health services in acute settings and A&E

We will be preparing for the Better Care Fund in 2014/15 by reviewing existing commitments, establishing an evidence base (including through piloting some schemes), sharing resources that will ensure real progress towards our vision for health and care services in 2018/19, with associated improvements in the quality and experience.

The planned changes will involve putting the people who use our services, and those who care for them, at the heart of everything we do. We believe that this is the only way we will ensure a sustainable, healthy future for the communities we serve and deliver services which promote independence. This means we will need to:

- Put people at the centre of their own health and care
- Embed choice and control and personalised care as a core principle of both health and social care provision
- Reduce the fragmentation of provision and the problems this creates.

- Invest in reablement, prevention and community recovery to reduce long term care needs
- Bring about better integration and engagement between social care, community and mental health, GPs and Medway Foundation Trust (including mental health services)

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Officers liaising with colleagues in Public Health and the CCG to gather evidence to support Medway's Case for Change.

LGA/NHS England guidance re what good looks like for this question:

• Provide a clear and quantified understanding of the precise issues that the BCF will be used to address in your local area

• Include risk stratification of entire population and segmentation of opportunity to improve quality and reduce costs

• Be supported by data – e.g. data that quantifies levels of unmet need, issues of service quality, or inefficiencies in service delivery

• Provide visualisations of data if appropriate – do you have any graphs or diagrams that illustrate these issues?

• Articulate at a high level how integration (of systems, processes, teams, budgets) could be used to improve this issue – i.e. set out in broad terms the theory of change or logic that supports your BCF plan

To help us to achieve our vision we will ensure people who use our services have safe, affordable and high quality services and by working in partnership**,** maximise outcomes across the health, social care, public health, housing and the community and voluntary sector. Our approach will be based on the principles of integration and a focus on preventative activities as the key drivers to secure better outcomes for our population and deliver the financial efficiencies that are required given the ever increasing demand for support and our restricted budgets.

We recognise that this transformation will require the input of a range of health and social care providers and greater integration with housing providers, including the development of additional extra care housing. At its centre will be the views and experiences of the local population, including those using services and those who care for them.

Medway GPs use a risk stratification system provided by Kent and Medway Health Informatics Service to proactively identify patients at high risk of hospital admission. This information is also available to Medway Community Healthcare case management teams.

Those patients identified through risk stratification as being at very high risk and high risk are considered for active case management by a multi-disciplinary team meeting. Practices can also nominate any patients they feel are suitable for active case management who may have been missed by the risk stratification protocol. During 2013/14, 35 out of 57 practices participated in risk stratification, case management and care planning, resulting in 126 patients being discussed at MDT meetings and having care plans in place. Case management will be further expanded during 2014/15.

Additionally the 2014/15 unplanned care admissions DES will identify the top 2% vulnerable adults aged 18 or over, and any additional children who have complex health and care needs which require proactive case management and personalised care plans. These will be considered for inclusion on the GP case management register.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Key Milestones

April 2014 to March 2015

- Establish Section 75 joint governance arrangements between Medway CCG and Medway Council
- Review existing services, specifications and contracts
- Complete detailed planning to implement concepts/projects developed during co-design phase to achieve our objectives
- Develop detailed operational project initiation documents
- Test models and share learning
- Monitor financial flows and shadow budgets to evaluate financial impact of possible models on different providers and on total costs to commissioners
- Review workforce requirements
- Explore low cost/no cost solutions
- Implement communication and engagement plan
- Complete Diversity Impact Assessments for individual schemes where there is potential impact on existing services
- Prepare workforce and implement duties under the Care Act
- Regular reporting of performance and progress of implementation to Medway's Health and Wellbeing Board, Health and Adult Social Care Overview and Scrutiny Committee, Medway CCG Governing Body and Medway Council's Cabinet

March 2015 onwards

- Implement Better Care Fund Plan in full
- Clinical and financial audits to determine what difference the money is making
- Regular reporting of performance to Medway's Health and Wellbeing Board,

Health and Adult Social Care Overview and Scrutiny Committee, Medway CCG Governing Body and Medway Council's Cabinet

A detailed Project Initiation Document has been developed for each programme identified under the Better Care Fund Plan for Medway held at an operational level and is available on request. A summary of each project has been included at Annexe 1 with key milestones and success measures.

b) Please articulate the overarching governance arrangements for integrated care locally

The Better Care Fund Plan submitted to LGA/NHS England in April 2014 was formally approved by both Medway CCG's Governing Body and Medway Council's Cabinet. The required revisions for September 2014 have been endorsed by the Health and Wellbeing Board for Medway at a special meeting on the 9 September 2014 and Medway CCG's Informal Governing Body on 27 August 2014.

Medway Council and Medway CCG have established a Joint Commissioning Management Group at senior officer level to develop and deliver joint commissioning plans for integrated care. This Group will oversee the mobilisation and implementation of the Better Care Fund Plan. Progress reports will be provided to this group on a 6-weekly basis. It will be the responsibility of the Group to ensure that the aims and objectives identified are achieved. The development of any strategies and operational plans will be subject to scrutiny and ratification via this Group.

Strategic oversight of the Better Care Fund Plan will be provided through regular reporting to the Health and Wellbeing Board, who will ensure that the plan continues to meet the strategic health and wellbeing priorities of Medway.

Effective oversight and co-ordination will be delivered through regular briefings to the Council's Cabinet and the Health and Adult Social Care Overview and Scrutiny Committee and to the CCG Governing Body. The Cabinet is the constitutional forum for key decision-making and a key part of the due process for the changes envisaged in this document and oversight, scrutiny and challenge will be provided through the Scrutiny Panel.

Throughout this process, we will ensure that the local Health and Wellbeing Board remains central to the development and oversight of the proposed schemes comprising our Better Care Fund, with a focus on helping to ensure effective debate and engagement and that our plans are aligned with the priorities of local communities.

The Local Area Team for NHS England has been consulted on the development of the Better Care Fund Plan.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Day to day implementation of the Better Care Fund Plan will be overseen by the Director of Children and Adults Services for Medway Council and Chief Operating Officer of the

Medway CCG, delegating responsibility to the Assistant Director for Partnership Commissioning. Exception reports and urgent issues will be escalated to the project sponsors (Director for Children and Adults Services and Deputy Director for Children and Adult Services for Medway Council and Chief Operating Officer for Medway CCG) that require immediate action or if there is a risk of deviation from the Better Care Fund Plan. Any significant variation in the plans, or where there is significant identified risk, will be addressed at Medway CCG Governing Body, Medway Council's Cabinet, and/or Health and Adult Social Care Overview and Scrutiny Committee.

The Better Care Fund plan implementation will have a dedicated Programme Manager, who will be able to access support from data analysis, HR, IT, finance, estates, legal and others across the partnership as required.

All schemes will have a project initiation document (PID) setting out aims, objectives, timescales, metrics, resources and risks, and a Lead Officer. The Joint Commissioning Management Group will meet 6-weekly to address barriers and ensure timely progress is made.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	**Infrastructure development and support** Preparing for the Care Act, reviewing existing services and contracts, workforce planning, information governance (including use of NHS number as primary identifier), capital investment in IT infrastructure and on-going associated revenue costs, and further investment in Partnership Commissioning. Much of this will be non-recurring activity to take place during 2014/15.
2	**Combatting Social Isolation** Investment in preventative activities, primarily through the local voluntary and community sector, including low cost/no cost solutions, initiatives to combat social isolation and the development of contracts with in-built incentives to re-invest in the community and targeted work at the most vulnerable populations. We will pilot initiatives during 2014/15 to take forward as part of wider integrated health and social care programme. This will include closer integration with the wider public health programme, which the Better Care Fund plan has been aligned with.
3	**Reablement, rehabilitation and intermediate services** Expansion of availability of reablement and greater integration with community rehabilitation and intermediate services. We will redesign our rehabilitation and reablement service model and pathway to provide, with

	our integrated rapid response service, a model which will work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and with appropriate information and support, to self-manage their health conditions and medication. There are currently a range of fragmented reablement activities which work in a reactive way. It is intended to enhance reablement services to prevent admission to care homes and speed up hospital discharge. As a priority for 2014/15, we will remodel the reablement pathway to ensure that all providers, including acute and mental health providers, will be clear about their contribution to community-based recovery following injury, falls or illness. This will include clear social and functional outcomes and will feed into any future homecare procurement. This will also include the development of intermediate care services, including a review of existing use of intermediate care beds, focusing on 24/7 solutions and less reliance on bed based services.
4	**Community Equipment and Assistive Technology** Building on the overarching vision of promoting independence and prevention, a specific agreed priority area is the increased use of equipment and assistive technology. This will incorporate adaptations and greater utilisation of Telehealth and Telecare. There will be a review of the use and access to complex equipment required for areas such as effective pressure management to reduce pressure sores, preventing falls and speeding up hospital discharges. This review will be across health, housing and social care, ensuring that there is an effective interface across the sectors and ensure that we are getting best value from our contracts.
5	**Carers' Support** Continue to commission carers' support services, whilst ensuring that they meet current requirements within an integrated model of care. This will include meeting requirements under the Care Act for an expansion in carers' assessments and additional support. Ensuring that Carers and family members are given the right amount of support is essential to preventing the breakdown of existing support networks and key to preventing inappropriate use of A&E as well as nursing and residential placements.
6	**Universal Information, Advice and Advocacy** Ensuring that the people of Medway have suitable information, advice and advocacy to access the most appropriate services, as well as ensuring that professionals are able to signpost people to preventative services rather than more costly statutory provision. This will include developing robust and reliable sources of advice and support for older people and their families before they become frail or need to access the statutory system. Such information will be easy to access, clear, friendly and personalised and made available in the right formats (including easy read formats). We will seek opportunities to transform how we do this with new and developing technologies and social media.

7	**Community Services Redesign** Improved integrated working across health and social care with a focus on co-ordinated care with a named lead professional, including 7-day working, single point of access, and risk stratification to identify the most vulnerable/high risk patients. Flexible provision over 7 days will be accompanied by greater integration with mental health services. A core focus will be on providing joined-up support for those individuals with long-term conditions and complex health needs. There are clear links with other areas of development notably integrated rapid response, hospital discharge and intermediate care. The redesign of community based services, with the GP at the centre of peoples care, is the central focus of the Better Care Fund plan of which other elements are dependent on. Practice co-design of the community model is essential.
8	**Integrated Rapid Response** Further investment in avoiding hospital admission and improve discharge through further developing and expanding the Integrated Rapid Response Service. The service will provide a rapid response to support individuals who are deteriorating and stabilising them so they can remain at home. The service will also introduce individuals to the potential of assistive technologies and where these are to be employed; will ensure individuals are familiarised and comfortable with their use.
9	**Care Co-ordination and Lead Professional** The development of new services aimed at providing care around the individual as well as named professional lead, including Community Health Worker for Older People. The GP will remain accountable for patient care, but with increasing support from other health and social care professionals to coordinate and improve the quality of that care and the outcomes for the individuals involved. We will deliver on the new provisions of General Medical Services (GMS), including a named GP for patients aged 75.
10	**Dementia Services** The Council and CCG will develop a Joint Medway Dementia Strategy that will seek to develop a whole community approach to supporting people and their carers. Adopting the national campaign to develop *dementia-friendly communities,* in support of the Prime Minister's Challenge on Dementia, the strategy will link together core services not only within health and social care but across the community. Fundamental to this development is the direct engagement of people with dementia, their families and carers as well as community groups (e.g. faith groups, voluntary organisations), statutory services (e.g. health, social care, public health, police) and local business (including those who have committed to supporting developing staff awareness on a national level such as Marks & Spencer, Lloyds Bank). The strategy will look at how a dementia-friendly community can develop community resilience and support people with dementia from early diagnosis through to end of life; redesigning existing services with the

	potential to develop new initiatives to reflect what the local community need and aspire to.
11	**Falls** Development of new services focusing on preventing falls, providing care in the community, reducing use of A&E and hospital admission.

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
MFT are unable to reduce overheads linked to a reduction in activity from BCF impact, compromising their financial position.	2	3	6	CCG and MFT are working closely together to ensure detail of plans aligned and impact understood.
Shifting of resources to fund new joint interventions and schemes will destabilise current service providers, particularly in the acute sector.				See comments above. A Transition Plan will be developed and implemented with Medway NHS Foundation Trust to ensure areas of concern are identified early and appropriate actions implemented in a timely fashion.

A lack of detailed baseline data and the need to rely on current assumptions means that our financial and performance targets for 2015/16 onwards are unachievable.				We are undertaking a detailed analysis of current data in order to validate our plans.
Operational pressures on the workforce will restrict the ability to deliver the required investment and associated projects to make the vision of care outlined in our Better Care Fund submission a reality, including workforce recruitment, skills analysis and change management.				Our 2014 schemes include specific non-recurrent investments in the infrastructure and capacity support of the overall organisational development including workforce.
Day-to-day operational involvement from providers prevents them from making the required changes to develop a long-term integrated vision.				Commissioners will work closely with providers throughout the process and ensure that they have the necessary support and resources to deliver the required changes in the timeframe required.
Inability within the timeframe required to address the cultural and competency requirements across the whole workforce to enable integrated working to be successful.				Through engagement with service providers we will ensure diverse staff groups are brought together to build a new integrated professional identity reinforced by physical co-

				location, joint management structures and shared training.
Preventative services will fail to translate into the necessary reductions in acute and nursing / care home activity by 2015/16, impacting the overall funding available to support core services and future schemes.				Business Support will ensure that activity is monitored and report any deviation from planned trajectory to the Joint Commissioning Board who will put in place remedial action in a timely fashion.
The introduction of the Care Act will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.				We have undertaken an initial impact assessment of the effects of the Care Act and will continue to refine our assumptions as we develop our final Better Care Fund response.
Performance levels impact on achieving Payment by Performance related funding and impact on overall Better Care Fund Plan and affordability.				We will ensure that the performance of all Better Care Fund funded schemes is robustly monitored allowing under-performance to be identified and proactively managed.
Improvements in pathway redesign could result in improvements in data collection and coding in acute care				Robust checking of data prior to setting targets.

adversely affecting baseline figures.				

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

LGA/NHS England guidance re what good looks like for this question:

- Quantify the amount of the pooled funding that is 'at risk'
- Demonstrate that this has been calculated using clear analytics and modelling. Link to Payment for Performance tab, Part 2 plan template
- Articulate an agreed plan for how this funding will be spent
    - What services or development will this be used to fund?
    - In which quarter will you receive this, and what are the implications for financial management?

• Confirm that the Health and Wellbeing Board has been consulted on this plan of action and that they are aware of the spend

• Articulate any other risks associated with not meeting the target for reduction in unplanned emergency admissions – will this have any knock on implications? How far can these be mitigated through pre-emptive actions?

• Articulate what proportion of the financial risk will be born by each party, and how these are reflected in contracting and payment arrangements

There will be robust monitoring of contracts, investing in services that will achieve outcomes, including the development of incentivisation clauses in some contracts. Through pump priming some projects in 2014/15, we will have greater clarity and information about what works and building on the evidence base, as well as possibility of releasing cash savings in 15/16. The CCG and Council will look to develop a contingency fund through identifying schemes/projects where funding can be ceased/diverted.

The BCF performance framework will be agreed and signed off by the Joint Commissioning Management Group. The performance against the BCF targets will be monitored on a monthly basis and reported to the Joint Commissioning Management Group. The Joint Commissioning Management Group will monitor performance and report to the CCG Governing Body, Council Cabinet and inform the Health and Wellbeing Board of progress in a timely nature.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Medway has already adopted a joined up approach at a community level with a number of integrated services, including a Rapid Response Team; Hospice Team; Stroke Team and Integrated Hospital Discharge Team. The introduction of the Better Care Fund

allows for the further development of integrated community based services aimed at avoiding unnecessary use of A&E, reduction in unnecessary hospital admission, reducing length of stay in hospital and improving outcomes for service users and carers. Further transformation/redesign is required to make our ambitions a reality, with a focus on wellbeing, prevention, self-care, reablement, striving for maximum independence and breaking down barriers to health and social care.

This will include exploring the introduction of systems that improve co-ordination of care, including incentivising providers to coordinate with one another. This will ensure there is accountability for outcomes to be achieved for individuals, rather than just making payments for specific activities. It also encourages provision of care to be provided in the most appropriate setting, by allowing funding to flow to where it is needed, with investment in primary and community care and primary prevention.

Through the planned changes we will coordinate activity across the full range of public service investments and support, including not just NHS and adult social services, but also housing, public health, the voluntary, community and private sectors. Importantly, it means working with individuals, their carers and families to ensure that people are enabled to manage their own health and wellbeing insofar as possible and in doing so to live healthy and well lives. Planned changes under the Better Care Fund plan are integral to the development of a Commissioning Strategy for Supported Housing and a planned growth in extra care housing.

Through improvements in community-based services, the volume of emergency activity in hospitals will be reduced and the planned care activity in hospitals will also reduce. A managed admissions and discharge process, fully integrated into local specialist provision and community based recovery, will mean we will eliminate delays in transfers of care, reduce pressures in A&E and wards and ensure that people are helped to regain their independence after episodes of ill health as quickly as possible.

Our plans are designed to ensure that mental health is integrated with community health services and social care teams with focus on increasing the identification and management of the full range of adult mental health conditions in primary care.
Ensuring ‘parity of esteem’ through mental health receiving an equal priority to physical health in service design and delivery through raising awareness within primary care and other health care professionals is a priority within Medway.

By improving the way we work with people to manage their conditions, we will reduce the demand not just on acute hospital services but also on nursing and residential care.

Several voluntary organisations already provide health and social care to Medway residents; however this is often not within the framework of any other care they receive. We want to ensure that the huge value of the voluntary and community sector is realised through better integrated care. We will work with the network of local voluntary organisations, CVS, to map the services that they offer, and are engaging in plans with them over the coming months in order to involve them fully in plans for integrated care, with a view to commissioning services from them.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The BCF plan aligns to the CCG 5 year strategy and 2 year operating plans as noted by NHSE Area Team in their review of the CCG plans. All key schemes are recognised in the CCG plans and the CCG and Medway Council provide joint oversight to BCF schemes through the Joint Commissioning Management Group and any changes to any aspect of the schemes (timeline, model etc.) are jointly agreed.

There are a number of key areas within the BCF where we are currently developing the strategy in order to inform the detailed model of care (i.e. intermediate care and dementia). This will further inform the detail of some of the plans for 15/16 and beyond which will be agreed through both governance structures. If risks are identified regarding the plans then this will be addressed through the joint group and through organisational governance structures as required. Over the past year we have worked together on a number of challenging joint commissioning issues and have used the structures described to manage to successful conclusions.

The governance structure established will ensure that we have a robust process for reviewing and refreshing our plans and will of course inform CCG plans for 2016-18.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

We are working with practices to form ‘hubs’ that community services can be wrapped around. We and practices recognise that one of the key elements for success is that patients have someone who is accessible, works as the advocate of the patient and is trusted by patients and carers. There are similarities between the model being developed for health and the model being developed by the council through DERiC for social care. Whilst we are not forcing a single solution for health and social care we believe that a common approach will lead to a single solution.

The CCG’s priorities start with prevention and this fits perfectly with the BCF which is in essence either primary or secondary prevention, to lessen peoples need for or reliance on health and social care. Support needs to empower individuals their families and their carers not make them more dependent. This is as much cultural as structural.

The CCG will be working with NHS England on co-commissioning primary care and has essentially requested that all resources are allocated on a population needs basis, and that apart from those services which form part of the core NHS General Medical Services GP contract that all other resource is available to the CCG to be allocated based on the needs of the population. We have also requested to work with Public Health England to co-commission outcome based services at CCG level rather than individual practice level. Final Guidance and position on co-commissioning is expected in September/October.

Practices have been actively involved in the development of ‘hubs’ and the core

elements of the community services and see this as helping them support patients and deliver the requirements of named GPs to the most vulnerable and avoidance of unnecessary admission. Co-commissioning aspirations have been shared with GPs and providers.

We are also working with Health Education England to develop a more locally tailored approach to training which will include training nurses in primary care.

Through software embedded into GP's clinical IT systems we have the ability to both audit care within primary care and also influence the care given and use data mining approaches to identify those who would potentially benefit from screening or a follow up intervention. No patient identifiable information leaves the practice and the system supports clinicians to provide better care its performance enhancing not performance management. Examples of the success of this approach have been shared at national and international conferences.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Protecting adult social care services in Medway means ensuring that those people in most need within our local communities continue to receive the support they need, in a time of growing demand and budgetary pressures. Whilst maintaining current eligibility criteria is one aspect of this, our primary focus is on developing new forms of joined up care which help ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and the local health and care economy as a whole.

A key driver to the proposed changes is an increased focus on preventative activities. We will proactively intervene to support people at the earliest opportunity and ensure that they remain well, are engaged in the management of their own wellbeing, and, wherever possible, enabled to stay within their own homes. Our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focussing on the supply of services.

Medway Council's eligibility criteria will remain the same at substantial and critical, however, there will be in addition an increased emphasis on supporting people at the earliest possible opportunity, reducing or delaying the need for statutory services. Funding currently allocated under the Social Care to Benefit Health grant has been used to enable Medway Council to sustain the current level of eligibility criteria and to provide timely assessment, care management and review and commission services to clients

who have substantial or critical needs, as well as information and signposting to those who are not FACS eligible. This will need to be sustained, if not increased, within the funding allocations for 2014/15 and beyond if this level of offer is to be maintained, both in order to deliver 7 day services and in particular as the new Social Care Act requires additional assessments to be undertaken for people who did not previously access Social Services.

It is proposed that additional resources will be invested in social care to deliver enhanced and integrated rehabilitation/reablement services which will help to reduce hospital readmissions and admissions to residential and nursing home care.

The capital funding associated with Disabled Facilities Grant (DFG) within the BCF will ensure joint working with housing partners in securing wider investment in homes that promote independence, as well as adapting existing housing stock. Any intended or unintended consequences for social care services will be monitored as part of our plan and is highlighted in our risk log. These will be mitigated by adopting a whole system demand and capacity.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

The Better Care Fund will be used to support adult social care services which also have a health benefit. The use of the fund and outcomes expected will be jointly agreed by Medway Council and Medway CCG, taking into consideration intelligence within Medway's JSNA and the CCG 5 year strategy and 2 year operational plan.

Social Care Services will be protected by:

- Ensuring a commitment to work towards achieving fully integrated health and social care services at a community level and develop fully integrated services with primary and acute care
- Reducing demand on acute services through investment in preventative schemes and maximising use of assistive technologies
- Diverting demand away from specialist services through better signposting and information
- Facilitating an adult social care market which delivers affordable, quality outcomes for service users
- Ensuring robust monitoring of services is in place to prevent harm to adults
- Encouraging provider organisations to develop collaborations and integrated services to meet demands
- Engagement with local interest groups
- Scoping new service models and encouraging innovation and creativity
- Investment in reablement services
- Working closely with the voluntary sector and communities to develop further capacity to complement that of the public sector services and to promote self-help and independence for people living at home
- Support for carers to continue in their role

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services (and please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Implementation of the Care Act 2014 is within the council's policy and budget framework including the Council Plan. Medway Council, as a Unitary Local Authority, has duties and powers to provide Adult Social Care; the council's budget sets out how Medway Council allocates funding for Adult Social Care and the Council Plan includes the priority of 'Adults maintain their independence and live healthy lives' arising from the council's values of 'Putting our customers at the centre of everything we do' and 'Giving value for money'.

The Care Act 2014 received Royal Assent on 14 May 2014 and comes into force in stages during 2015 and 2016. From April 2015, the Care Act 2014 will replace various pieces of existing legislation, which will be disapplied or repealed, so they will no longer have force in relation to England. The Care Act 2014 and its supporting regulations and guidance will also replace a number of existing regulations, directions and guidance. The scale of the legislative change can be seen in Fig. 1 below.

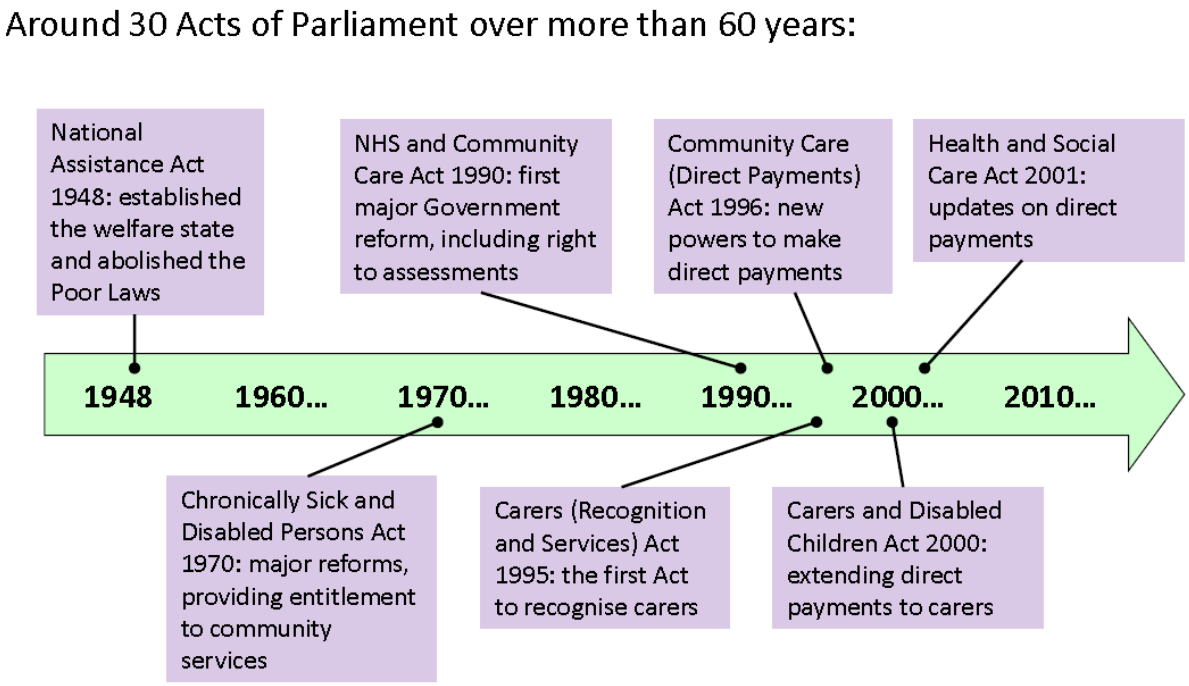

Fig 1.

The Care Act 2014 timeframes are as follows:

Key requirements

From April 2015

- Duties on prevention and wellbeing

	• Duties on information and advice (paying for care) • Assessments (including carers' assessments) • National minimum threshold for eligibility • Personal budgets and care and support plans • Safeguarding • Universal deferred payment agreements • Duties relating to carers • Duty on market shaping and market failure • New charging framework
From April 2016	• Extended means test • Care Accounts • Capped charging system • Appeals system

The Care Act 2014 reinforces the personalisation agenda and, for the first time, establishes primary legislation in relation to carers. It also establishes new duties on the Local Authority – most notably in relation to prevention, carers, market sufficiency and establishes Safeguarding Adults on a statutory footing.

Whilst much of the national attention has been focused on financial reforms, the Care Act 2014 will also have significant impact on the council and on the services it provides and commissions. It also continues the drive towards ever closer integration with the NHS.

Draft regulations and guidance have been issued for consultation. Finalised regulations and guidance are expected from the Department of Health in October 2014.

Financial modelling is continuing to ensure that the best possible representation can be made to Government about the financial provision that needs to be made to implement the Care Act 2014. There is a significant risk that these are under estimated and it will be important that new money will be made available to meet the costs.

Eligibility: from April 2015 new national eligibility criteria for people accessing Adult Social Care will be established. The purpose of this reform is to ensure a more consistent approach across the country and to make it easier for people to move location, with greater certainty that their care and support needs will be met. Whilst this is a welcome change in many ways, there is widespread concern that the threshold for eligibility being set by Government, although described as "substantial need" (the current Medway Council threshold) will make many more people eligible than is currently the case. This is because draft guidance includes characteristics of need that would not currently be considered "substantial" under the current Fair Access to Care Services (FACS) criteria.

Carers: for the first time this legislation puts carers on an equal legal footing as those they care for. Again, this is a welcome development as the vital role of carers is widely understood and we need to do all we can to support them. The council, and its NHS partners, has well-established support arrangements for carers (including young carers) but it is likely that the Care Act 2014 will lead to a significant rise in carers' assessments

and further financial pressure as more carers seek our support. The current projections estimate a sevenfold increase.

Prevention: the new duty of prevention is not yet widely fully understood but is, again, a welcome development. We all understand that people and communities need to be given ready access to advice and information and early help to meet their own needs and to reduce reliance on statutory services. The case for prevention in terms of better outcomes, quality of life and value for money is well evidenced in Adult Social Care. Whilst the new duty of prevention may appear to be a new burden in the short-term, it could be considered to be a helpful formalisation and reordering of practice and commissioning to achieve these aims. The role of Public Health, especially in prevention and early help is expected to be significant.

A responsibility to all Medway's citizens: crucially, the provisions of the Care Act 2014 apply to all citizens, whether buying and arranging their own care or when their carer is commissioned by the council. Coupled with the funding reforms it is clear that many more people will contact the council for assessment and other assistance each year. It will be necessary to develop new ways of working to manage this demand in order to fulfil our new responsibilities and to minimise the financial impact on the council.

Health and Social Care: the Health and Social Care Act 2012 set the direction for closer working between health and social care, and the Care Act 2014 continues this direction of travel. Developing whole system, personalised solutions that place the individual at the heart of our commissioning and service design will require ever closer integration between health and social care. We already have integrated working in the way that we commission some services and in our approach to care management (e.g. joint assessment); the Care Act 2014 will require us to consider the extent to which we integrate both in terms of commissioning and service provision for the people of Medway.

Funding reforms: From April 2015 a new charging (contributions) framework comes into effect. From April 2016 we will see the final stage of the Care Act 2014 come into force when the funding reforms are implemented. These reforms will set new financial thresholds for contribution and place a cap on the contribution that individuals will make towards their lifetime care cost. It also requires councils to make deferred payments available so that people do not have to sell their home should they need care. Details of the charging framework are yet to be finalised so it is not yet fully clear what impact this aspect will have; however, significant changes to the way we undertake client financial assessments, the scale and timeliness of those assessments, will be necessary and the synchronicity of financial assessments with care assessments will be essential to minimise the impact on service users and the council. The council already has a deferred payment scheme (although it is likely that some work will be needed to adapt our scheme to the national regulations) but the wider funding reforms potentially represent a very significant risk to the council. Further work on modelling this impact is continuing both within the Council, and regionally and nationally through ADASS (Association of Directors of Adult Social Services).

From October 2015 people will be able to apply to the council to set up care accounts to track their expenditure against their lifetime cost of care, currently set at £72,000. There is a widespread lack of public understanding about this and it is likely that people will think it will help them far more than is likely to be the case. This is for a number of

reasons:

- It only applies to eligible need, so the council will first need to satisfy itself that the service being purchased by an individual meets the eligibility threshold
- The allowable costs are not prescribed nationally but relate to the usual costs that would be incurred by the Local Authority; if for instance an individual is paying in excess of the level determined by the council, the excess would not be counted
- If someone is in a care home they will be expected to pay their hotel costs i.e. accommodation, utilities, food as they would have done had they been at home. Currently these are understood to be £12,000 per annum. The amount that counts towards the cap is therefore limited to the costs of care

Taken together, it is estimated that only 8 to 12% of the population will reach the cap level. However, the fact that most self-funders will apply for a care account will bring many more people into contact with the council, and make transparent the transactions that currently take place between self-funders and providers and in doing so will impact on the relationship between the council and these providers, especially if people ask the council to arrange their care for them.

Market sufficiency: greater understanding of the private market will give the council a much more rounded understanding of local and neighbouring care markets and this will be helpful in understanding how effectively they are meeting need, need to change to better respond to changing patterns of need and what role the council should play in supporting them. Equally, it will mean a change to the way that providers engage with those service users who currently have no contact with the council and this will need to be carefully managed. Considerable work will be required, although prior work on the council's market development strategy should prove helpful.

The Care Act 2014 has been welcomed as an important and long overdue reform and, in many ways, it consolidates and strengthens the direction of travel that health and social care is taking. Its impact will be far reaching and the implications for the council are significant. There is a clear understanding that, to prepare effectively, there needs to be a commitment across the organisation at a very senior level and that this be reflected in the make-up of the major programme board. As work progresses and implications become clearer, widespread communication will be needed, with partners and providers, and with the general public.

We are proposing to establish a reference group. Service user and carer voice will be an essential element and in addition to the reference group it is proposed that they be directly represented on a programme board. Medway Council, like all Local Authorities, has received funding under a Memorandum of Understanding with the Department of Health for the employment of a Programme Manager and to resource backfill of operational / practice input into implementation arrangements.

The Care Act 2014 provides Medway Council with an opportunity to more than enact new legislation, albeit a major piece of legislation with associated change. There is an opportunity to refresh the council's Vision for Adult Social Care and to set out these changes as person-centred and resilience-building for individuals, families and our community. The Care Act 2014 provides the beginnings of a new vision and rather than approach this from an 'implementing new legislation' perspective, there is an opportunity to undertake this work as the co-design and co-production of our new vision. At the

heart of all these changes is an aspiration to *transform lives* and Medway may choose to frame the entire programme in that way and to take the opportunity to set this, from the outset, in a way that expresses our local motivation and ambition.

Communication and engagement will be essential and discussions have already commenced with Communications colleagues regarding the programme, including the need for impactful visual communications e.g. video, animation and easy read. A series of presentations and briefings, including for Members, will be necessary early on.

The Department of Health requested that all Local Authorities complete a financial model developed by Surrey County Council and the Local Government Association in March 2014. ADASS have raised significant concerns regarding a potential under estimation of financial impact in this model and Oxfordshire County Council are currently undertaking work with the Local Government Association, the Treasury, LG Futures (consultancy), the Personal Social Services Research Unit at the University of Kent and the London School of Economics and Political Science to refine the modelling.

The new legal framework will need to be understood in detail and staff prepared accordingly. The new duties will need to be appropriately resourced.

v) Please specify the level of resource that will be dedicated to carer-specific support

Medway has allocated £878,000 for carers' specific support during 2014 -15 with this figure increasing to £1,900,000 in 2015-16.

Medway Council and Medway CCG have entered into 3 year contracts from 2014 to 2017 for the provision of Carers Support Services covering three service areas:

- Emotional, Health and Wellbeing Services, Carers' Training, Information and Support, Advocacy and Carers Shaping Policy and Services
- Breaks for Adult Carers from their Caring Role
- Carers' Support Payments

Commissioners recognise the importance of support services for carers and the individuals they care for as a means of enhancing wellbeing and quality of life by enabling people to maintain their independence and remain in their own homes. Commissioners acknowledge that better recognition is required of the practical support that carers provide and that future services should be available that support carers to maintain their social, physical and emotional well-being and maintain a positive relationship with the individual they care for. The service outcomes to be achieved through the above contracts include:

- Carers will be supported to access community activities/services that will reduce social isolation through accessing peer support and advice and information delivered at a time and place that is appropriate to their wishes and needs
- Carers health needs are met in a timely manner and they are supported in their caring role
- Carers support is embedded into GP surgeries and GP surgery staff are able to respond to carers' needs effectively
- Health professionals have an increased understanding of the need of Carers and are better able to support them in their caring role
- Carers are better able to access health and well-being support for themselves

- Carers are able to access more employment opportunities
- Carers are empowered to make informed choices
- Carers are respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role
- Carers receive a payment that enables them to have a meaningful break from their caring role

Medway will continue to commission carers' support services, whilst ensuring that they meet current requirements within an integrated model of care. This will include meeting requirements under the Care Act for an expansion in carers' assessments and additional support. Ensuring that Carers and family members are given the right amount of support is essential to preventing the breakdown of existing support networks and key to preventing inappropriate use of A&E as well as nursing and residential placements.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

LGA/NHS England guidance re what good looks like for this question:

- Set out the amount of funding that has been affected within the local government budget, if any
- Set out any further implications to local authority services as a result of the change

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Medway is committed to developing more flexible and integrated ways of working focused on people's needs as described in Medway's Joint Health and Wellbeing Strategy. Partners will, over the coming months, assess what additional capacity will be required to sustain an on-going 7-day offer and to evaluate how successful the current approach is to facilitating hospital discharges and avoiding unnecessary admissions.

Work is being undertaken to understand the interfaces between health and social care providers to enable safe timely assessment and transfer if undertaken out of normal working hours. The Integrated Discharge Team already operates at weekends and evenings and is able to facilitate hospital discharge during these times, including where there is a need for social services involvement. The extension of seven day working in community therapy services has also been agreed for 2014/15 and a CQUIN is in place with Medway Community Healthcare to support this. It is acknowledged that arrangements could be expanded and a costed plan for 7-day services will be developed in 2014 for staged implementation during 2014/15. This will include procurement activity ensuring that domiciliary care, reablement and residential

contracted providers are able to start care packages out of normal office hours.

All relevant contracts, across health and social care, will be reviewed through 2014/15 and where necessary variations negotiated or re-commissioning of services to ensure that appropriate care and support is provided to avoid unnecessary hospital admissions and support discharges. This will include the primary care offer. This will also look at the access to mental health services both in primary care and in the acute sector (including in A&E). Seven Day service development has been included in as part of the Service Development and Improvement Plan (SDIP) as part of the contract with Medway Community Healthcare (MCH) and Medway NHS Foundation Trust (MFT). A CQUIN scheme has also been agreed with MCH to incentivise further development of 7 day working in key therapies which will support both discharge and admissions avoidance at MFT.

Seven day working is considered a key part of developing system resilience in Medway, and several schemes are currently being pursued. The Medway and Swale Executive Programme Board oversees this as part of wider resilience to ensure engagement at a Medway and Swale level in the planning and co-ordination and integration of services focused around primary care, better data sharing and seven day working with the key focus being reducing emergency admissions. This will ensure agreed, consistent priorities across Medway for implementing seven day services and an integrated plan which will ensure that primary, community, mental health and social care services are able to support the move to commissioned seven day services in the acute trust. This clinically and commissioner led approach to transformation will drive the development of the system wide integrated emergency and urgent care pathway for our patients. In the current situation, Medway CCG and Medway Council will be working with the Trust and Monitor to ensure that there is a common understanding of the needs of the population we serve and that a co-ordinated plan is in place to meet the needs of the local health and social care economy, which includes a high quality sustainable acute hospital in Medway. Some examples of 7 day working underway and planned include:

- An Easter Pilot showed the ability to improve 7 day discharges. This pilot was repeated 2nd/3rd August with a 60% increase in discharges. As a result of this, the Trust is urgently job planning to increase 7 day discharges.

- Extension of 7 day therapy provision pilot to increase capacity for step down patients from MFT, supported by Consultant Geriatrician post. Ability to step up patients from GPs and SECAmb with appropriate medical input and provide increased therapy provision to enable patients to return home earlier.

- Dementia A&E and Early Support Discharge Team to avoid admission and facilitate earlier discharge. Providing 7 day cover between 8am-8pm working in liaison with ED and the IDT and Dementia Support in the community.

- Expansion of the Integrated Discharge team at MFT providing support to the admissions/discharge processes within the hospital setting 7 days a week.

Further to Medway's BCF Plan being submitted in April 2014, the local authority has committed to undertake a 3 month trial of 7 day working across Adult Social Care beginning 1 September 2014. Staff will work 8am to 8 pm Monday to Friday, 10 am to 4 pm Saturdays, with flexibility built into the model for staff to work on Sundays providing

medical cover is also available. Previous trial periods in April and May 2014 have highlighted market development areas and ensuring the local private and independent sector is responsive at weekends.

Medway CCG, in partnership with Medway Council, are currently considering options to trial an incentive scheme across the local private and independent sector by commissioning additional Step Down capacity from the Acute Setting in order to facilitate timely discharge. The scheme will offer providers a one off payment for assessments of patients in hospital to be completed and accepted on the same day as the referral is received. This additional capacity will be up to 12 beds in blocks of 4-6 available across a range of nursing home providers in Medway. Current proposals include an enhanced incentive payment at weekends. This will be trialled across a 6 month period as part of the winter resilience funding.

Medway CCG Plans clearly identify integrated care teams as one of three main strands of improving care for long term conditions. The Community Service Redesign project aims to improve the integration of care teams to deliver a case management approach to the management of patients with complex long term conditions. This project represents a fundamental change in the way community services will be provided in Medway aiming to reduce complexity across the system and wrap services around primary care in defined geographic locations:

- Case Management as a service combines both preventative and responsive care, for patients with multiple long term conditions and those identified as high risk of deteriorating health state.
- It focuses on the availability of a skilled professional, working closely with patients and their families, co-ordinating care and regularly evaluating the effectiveness of service provision.
- All patients referred for case management have a lead professional responsible for agreeing ‘My Plan’ with the patient. This plan of care is shared with the patient’s GP, and other health professionals can access the plan via the local community health system.
- The logistics of sharing ‘My Plan’ with other organisations e.g. social care and acute trust are currently being worked through, so an interim measure of a patient held record is currently being piloted.
- The model is not yet fully implemented across Medway and there are currently 5 case managers in place.
- Approximately 85% GP practices are signed up to case management, and currently the majority of these have case management meetings underway.
- A business case is being developed to support the preferred case management model including increasing the numbers of case managers but also utilising skills and expertise from existing roles e.g. from condition specific teams (e.g. respiratory, cardiology, diabetes stroke).
- The risk stratification Directed Enhanced Service (DES), using the HISBi risk stratification tool, is running alongside the redesign work to support both the identification of high risk patients with multiple long terms conditions, and inclusion in the case managers multi-disciplinary team meeting reviews.
- The Community Services Redesign project will consider the benefits of a Care Navigator Role. Research is currently being undertaken around how other areas have benefitted from such a service.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Health services do already use the NHS number but work needs to be taken forwards for this to be possible in social services. The NHS number is being requested for all new service users accessing social services and for existing clients through annual reviews. Therefore, the Council will be in a position to use the NHS number as the primary identifier for all correspondence from April 2015.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The Better Care Fund will help to further enhance existing integration. This will include interoperability between health and social services by joining up health and social care data across Medway utilising the NHS Number as the unique identifier. A scoping exercise will be undertaken in early 2014/15 to explore a potential interface between systems that already exist across adult social care, acute, primary and secondary care (including mental health services).This will link with the CCG IT Strategy and introduction of Vision 360, being introduced as a remote access solution for its practices, also giving flexibility as part of a Medway clinical portal to improve data sharing between acute, community and primary care, as well as social services. Data sharing will also cover both the My Wishes (palliative care/end of life register) and out of hours cover through MedOCC. We already have secure email facilities in place and use this as a tool to correspond between social care and NHS colleagues (GCSX, CJSM, nhs.net). Health and Social Care are working together over the next 12 months to join up their IT systems to share information, exploring the possibility of utilising an existing NDL secure middleware system interface. Medway Council has a valid Information Governance Toolkit Assessment as is required to access the NHS N3 secure network. A task and finish group will be established in 2014 to facilitate any changes required, including ensuring the active involvement of provider agencies including the acute and secondary care sectors.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

We are committed to ensuring appropriate Information Governance Controls are in place. This includes, ensuring that:

- All partners are compliant with legislation, including the Data Protection Act
- Confidential information about people is treated confidentially and respectfully
- Members of a care team will share confidential information only when it is needed for the safe and effective care of an individual, including where there are concerns around safeguarding
- Information that is shared for monitoring and other strategic purposes will be anonymised
- A person's right to object to the sharing of confidential information about them will be respected
- Organisations should put policies, procedures and systems in place to ensure that confidentiality rules are followed at all times
- Protocols for sharing information will be agreed by the Joint Commissioning Management Group and reviewed on an annual basis

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Under the plans for community service redesign, Multi-Disciplinary Teams (MDT) will be developed for delivering integrated health and social care at a local level with GPs at the centre. These will provide the multi-disciplinary and multi-agency support needed by those most at risk of hospital or care home admissions and those with complex or long term conditions. Primary care, community healthcare and social services will form the core to these arrangements with voluntary sector input as appropriate. Through the Integrated Discharge Team and the Rapid Response Team there are already elements of joint assessment processes and integrated working which will be further developed and expanded into community settings.

Through investing in primary care, we will ensure that patients can access GP help and support in a timely way and via a range of channels, including email and telephone-based services. The GP will remain accountable for patient care, but with increasing support from other health and social care professionals to coordinate and improve the quality of that care and the outcomes for the individuals involved.

We will deliver on the new provisions of General Medical Services (GMS), including a named GP for patients aged 75. Flexible provision over 7 days will be accompanied by greater integration with community nursing and care services, mental health services and a closer relationship with pharmacy services.

See answer to question 7 d) iii).

We are currently working with the Medway GPs to highlight the importance of practice awareness of dementia, the importance of early diagnosis and support. A training programme is being developed which will be promoted to GPs to increase their awareness of dementia and enable them to feel confident about becoming involved in primary care based diagnosis initiatives. All GPs will be invited to become Dementia

Friends and a session is planned for one of the monthly Medway GP meetings. A presentation has been designed jointly between Adult Services Partnership Commissioning and Public Health to introduce GPs to a revision in the Dementia chapter of the Joint Strategic Needs Assessment and to offer them an opportunity to comment on the developing Medway Dementia Strategy.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Our plans for the local integrated teams include having an accountable or lead professional where appropriate. The criteria of when an individual will need a named professional will be developed, including how the accountable GP agenda will fit within our plans. This is a core part of our community redesign project. However we are committed to ensuring that any individual who will benefit from coordinated supported will have a named professional who will help them co-ordinate their pathways of care and support.

We envisage that all members of the team will be a lead professional, and that both the needs and wishes of the person will, wherever possible, determine who should be that named professional. This will include the voluntary sector who can provide the role for individuals who may have a lower level of presenting need, but without proactive support may not utilise the services in the community and therefore the risk of admission to the acute sector would increase.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

We will classify people as high risk based on a combination of factors including if they have a number of long term conditions identified through the HISbi risk stratification tool if they are over 75. Based on these indicators as well as regular attendance for outpatient appointments and A&E for people with long-term conditions, local information would suggest that there are approximately 1200 people deemed as being at highest risk of hospital admission across Medway. The risk stratification tools used to predict emergency hospital admission in the next year will draw on information from primary and acute care and build on the significant progress already made in this area. Currently, 35 out of the 57 GP practices in Medway are signed up to the scheme through a DES. This represents 67% of the total CCG registered patient population, and it is aimed to expand this over 14/15. Those patients identified through risk stratification as being at very high risk (0.4%) and high risk (4%) are considered for active case management by a multi-disciplinary team meeting. Only those considered suitable for case management led approach and community intervention are considered for this. So far 126 patients have been taken forward into this approach. As the scheme develops and widens to cover social care then this is expected to rapidly grow.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

The values and principles underpinning the Medway Better Care Fund Plan include ensuring that the voice of people who use our services and their carers is heard and shapes the quality and design of services that are provided.

Our vision for integrated care is based on what people have told us is most important to them; this has been through public workshops, interviews and surveys across Medway over the past few years. Through on-going engagement, we know that what people want is greater choice and control and for their care to be planned with people working together to help them live independently in their own home. They also want their care to be delivered by people and organisations who show dignity, compassion and respect at all times. These messages are at the centre of our vision for integrated care in Medway. We will continue to engage with people who use our services and their carers throughout 2014/15 as our plans for specific services are firmed up and ensure that there is co-production of the services commissioned as a result of this plan.

Specific examples of engagement activities include:

- As part of the Call to Action, Medway CCG in 2013 posted online patient and staff surveys ("Blue Sky Thinking Survey" and "Staff Blue Sky Thinking Survey"). Intelligence gathered from all responses has been used to inform the Better Care Fund Plan.
- A key component of previous and on-going engagement plans will include Medway Health Network, a virtual group of patients, public and voluntary groups interested in getting more involved in how services are planned and designed will be prioritised.
- The vision and outline plans have been shared with the Medway Carers Partnership Board in January 2014, whose involvement is key to on-going engagement with carers and ensuring that their experiences and views are fully considered in the Better Care Fund Plan.
- We have drawn on information from both Medway Council's Adult Social Care Survey 2012 and Carers' Survey 2013 to inform the development of this plan. We will use the Adult Social Care Survey 2013 as an opportunity to consult with people about their opinions of health and social care services and gather intelligence around social isolation and access to 7 day services.
- Community and parent engagement as part of our Big Lottery, Better Start, bid looking at remodelling systems including a reduction in children's attendance at A&E and admittance to hospital, forms part of our whole system transformation.
- Representatives from Healthwatch Medway have been consulted on the direction of the Better Care Fund and have attended public engagement events as part of the process. Healthwatch Medway has agreed to carry out both joint and independent engagement on specific project development areas in relation to this plan.

Our Joint Communications and Engagement Plan ensures that people who use our services are put first – as is the nature of the Better Care Fund.

Individual human stories will be the focus of the communication and engagement work and will be developed to fit in with the target audiences of the fund. We are planning a number of scenario based simulation events in order to identify current and future pathways. The simulation events are an essential part of the on-going planning activity of the various schemes that will be introduced and commissioned as part of the Better Care Fund.

These will help to address a number of issues, including:

- What is happening now?
- What is working well?
- Where are the gaps?
- How will we address these?
- What will the outcomes be for the target groups of people?

Since submitting Medway's Better Care Fund Plan in April 2014, Medway Council and Medway CCG hosted the first simulation event (noted above) on the 22 July 2014 at Priestfields Stadium, Gillingham titled 'Shaping the Future'. More than 90 key stakeholders were represented at this event facilitated by Institute of Public Care (Oxford Brookes University). The following were the major key themes that emerged from the workshop:

- The need to integrate IT systems
- One assessment to exist for each client/patient
- One plan to exist for each client/patient
- One person should take the lead in coordinating all plans and services for clients/patients
- Funding should be pooled across Health and Social Care
- All commissioning should be fully joint
- A Navigator role with an in – depth knowledge of Health and Social Care is vital in order to enable clients/patients to have access to and the choice of all services that are available
- A directory of services should exist
- Services across Health and Social Care should be fully integrated
- Further promote and integrate personal care budgets
- All services should be proactive rather than reactive
- Pathways need to be far less complex

- Communication needs to be far clearer
- Empower the client/patient

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Through the engagement of providers and people using our services, our aim has been to identify how the Better Care Fund can be used to deliver better results and an improved experience for the people of Medway through the development of an integrated health and social care system.

A wide range of health and social care providers, including both statutory and voluntary and community sector (VCS) organisations, have been involved in the development of this plan. We will continue to engage with our providers throughout 2014/15 as our plans for specific services are firmed up.

Medway Council and Medway Clinical Commissioning Group (CCG) hosted a provider stakeholder event (Integration Transformation Fund Workshop) on 6 December 2013 to seek the views and input of Health and Social Care professionals across the Medway area. The event was attended by a range of VCS providers, statutory providers as well as representatives from patient fora and Healthwatch Medway. The workshop focussed on transformational activity to improve health and social care in Medway and a number of key priorities were identified as a result. The issues identified align with the national conditions for the Better Care Fund guidance and marry with the underlying principles identified in Medway's Joint Health and Wellbeing Strategy (JHWS): a commitment to an integrated systems approach and partnership working; a focus on prevention and early intervention in all areas; on-going and effective stakeholder communication and engagement and a commitment to sustainability. Sixty stakeholders were represented at this event. Intelligence gathered from the 5 workshops (Prevention, Primary Care, Accident & Emergency, Community Services and End of Life) together with public engagement, have helped form the basis of the Council's and Medway CCG's vision for the Better Care Fund and aims and objectives.

As part of the formation of the BCF Plan, a high level executive meeting has been held with the key health providers in Medway – Medway Foundation Trust (MFT), Medway Community Health (MCH) and Kent and Medway NHS and Social Care Partnership Trust (KMPT). At this meeting the partners confirmed their commitment to working with the CCG and the Council in delivering the vision, aims and objectives described in this Plan. This included a commitment to delivering the necessary transformational agenda, including senior clinical input to the various community based and preventative schemes being developed. At an executive level the partners will continue to meet with the Council and the CCG on a regular basis and a number of operational level groups will be developed which are both project specific and cover wider integration.

The principles and impacts of the Better Care Fund have been discussed with Medway NHS Foundation Trust at a board level, as well as on-going discussions happening with executive and operational staff as plans are developed and aligned to the Trust's own internal plans, specifically around emergency flow.

The Medway Community Healthcare contract ends on 31 March 2016. The CCG is currently undertaking reviews of all services to determine next steps in terms of procurement or extension at service level. Some notices have already been serviced to redesign current services in year linked to BCF projects.

Medway Council and Medway CCG have worked with iMPOWER as part of the Home Truths work stream, which involved significant consultation with stakeholders in health and social care. Two projects identified through the Home Truths work are being taken forward under the Better Care Fund Plan: community health visitors for older people and a GP signposting scheme. Both schemes will be piloted in 2014/15 to ascertain their level of effectiveness and impact on the acute sector. This will ensure that projects will be adapted or, where necessary, halted and alternative provision developed, in a timely fashion to ensure maximum effect in 2015/16.

Moving forwards, a Communications and Engagement Plan has been produced jointly by Medway Council and the Medway CCG Communications Teams to ensure that all relevant providers are engaged throughout the on-going development and implementation of the Better Care Fund Plan and general health and social care integration. This will include NHS providers, social care providers, the VCS, providers of housing and any other related services.

ii) primary care providers

There has been on-going engagement with primary care through the GP Monthly Meeting with a particular focus on specific projects, for example, the GP sign posting scheme. The February GP Monthly Meeting focused on primary care transformation and integrated services to inform the wider BCF plans. The March GP Monthly Meeting, focused more specifically on the requirements for Community Services Redesign and its inter-relationship with Urgent Care redesign work, all under the auspices of integrated care and the Better Care Fund. The July meeting focused on the community redesign with practices working in their new 'practice groupings' to discuss and influence the model of care that will wrap around practices.

In addition to the above the CCG has established a Primary Care Interface Group which essentially operates via a number of task and finish groups supporting the work detailed above.

The Medway GP meeting held in June gave all GPs an opportunity to hear a presentation from Professor Sube Banerjee on the importance of the GP in dementia care. This was followed by an introduction to the plans to develop a Medway Dementia Strategy. A joint presentation between Adult Services Partnership Commissioning and Public Health will introduce GPs to a revision to the dementia chapter in the Joint Strategic Needs Assessment and provide GPs with an opportunity to contribute to the developing Medway Dementia Strategy.

The number estimated for the registered population for Medway CCG is 2,783. Data from the Quality and Outcomes Framework primary care dementia registers in 2012/13 have only identified 1,332 patients in Medway as having dementia. The estimated diagnosis rate for Medway CCG population is 47.87%, which is higher than the Kent and Medway average of 42.94% and the South of England average of 45.65%. The diagnosis rate has fewer than half of the population who are estimated to have dementia receiving a diagnosis. This could be due to a number of factors including late presentation and underdiagnoses. Nationally late diagnosis has been recognised as a problem and earlier diagnosis could be more cost effective in that it could slow progression of the disease and reduce costs. There are a number of actions being undertaken to improve the diagnosis rate. These include;

(a) Medication analysis - using Audit Plus to identify patients who have been prescribed dementia medication but who do not have a recorded diagnosis
(b) Coding cleansing – based on work undertaken at Waltham Forest CCG to support GPs to identify problems in coding, which are contributing to low rates of dementia diagnosis on practice registers.
(c) Care Home Population analysis – Liaison with care homes to identify residents who clearly have dementia and liaise with practices to check that formal diagnoses have been made

The central role of GPs is recognised in the Dementia Strategy and initiatives are being developed to develop a greater understanding and awareness of the importance of early diagnosis, treatment and providing patients and carers with meaningful information about care and support services that are available through the NHS, Adult Social Care and the independent sector.

An overriding approach adopted by the Dementia Strategy will see integration with the CCG's key clinical strategies and the Partnership Commissioning themes within the Better Care Fund. Knitting together the various strands that make up the communities complex needs is vital to ensuring those needs are met.

Statutory services are trying hard to work together to ensure that the services they provide offer people a coherent pathway as their dementia illness develops and needs become more complex. Most people will approach their GP when they feel that something is not right and support is being provided to local Practices to help Doctors and other professionals gain a better understanding of dementia and the importance of obtaining an early diagnosis.

iii) social care and providers from the voluntary and community sector

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Medway Foundation Trust is one of the hospitals identified as part of the Keogh review. Foundation Trusts are regulated by Monitor and the CQC, both have and continue to express concerns and have issued undertakings or conditions on the Trust. We have shared the potential impact of the BCF on MFT with the Trust. Medway CCG and Medway Council will be working with the Trust and Monitor to ensure that there is a common understanding of the needs of the population we serve and that a co-ordinated plan is in place to meet the needs of the local health and social care economy, which includes a high quality sustainable acute hospital in Medway.

LGA/NHS England guidance re what good looks like for this question:

- Evidence that it has been produced in consultation with the acute providers. Cross ref with Annex 2 – Provider Commentary
- Evidence of basic modelling to show potential impact of the BCF on the acute sector Evidence of moderation that has been done to ensure that the BCF plans have not duplicated QIPP planning
- An assessment of future capacity and workforce issues across providers
- Evidence of modelling to show the impact of not delivering the BCF activity on the acute sector, e.g. ability to deal with a potential increase in demand
- Confirmation, in line with the Mandate requirements on achieving parity of esteem for mental health, that plans do not have a negative impact on the level and quality of mental health services

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance below.

Scheme ref no.
BCF2 (b)
Scheme name
Combining Personalisation with Community Empowerment - Developing and Empowering Resources in Communities (DERiC)

What is the strategic objective of this scheme?

Medway Council is one of seven authorities participating in a unique programme using the Combining Personalisation and Community Empowerment (CPCE) model, working with Developing and Empowering Resources in Communities (DERiC) a Community Interest Company (CiC) that operates as a Social Investment Finance Intermediary (SIFI). Increasing community generated social capital will make it possible to deliver alternative community brokered and provided support to vulnerable adults. Community Dividends will provide incentives for communities to share the benefits of locally generated social capital. To work with local voluntary and community sector providers/social enterprise to deliver cost effective, preventative, alternative social care services through an incentives scheme.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

With the support of DERiC and working with the other partner Local Authorities, Medway Council will support the creation of local Community Interest Companies with a mandate to work with both FACS eligible and Prevention and Enablement clients to identify community alternatives to costly commissioned care.

The CPCE model has the following characteristics:

- CPCE shows clear, demonstrable community engagement and ownership. Communities and organisations demonstrate and evidence that successful attempts have been made to explain the purpose of the CPCE programme approach to the whole community in which it is to be sited, and that the community leads the organisation which takes forward CPCE implementation.
- For all CPCE programmes the implementation vehicle must be neutral. This means that it cannot be or be part of an existing organisation, although it can be set up from or linked to one. The organisation/vehicle for implementation must be inclusive and cannot represent only one part of a geographical community.
- The chosen setting for implementation must be 'locality' focused. This can be at ward or multi-ward level. It must embrace all parts geographically of the community that its serves.
- All CPCE programmes must be seen to address social care needs. This can allow for a focus on any 'client group', but it must be seen to address the needs of vulnerable people and involve vulnerable people and the whole community in supporting each other.
- CPCE can and should be seen as taking an asset based approach, which enables communities to take a lead in identifying assets, issues and solutions. It therefore will reflect wider community issues and agendas as agreed by the whole community it serves.
- All CPCE programmes must promote, develop and utilise local community based social capital as identified and led by residents.
- CPCE programmes should be able to demonstrate clearly an emphasis on the training and development of community supporters on pathways into work
- CPCE organisations should not become delivery organisations and primary service providers. There should instead be an evidenced demonstration of a clear focus on commissioning and wider transactional approaches such as

brokering and development of new ways forward.
- Wherever possible CPCE should encourage appropriate partnership with local private companies.
-

As the CPCE Programmes will be geography based rather than linked to a specific client group they have the potential to impact across all adult social care groups, a range of NHS patient groups particularly those with Long Term Conditions and older adults and early intervention work in children's services. The programmes will not work with service users in permanent 24hr care settings.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The project lead is a qualified social worker and is supported by an Advisory Board of colleagues from Partnership Commissioning, Adult and Children's Social Care, Medway CCG, Medway Community Healthcare and Public Health Medway.

DERiC is providing close support from its Business Lead and its Programme and Development Lead in the development and implementation of the Medway Programmes.

Stakeholders from small closely defined areas of the Authority will be supported to set up a new CIC and this will be supported by existing contracted voluntary organisations and public sector departments.

Each geographical area will have a programme that reflects the community makeup and the organisations currently engaged in provision there. This means that Voluntary Organisations, Social Enterprise Companies and Community Groups involved will vary with each project.

Early conversations have elicited interest from Age UK Medway, Sunlight Development Trust, Carers First and CVS. The role these organisations and others will take will be negotiated area by area.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A range of research demonstrates the impact of social isolation on health and well being.

http://www.scie.org.uk/publications/ataglance/ataglance60.pdf

This was also highlighted in Fair Society, Healthy Lives (Feb 2010) the report that concluded the Marmot Review.

The impact of an aging society that is no longer structured in a way that allows for families to easily care for their own is increasingly a worry to health and social care professionals. This paper looks at these issues and includes recommendations that support CPCE: The Generation Strain, Collective Solutions to Care in an Aging Society

– Clare McNeil and Jack Hunter (April 2014)

The use of small local services that understand the benefits of mutuality and reciprocity have been shown to be more effective in delivery of community services:
Widening Choices for Older People with High Support Needs - Helen Bowers et al JRF (January 2013)

There have been some papers, reports and media coverage regarding the DERiC supported CPCE projects in other areas:
Community capital and the role of the state: an empowering approach to personalisation – working paper, Patricia A Jones (October 2013) – this is about Soho Victoria Friends & Neighbours in Sandwell
http://betterlivesleeds.wordpress.com/2013/05/31/501/ - interview with Social Worker seconded to the Leeds Projects.
http://www.theguardian.com/social-care-network/2012/oct/24/work-practices-social-care - article about early days of Leeds Projects (Oct 2012)
http://www.theguardian.com/society/2014/feb/11/neighbours-care-old-age-social-volunteers-belfast - Online Guardian article about the Belfast Project (Feb 2014)

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Improved services for isolated vulnerable people
- Improved economic and social sustainability
- Increased opportunities for volunteering, employment and training close to home
- Improved joint working between the Local Authority and the NHS to achieve overlapping health and social outcomes
- More effective joint working between departments and directorates within the Council

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

All CPCE programmes will be evaluated through DERiC who have commissioned this work to be undertaken by The Universities of Leeds, West of England and Huddersfield.
CPCE programmes will keep clear data regarding all contacts made and outcomes for individual clients
CPCE programmes will keep clear data on volunteers recruited

What are the key success factors for implementation of this scheme?

- Project Manager in post
- Greater choice and control through personal budgets being used for more diverse range of services
- Increased capacity within the voluntary and community sector to deliver services
- Incentivisation scheme in place and money re-invested in community projects

- Services exist that achieve aims and objectives of Better Care Fund
- Services support delivery of BCF and positively impact on Payment by Performance measures
- Reduced demand for costly home care packages
- Reduction in attendance at A&E
- Increased support for carers with more contact with a larger number of carers both by the Council and also contracted Voluntary Organisations
- Increase in number of volunteers in areas with CPCE
- Reduced hospital admissions and re-admission in areas with CPCE

Scheme ref no.
BCF2(c)
Scheme name
Combatting Social Isolation – Public Health
What is the strategic objective of this scheme?
Develop initiatives to alleviate loneliness and social isolation and joint working with Public Health. Targeting social isolation in older people is a growing public health concern due to Medway's rapidly ageing population. An activity for 2014/15 is to develop a Joint Strategic Needs Assessment chapter that can be used to inform a Social Isolation Strategy for Medway. Explore closer working with the voluntary and community sector to develop signposting, befriending, mentoring and buddying schemes and to work with the hospital to identify those that are socially isolated.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The scheme is to ensure that a strategy is developed to reduce social isolation in Medway. A Joint Strategic Needs Assessment (JSNA) chapter for social isolation will be undertaken in order to inform the development of a strategy. An estimate 'isolation index' will be constructed from Mosaic data to identify clusters of households that are potentially vulnerable to loneliness and isolation at Lower Super Output Area (LSOA) level. The JSNA will also include qualitative data that takes account of the views and experience of older people and other population risk groups in relation to social isolation and loneliness. The strategy will highlight priorities based on the need identified from the data, current services, utilisation of good practice from other areas and research evidence. The strategy will be cross-cutting produced with input from a range of stakeholders. Potentially any of the Medway population could be at risk from social isolation, although there are a number of population groups that have an increased vulnerability. Older people are significantly more likely to suffer from social isolation with contributing factors being 'loss of friends and family, loss of mobility or loss of income'. Other population groups at risk include carers, those from a different ethnic background and those with mental health problems. The strategy will have a focus on those at greatest risk.

The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The delivery chain will in part be determined by the strategy to be created. This will reflect the content of the strategy once it is developed. The organisations that will be involved will be Medway CCG, Medway Council, GP's, providers and the private and independent sectors.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
The National Service Framework for Older People (2001) acknowledged isolation in relation to falls and depression and linked the differential access to services between rural and urban areas to social isolation. Putting People First (Department of Health, 2007) prioritised the alleviation of loneliness and isolation and recognised the importance of strong social relationships. The Marmot Review (2010) highlighted the importance of loneliness and social isolation in the promotion of health and wellbeing and in tackling inequalities. The Adult Social Care Outcomes Framework for 2013/4 contains a new measure of social isolation, shared with the Public Health Outcomes Framework, which draws on self-reported levels of social contact to provide an indicator of social isolation. There are two indicators that are directly related to social isolation in the framework. These are the percentage of adult social care users who have as much social contact as they would like and the percentage of adult carers who have as much social contact at they would like. The values for Medway are 43.1% and 44% for the respective indicators which are similar to the England average. A range of research demonstrates the impact of social isolation on health and wellbeing. http://www.scie.org.uk/publications/ataglance/ataglance60.pdf Loneliness and social isolation can have a considerable impact on the health and wellbeing of an individual. Loneliness is associated with a range of negative health outcomes including mortality, dementia, high blood pressure, increased stress levels and suppression of the immune system. People with stronger social relationships have a 50% increased likelihood of survival than those with weaker social relationships. This mortality difference is comparable with well-established risk factors for mortality such as smoking, obesity and physical inactivity (Holt-Lunstead et al. 2010).
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
It is proposed that once the strategy has been developed that an implementation group will be established to monitor progress as to how the actions are implemented. This group should report to the Medway Health and Wellbeing Board. Measures for any interventions should use valid scales such as De Jong Gierveld Scale.
What are the key success factors for implementation of this scheme?
Reduction in number of individuals that are socially isolated Increase in number of social contacts Increased support for carers Increase in community engagement activities Increase in number of volunteers Reduce reliance on primary care by older people Reduction in use of A&E services Reduce repeat visits to A&E by older people

Scheme ref no.
BCF3 (a)
Scheme name
Reablement, rehabilitation and intermediate services - Intermediate Care
What is the strategic objective of this scheme?
The strategic objective of this scheme is as stated in the Department of Health document - Halfway Home, to ensure the development of 'a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living'
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The most immediate issues that require to be developed are: • to create and agree a pathway for intermediate care • to create a single coordinating function for intermediate care (led by a single Manager) • Devise an intermediate care strategy

- agree a service specification for each element included in the service specification
- Increase step up beds with the emphasis on admission avoidance
- Review the numbers of step down beds required
- Configure/commission an effective rehabilitation service
- Develop a workforce strategy that both supports the workforce to develop its skills and also moves services toward an enabling ethos
- Ensure joint commissioning of Intermediate Care including social care enablement
- To develop a single point of access to intermediate care incorporating an out of hours access point
- Increase access to and uptake of equipment and adaptations
- Improve assessment and discharge processes
- Commission transitional beds
- Explore the potential of extra care housing for less intensive intermediate care
- Strengthen monitoring and performance management processes within the commissioning organisations
- Raise GP awareness

Find solutions for the following gaps that have already been identified

- increase the provision of services for patients and service users with dementia
- provide staff training in dementia care
- improve provision of mental health assessments
- ensure the provision of suitable provision of services for people with a learning disability after an acute episode
- increase availability of night sitting/nurse support to reduce likelihood of admission to A&E

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The delivery chain will in part be determined by the pathway to be created. This will reflect the content of the strategy once it is developed. The organisations that will be involved will be Medway CCG, Medway Council, GP's, providers and the private and independent sectors.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The evidence for this model has been drawn from a review of intermediate care services in Medway undertaken by the Institute of Public Care that took place in February 2012. The 2012 review was 'refreshed' by the Institute of Public Care in April 2014. The refreshed review reinforced the necessity for the original recommendations to be implemented as soon as possible.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Understanding how effective services are is an essential component of good commissioning practice and therefore it is intended that data will be routinely collected and analysed which, at a minimum, monitors: • Sources of referral • Reasons for referrals not accepted • Case mix of referrals • Numbers of people receiving the intermediate care service • Timeliness of responses • Time from referral to admission/transfer • Number of delayed transfers of care • Length of stay in acute care and subsequent placement • Occupancy rates • Number of beds • Discharge destinations at various intervals • Readmission rates • Documented achievement of individual goals • Change in functional capacity before and after intervention
What are the key success factors for implementation of this scheme?
• Adequate provision of intermediate care beds • Adequate provision of alternative intermediate care services • Reduction in delayed transfers of care • Reduction in attendance at A&E • Reduction in admissions to residential and nursing care • Reduce length of stay in hospital • Reduce readmission to hospital • Reduce repeat visits to A&E

Scheme ref no.
BCF4 (b)
Scheme name
Community equipment and assistive technology – Community Equipment
What is the strategic objective of this scheme?
The strategic objective of the scheme is to combine the three service strands that currently form the equipment service for Adults and Children across Health and Social Care in Medway in order to form one single contract with one service specification and for this to be procured from a sole provider. The purpose of this is to both enable a more effective operation of the service and to potentially reduce the overheads and associated

costs that are involved in having more than one provider.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

The scheme will be to ensure that one provider delivers a single high quality equipment service to all adults and children in Medway that will ensure a speedy and flexible supply of equipment. The intention is to ensure that identifying the need for equipment provision becomes an integral part of any assessment, treatment or care plan, whether in hospital or in a community setting. The outcome of this will be to take a proactive preventative approach, to enable people to maintain their independence and live at home, slow down deterioration in function and consequent loss of confidence and self-esteem, prevents accidents, and supports carers more effectively.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

At this time there are three providers of this service. Medway Community Healthcare, Kent County Supplies and Family Mosaic. Each provider has a different method of accessing the equipment and the purchasing models between Health and Social Care are very different. This can lead to clients and patients having complicated pathways to negotiate, particularly those that require more than one piece of equipment. This can also lead to delays in the receipt of equipment. This is not satisfactory, particularly for those in receipt of end of life care. The intention is therefore to go out to tender for one single provider and to pool the Health and Social care budgets under either a section 75 or section 25 agreement. Social Care are to lead the commissioning process. This should ensure that processes are streamlined and accountabilities across both commissioners and providers are clear.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The service will contribute to the implementation of the following national policy guidance:
- Our Health, Our Care, Our Say (2006)
- Improving the Life Chances of Disabled People (2005)
- NSF for Children, Young People and Maternity Services (2004)
- Healthy Lives, Brighter Futures (2009)
- The Children Act (2004)
- Every Child Matters, Change for Children (2005)
- Aiming High for Disabled Children (2007)
- National Service framework for Older People (2001)
- National Service Framework for Long Term Conditions (2005)
- A Vision for Adult Social Care: Capable Communities and Active Citizens (2010)
- Healthy Lives, Healthy People Our Strategy for Public Health in England (2010)

As stated in the report of the Community Equipment Review undertaken by the CCG in

2012 and then in a further review undertaken by the Institute of Public Care in January 2013: 'Community Equipment is seen as vital to the success of overall social care transformation and governmental policy has sought an integrated Health and Local Authority approach.' This review by the Institute of Public Care recommended the development of a common Service Specification and retendering for one single service. Extracts were taken from Wiltshire Council Service Specification as an example of a joint service specification.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Part of the process of devising the 'new' joint specification will be creating a set of performance indicators that measure the outcomes of this scheme. These will be reported on a monthly basis to the Joint Equipment Board.
What are the key success factors for implementation of this scheme?
Increase uptake of community equipment Jointly commissioned service in place Older people able to remain living at home for longer Support for carers Service users able to remain living at home for longer with suitable equipment to be able to self-manage their health and social care needs. Reduction in admissions to residential and nursing care Reduction in attendance at A&E Reduce length of stay in hospital

Scheme ref no.
BCF5
Scheme name
Carers Support
What is the strategic objective of this scheme?
Continue to commission carers support services whilst ensuring that they meet current requirements, particularly with regard to Medway Council's legal obligations set out within the Care Act 2014 and Children and Families Act 2014. This will be delivered within an integrated model of care. The strategic objectives of this programme of work is to:

- Support all carers to have a life outside of their caring role. Personalised support both for Carers and those they support, enabling them to have a family and community life.
- Realising and releasing potential: Enabling those with caring responsibilities to fulfil their educational and employment potential.
- Supporting Carers to stay healthy: Supporting Carers to remain physically and mentally well.
- Identification and recognition: Supporting those with caring responsibilities to identify themselves as Carers at an early stage, recognising the value of their contribution and involving them in designing local care provision and planning care packages.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Health and Wellbeing Services, Carers' Training, Information and Support, Advocacy and Carers Shaping Policy and Services

- Service will be delivered by Carers First Kent & Medway
- Service is aimed at all young and adult carers. The 2011 Census identified over 25,000 unpaid carers in Medway of which only a small number are known to statutory and voluntary services. The aim of the service is to increase the number of those who identify themselves as Carers and seek support to maintain their caring role
- The service will be delivered throughout Medway and will be delivered across the week, including weekends and evenings

Whole Family Support and Education and 1:1 Support

- Service will be delivered by Medway Youth Trust
- The service is aimed at those unpaid young carers up to the age of 18. 2011 Census identified 661 young carers in Medway aged 5 – 15. It is not possible to identify accurate figures for those 6- 18 as this cohort is included in age bracket up to 24 years. The aim of the service is primarily to improve educational and employment opportunities for young carers and to support young carers away from inappropriate caring roles.
- The service will be delivered primarily in schools and colleges but support must also be offered across the week, including weekends and evenings.

Breaks for Adult Carers from their Caring Role

- Agincare will deliver the service
- 32,000 hours of respite support will be provided to Carers and the person they support per annum. A maximum of 4hours per week is available to the Carer. The service is aimed at unpaid adult Carers, supporting an adult 'cared for' person.
- The service will be delivered across Medway and will be provided either in the home or out in the community. The delivery of a break will be available across the week, including weekends and evenings and will be deliver

Carers' Support Payments

- Crossroads Kent & Medway will deliver the service
- A one-off payment up to £400 per year will be available to unpaid adult Carers who provide more than 20 hours on unpaid care per week for an adult 'cared for' person. 573 payments will be made per year.
- The assessment process will be provided primarily Mon to Fri 9-5. However, if appropriate assessments will be carried out outside of these hours is it suits the needs of the carer.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

All the above services are jointly commissioned by Medway Council and Medway CCG. Medway Council, via the Partnership Commissioning Team, is the lead commissioner and is responsible for the delivery and implementation of the projects.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Part of the commissioning cycle to inform the design and delivery of the carer services was to evaluate the carer services that were in place. This was achieved through monitoring visits and discussions with providers, consultation with social care and health colleagues and consultations with carers and those they care for. Consultations took place through formal groups, one to one meetings, questionnaires and fun activities for young carers.

Through the SE ADASS Carers Network the commissioning team investigated other carer services and the development of good models of practice within other local authorities. An example of how this helped develop services within Medway was the issue of whether carers' services should be free or whether they should be subject to a financial assessment. Medway took the decision that good practice meant that carers' services should not be subject to a financial assessment.

The outcomes of the carers services reflect the vision outlined in the refreshed national strategy, Recognised, valued and supported: Next Steps for the Carers Strategy 2010, that stated that by 2018:
'Carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to the person they support to be a full and equal citizen.'

The services will deliver a model of comprehensive carers support that is based on outcome headings for the Carers Hub:

- Emotional support and counselling
- Access to health and well being services
- Carers training
- Information, signposting and support
- Carers shaping policy and services
- Whole family support

- Education and 1:1 support

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

KPI's have been drafted in consultation with the providers of each service. KPI's reflect the outcomes in the service specifications. The commissioner and the providers are currently agreeing how information will be recorded and monitored. As levels of activity in previous carers services had not been accurately recorded part of the monitoring will be to measure level of activity in order to support the development of outcome based KPI's. There is an expectation by both commissioning and the providers that KPI's will develop across the length of the contract as more robust activity information is obtained which can feed into outcomes based monitoring. Monitoring of provision will be quarterly and will involve input and comments from the provider, commissioner, carer and the person they support.

A Partnership Commissioning Manager and the Deputy Director of Social Care for Medway Council are both members of the Carers Partnership Board and the monitoring and oversight of these services will be reported at this Board and the Board will be able to ask questions of both the providers and the commissioners.

The Carers Partnership Board is leading the development of the new Carers Strategy and the work plan that will sit alongside the Strategy. Included in the work plan will be all the newly commissioned carers services and how they contribute to the main priorities outlined in the Carers Strategy.

What are the key success factors for implementation of this scheme?

The physical health of carers is maintained
Carers support is embedded into GP surgeries and GP surgery staff are able to respond to carer's needs effectively
Universal services are available that will support the emotional wellbeing of all Carers and the person they care for
Services are delivered in a person centred way, focusing on the individual needs of the Carer and the person they care for in a range of settings
Carers are supported to access community activities/services that will reduce social isolation
Health professionals have an increased understanding of the needs of Carers and are better able to support them in their caring role
Carers not yet identified or accessing support or services are identified and made aware of provision
Young Carers are not in an inappropriate caring role

Young Carers educational and employment aspirations are supported Carers receive a payment that enables them to have a meaningful break from their caring role Carers receive a meaningful break from their caring role Service users able to remain living at home for longer with suitable support for their carers to be able to manage their health and social care needs. Carers and the person they care for are involved in the design and delivery of services they receive

Scheme ref no.
BCF6
Scheme name
Universal Information, Advice and Advocacy - Practitioner Signposting
What is the strategic objective of this scheme?
GP knowledge of adult social care options other than residential care is self-reported as poor, and as a result GP referrals into preventative and early interventions services are low. Intelligence gathered through iMPOWER suggests that older people see their local GP (and other primary care professionals like Practice Nurses) more than other local professionals and state that they are the most influential local professional when considering their future health and social care options. This highlights the importance of GPs giving the right information to older people at the right time. This project would explore improving general signposting via GP's to preventative/reablement services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The project aims to achieve a positive shift in understanding, willingness, knowledge, commitment and cultural receptivity to integration across all stakeholders (with a focus on health and social care practitioners and service users) in order to improve care around the user.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The key stakeholders for older people (service users and their carers, social care staff, the CCG, GPs and GP practice staff and community health practitioners) will be prioritised in the project. Stakeholders representing the wider sector will be involved but at a lower level through cross-sector engagement. The project will not reach every practitioner in the borough directly but the messages and opportunities should be disseminated through the representatives involved in the engagement events.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme

- to drive assumptions about impact and outcomes
Home Truths is a national programme- funded by a mix of local authorities and CCGs, with the University of Birmingham (INLOGOV and HSMC) in a critical friend role. Home Truths is working with 13 authorities across the UK. The core hypothesis of Home Truths is that by improving relationships and trust between Health and Social Care professionals we can facilitate optimal pathway decisions, reducing demand for care, improving social care outcomes and saving money. The Home Truths approach to health and social care integration is based on transforming relationships and behaviours, alongside changes to systems, processes and responsibilities. It recognises that system changes on their own will not be effective – relationships and behaviours need to be addressed at the same time. Part of the Home Truths diagnostic project in Medway identified a range of practical solutions to help improve health and social care joint-working in the Medway area. Medway have moved forward with all the main opportunities identified; preventative respite, falls response vehicle, proactive reablement, and practitioner signposting iMPOWER have been commissioned to lead on the delivery of the practitioner signposting opportunity. During the detailed project planning phase the scope of the project widened to focus on key interaction points between practitioners throughout the Health and Social Care system. The Joint Commissioning Management Group (JCMG) agreed to focus on practitioner signposting, with a specific targeting of GPs through the map of medicine tool. Whilst this work sits independently, it is recognised that there are a number of linkages and dependencies to other projects underway with the Council and CCG, and in support of the identified Better Care Themes identified by the Council and CCG.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Financial information will be developed as part of the evaluation phase in order to report potential future savings to the Joint Commissioning Group. Resources have been agreed with iMPOWER for the project with the scope above. Further resources will depend on the options chosen for engagement and delivery which will, in turn, depend on what the analysis shows and the decisions made by senior stakeholders. Any investment that is required will be detailed in the review session (delivered at end of signposting analysis phase)
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

A positive shift in understanding and motivation for integration amongst key health and social care stakeholders in Medway

- A positive shift in understanding, willingness, knowledge, commitment and cultural receptivity to integration across all stakeholders.
- That the Map of Medicine truly reflects the full range of services that comprise the 'trusted community offer'
- A series of piloted activities that demonstrably improve practitioner knowledge and relationships
- An understanding of how integration will improve care for older people, what it means in practice for practitioners and their ambition as it relates to the 'top down' vision.
- A common understanding of what integration means across all stakeholders/providers involved in the system and buy in to the future vision and practice.

Operational plan for effective future governance and delivery of health and social care integration in Medway

- An understanding of what communication methods will be needed that will suit all stakeholder groups about the progress of integration and how these will be put into practice.
- Identifying from engagement events, leaders from across the sectors at all levels to champion and ensure the key principles and messages of integration are sustainable, during and after the project.
- Designing a governance mechanism which enables on-going 'champion' input into system design.
- How integration will engage and fit with wider community strategies and identification of what is incompatible.
- Positive feedback from engagement exercises in relation to the approach, knowledge, style, method and attitudes of the facilitation of the event.

A centralised repository of knowledge about health and social care integration in Medway, gained throughout the project

- A visual representation (ideally a map) of services and whether they are integrated and at what stage.
- A library of the feedback regarding integration and how this has been responded to, either as something that could not be taken forward or the influence it has had on design, (including the practical answers that need to be addressed by senior managers to positively support integration).

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Home Truths seeks to change relationships by first recognising the key decision-making points where the issues lie, identifying who is involved at those decision points and their motivations for making the decisions.

Once the key points are identified Home Truths uses on-the-ground delivery of pilot change projects to give coherence to the actions that can be taken to change relationships. In our experience to get commitment to change practitioners need to see

some initial change happening in addition to general engagement.

This work will be specifically focused on practitioner signposting interventions and will align closely with the map of medicine tool commissioned by the CCG which will represent the core mechanism for engaging and getting information to GPs and other primary care staff. It is recognised that where possible the tools developed will be scalable to include other services and practitioner groups.

What are the key success factors for implementation of this scheme?

Increased referrals to preventative/early intervention/reablement services
Reduce reliance on primary care
Reduce social isolation amongst older people
A lead professional for all adults over the age of 75
GPs will be at the centre of organising and coordinating people's care.
Reduction in attendance at A&E
Reduction in admissions to residential and nursing care
Increase uptake of community equipment and telecare/telehealthcare services
Support for carers
Older people able to remain living at home for longer

Scheme ref no.
BCF7(b)
Scheme name
Community Services Redesign
What is the strategic objective of this scheme?

The strategic objectives of the community redesign are to improve integration of care teams to deliver a case management approach for patients with complex long term conditions and to support patients by providing joined-up care for those individuals with long-term conditions and complex health needs. This programme of work represents a fundamental change in the way community based services will be provided in Medway by re-aligning services, so that organisations are not working in ‘silos’, as well as tackling/challenging duplication between community-based services in health and social care.

There are some clear synergies linked with other proposed projects for the Better Care Fund including developments of dementia and intermediate care strategies, 'Community Health Worker for Older People' and 'Practitioner Signposting'. Data sharing will be a key element to ensuring the success of this work stream.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

Through investing in primary care, we will ensure that patients can access GP help and

support in a timely way and via a range of methods. The GP will remain accountable for patient care, but with increasing support from other health and professionals to co-ordinate and improve the quality of that care, and the outcomes for the individuals involved. The roles and responsibilities of a joint health and social care navigator signposting role aligned to GP local care teams will be considered. This role will facilitate a single point of access for patient, carers, GPs and case managers and will be an integral part of the MDT meetings to consider patient care and aid with care planning. The care navigator role will interface with health based Case Managers who in turn will develop and manage care plans for adults over 65 with complex multiple long term conditions (top 2%) via multi-stakeholder. MDTs. Patients for consideration at MDT meetings will be identified through GP risk stratification tools as being at very high risk of future A&E attendances/admissions.

GP surgeries will be clustered into smaller local care teams to allow for alignment of core and wrap around services to facilitate MDT meetings and care planning. Core and wrap around services will be defined by local GP care teams and will include community nursing, case managers and care navigators at the core, with the potential to draw upon the specialist nursing, dementia nurses, community pharmacies and End of Life champions aligned to each local care team as wrap around services supporting each patient.

Medway would look to test the care navigator role in collaboration with existing case management approach in 2014/15 within the Primary Care/Social care systems with a view to potential procurement should the pilot results support continuation of the role.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Local GP practices will cluster into groups with integrated local teams, consultation with GPs will be focused through the primary care interface task and finish groups, and wider GP engagement at regular GP monthly educational sessions. GPs will risk stratify their patient lists and facilitate MDT meetings for patient case management and care planning.

The care coordination role will be commissioned by MCCG and piloted for one year. This role will potentially be procured from voluntary sector or alternative provider.

Community services are currently providing health case managers with MDT case management and care planning; community and specialist nursing services.

Discussions with social care re alignment are underway, discussions with Dementia lead and MCCG Pharmacy lead are underway.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

National drivers

In 2012 Medway CCG commissioned a Home truths report as part of the National Home Truths programme which is led by 13 Clinical Commissioning Groups and Councils

across the UK in collaboration with iMPOWER (consultants). The Home Truths report identified that “Practitioner signposting work would be a crucial enabler of existing and planned services and would deliver substantial indirect savings by enabling local services to work more efficiently”.

The NHS England operating framework – “Everyone Counts” establishes the framework for ensuring tailored care for vulnerable and older people in the form of a comprehensive and co-ordinated package of care, and securing integration with primary care provision.

Local evidence base:

Research has been undertaken on a variety of care models around the UK. Neighbouring CCGs have been approached for advice and support as well as their experiences and lessons learned for their regional models.

GP task and finish groups, as part of the Primary Care Interface group have led discussions for the care navigator role and the core and wrap around services and their knowledge, advice and lessons learned.

Local stakeholder events for Dementia, Intermediate care and Long term conditions management have identified that care needs to be integrated, to have simper pathways and for there to be a patient champion to assist with signposting to a variety of primary care, social care and voluntary sector services.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Our key outcomes for the service redesign are to provide patient centred care with integrated services, to support patient to self-manage and to reduce unnecessary A&E attendances and emergency admissions.

Monitoring will be by patient questionnaire and by joint KPIs for key stakeholders alongside reduction in A&E attendances and emergency admission for patients. The KPIs will be developed to support the services that are put in place to ensure that the outcomes can be monitored and evaluated.

What are the key success factors for implementation of this scheme?

Integrated teams across health and social care, including GPs

Case management approach implemented and rolled in primary care GPs will be at the centre of organising and coordinating people's care. Reduction in attendance at A&E and emergency admissions for people with long term conditions and complex health needs. Reduction in admissions to residential and nursing care homes Older people able to remain living at home for longer

Scheme ref no.
BCF10
Scheme name
Dementia Services
What is the strategic objective of this scheme?
Dementia Care Services is a growing area of demand together with providing support to the wider family and social networks of people with dementia. The Better Care Fund provides an opportunity to undertake a scoping exercise, including visits to other pioneer sites to understand best practice to better support people with dementia. Medway Council and the CCG are committed to a joint approach to addressing dementia. There is a need to have a more coordinated pathway for care from earlier diagnosis in general practice through an improved quality of care when in acute care to comprehensive co-ordinated packages of care for people with advanced disease and at end of life. We will redesign a coordinated pathway to improve the early diagnosis, care planning and quality of care that service users receive. A review of existing provision in 2014/15 may lead to new joint procurement activity for new services in 2015/16.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
A new dementia pathway will provide timely interventions which will focus on early diagnosis thus reducing admissions to hospitals and mental health units and avert a crisis. It will improve quality of care for patients with Dementia in acute hospitals and supported early discharge. The pathway will be setup to provide a flexible crisis response service in the community by co-ordinating with multi-agencies. Support will be provided to residential/nursing homes in order for them to optimise management of difficult behaviour and to use behavioural approaches. The Council and CCG will develop a Joint Medway Dementia Strategy that will seek to develop a whole community approach to supporting people and their carers. Adopting the national campaign to develop dementia-friendly communities, in support of the Prime Minister's Challenge on Dementia, the strategy will link together core services not only within health and social care but across the community. Fundamental to this development is the direct engagement of people with dementia, their families and carers as well as community groups (e.g. faith groups, voluntary organisations), statutory services (e.g. health, social care, public health, police) and local business (including those who have committed to supporting developing staff awareness on a national level such as Marks & Spencer, Lloyds Bank). The strategy will look at how a dementia-friendly community can develop community resilience and support people

with dementia from early diagnosis through to end of life; redesigning existing services with the potential to develop new initiatives to reflect what the local community need and aspire to.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The delivery chain will in part be determined by the pathway to be created. This will reflect the strategy once it is developed. The organisations that will be involved will be Medway CCG, Medway Council, GP's, providers from the private and independent sectors.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Department of Health (2009) Living well with dementia: a national dementia strategy
https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy
This strategy provides a strategic framework within which local services can; deliver quality improvements to dementia services and address health inequalities relating to dementia; provide advice and guidance and support for health and social care commissioners and providers in the planning, development and monitoring of services provide a guide to the content of high-quality services for dementia.

Department of Health (2013)
Dementia: A state of the nation report on dementia care and support in England
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/262139/Dementia.pdf
This Dementia report, with its accompanying map of variation, available at http://dementiachallenge.dh.gov.uk/map/, shines a light on the quality of dementia care in England. The very best services are excellent and show what is possible. But the worst show that we still have some way to go. The message is clear: we can and must do better.

Dementia Challenge (2012)
http://dementiachallenge.dh.gov.uk/
The Prime Minister's Dementia Challenge launched in March 2012. It sets out plans to go further and faster in improving dementia care, focusing on raising diagnosis rates and improving the skills and awareness needed to support people with dementia - and their carers. It also has details of plans to improve dementia research.

Dementia Partnerships (2012)
http://dementiapartnerships.com/wp-content/uploads/sites/2/models-of-care-for-dementia.pdf
Dr Edana Minghella, proposes a new understanding of the dementia journey and a revised model of care for dementia, aimed at improving experiences and outcomes, and informing service redesign and commissioning.

The Prime Minister's Challenge on Dementia (2012): delivering major improvements in dementia care and research by 2015: Annual report of progress
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200030/9535-TSO-2900951-PM_Challenge_Dementia_ACCESSIBLE.PDF
The progress of the Dementia Challenge is overseen by three groups of 'champions'. This is their latest progress report.

NICE/Social Care Institute for Excellence (2006) CG42 Dementia: supporting people with dementia and their carers in health and social care
http://www.nice.org.uk/nicemedia/live/10998/30318/30318.pdf
This guideline makes recommendations for the identification, treatment and care of people with dementia and the support of carers. Settings relevant to these processes include primary and secondary healthcare, and social care. Wherever possible and appropriate, agencies should work in an integrated way to maximise the benefit for people with dementia and their carers.

NICE (2010) End of life care for people with dementia: commissioning guide: implementing NICE guidance
http://www.nice.org.uk/media/0A2/66/CommissioningGuideEoLDementia.pdf
This commissioning guide has been developed to help support the local implementation of NICE clinical guidelines to commission integrated end of life care services for people with dementia. The guide makes the case for commissioning end of life care for people with dementia, highlighting key benefits.

NICE (2011) Dementia: care pathway
http://pathways.nice.org.uk/pathways/dementia
This pathway covers supporting people with dementia and their carers in health and social care. It considers pharmacological and psychosocial interventions.

SCIE (2012) End of life care for people with dementia living in care homes
http://www.scie.org.uk/publications/briefings/briefing40/
This research briefing is about the care provided in care homes to people with dementia in the period leading up to the end of their lives. It aims to provide an overview of a range of issues important to care home residents, carers and providers.

Alzheimers Society (2011) Optimising treatment and care for people with behavioural and psychological symptoms of dementia
http://www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=609
This best practice guide was developed in consultation with an advisory group of leading clinicians specialising in dementia. It is aimed at a wide range of health and social care professionals caring for people with dementia who have behavioural and psychological symptoms to provide evidence-based support, advice and resources.

Dementia Partnerships (2014) Dementia: 10 key steps to improving timely diagnosis
http://dementiapartnerships.com/10-key-steps-for-general-practice
This Briefing is designed to support GPs and primary health care teams to improve the recognition, diagnosis and management of dementia.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Make Medway a Dementia Friendly Community Develop awareness across Council departments Support the PHE Dementia Friends Campaign Increase the number of Dementia Friends Champions Achieve 6,000 Dementia Friends (pro rata to PM's target of 1 million) Run a campaign to support Dementia Awareness Week Achieve DFC status with Alzheimer's Society Sign up to the National Dementia Declaration Join the national Dementia Action Alliance Support the development of a local Dementia Action Alliance **Understand the current health and social care needs of people in Medway living with dementia** A Medway local Dementia Action Alliance is being established and this will provide feedback as to the success of initiatives from a user and carer perspective. A revised JSNA A map of current services A record of the expressed needs and aspirations of people living with dementia and their carers An analysis of good practice An identification of gaps in current care and support Recommendations for improvement **Develop a Medway Dementia Strategy** A set of partnership commissioning options **Develop an Implementation Plan** A range of agreed commissioning options Timescales for implementation Improved diagnosis rates (national aspiration is 67%) A focus on early and earliest care and support Care and support which develops sensitively from prevention to responsive intervention A reduction in the length of stay in acute settings Improved diagnosis rates Reduction in inappropriate admissions from nursing home to hospital Supported transitions from specialist facilities to residential and nursing homes Standardised training in dementia care
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The Medway local Dementia Action Alliance will feedback from a user and carer perspective as to whether initiatives and the creation of Medway as a dementia

friendly community are on track.

A revised Joint Strategic Needs Assessment has been completed and this provides up to date assessment of current and projected need.

The Dementia Strategy is being developed in consultation with key stakeholders (users, carers, providers, commissioners, GPs). It is then being subject to overview and scrutiny within the Council and CCG Governing Body.

The feedback for elements of the implementation plan do depend to some extent on the commissioning options identified through the development of the dementia strategy. However as detailed in the outcomes it is expected that KPIs from providers will report on elements such as the expected reduction in admissions to hospitals and acute settings.

What are the key success factors for implementation of this scheme?

People with dementia are able to 'live well' and feel empowered to have high aspirations, confidence and know they can contribute.

Commissioning processes are evidence based and reflect current need.

A clear partnership commissioning strategy upon which intelligent and responsive services are created, maintained and developed to ensure an enhanced quality of life for people living with dementia and their carers.

A dementia pathway that will provide timely interventions that focus on early diagnosis reducing admissions to hospital and mental health units and averts crises

Improved quality of care for patients with dementia in acute hospitals and supported early discharge

High quality care for adults with dementia at the end of their lives

Scheme ref no.
BCF11
Scheme name
Falls
What is the strategic objective of this scheme?

Background

The specialist falls vehicle project was a key deliverable of the urgent and emergency care clinical strategy for Medway Clinical Commissioning Group (CCG) and a joint priority within the Better Care Fund plans with Medway Council. The aim was to develop a specialist vehicle to respond to fallers, thereby reducing ambulance conveyance to the Emergency Department (ED), and increase the speed of access to a specialist falls service.

Although the idea originated from the Hertfordshire model for a falls response vehicle,

and from findings from the iMPOWER Home Truths report, South East Coast Ambulance NHS Foundation Trust (SECAmb) is also supportive of the model.

The intention was that two falls vehicles would be available 24 hours a day with a social care professional and/or an Emergency Care Practitioner on board to assess the patient in their home and where it is safe to do so, provide support to enable the patient to remain at home, as well as referring the person into the falls liaison service to receive further support.

A discussion with East and North Hertfordshire CCG who commissioned a falls response vehicle from March 2010 to March 2013, confirmed that they have de-commissioned the service as they found it difficult to evidence a reduction in conveyances and attendances at ED.

In June 2014, the Joint Commissioning Management Group agreed that development of an alternative model (rather than a specialist vehicle) is required for Medway.

The intention is still that the alternative model will include a health care professional to assess the patient in their home and where it is safe to do so, provide support to enable the patient to remain at home, as well as referring the person into the falls liaison service to receive further support.

The new model needs to be further developed and finalised and discussions have started to take place with Medway Council Social Care, Medway Community HealthCare, Medway Foundation Trust, South East Coast Ambulance, Primary Care involvement for prevention (GPs) and Medway Care, Nursing & Residential Homes.

The new model aim is :

- Reduce the number of ambulance conveyances to ED for patients that fall ensuring that there is much greater speed in reviewing the patients' reason for falling and take action for future falls avoidance.
- Significant improvements in falls prevention advice/interventions and supply of appropriate equipment.
- Improved interaction with care homes and community falls service

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Improve outcomes for older people within their own homes by preventing unnecessary conveyance to hospital for people aged 65 and over who have fallen at home minimising the disruption and the risk of disorientation and subsequent lessening in confidence for the older person; operating falls prevention and offering training, advice and guidance to the management of falls in care homes; to make efficiencies across the health economy by reducing the costs of conveyance to hospital, triage and treatment, transfer home and potential admission.

The service would draw on an equipment store/equipment support and install any equipment as needed to prevent an attendance or admission.

As detailed above, due to a change in approach the model is currently being developed.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Ben Keeble, Project Manager,	Medway CCG
Sharease Gibson, Project Lead,	Medway CCG
Chris Markwick, Clinical Lead,	Medway CCG
Carla Vanzyl, OT Team Manager,	Medway Council Social Care
Lisa Sladden, Clinical Services Manager,	Medway Community HealthCare
Terry Baker, Clinical Operations Manager,	South East Coast Ambulance
Dr Sanjay Suman, Consultant Elderly Care,	Medway Foundation Trust
Dr Saloni Zaveri, Consultant In Public Health Medicine,	Medway Council

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Falling is a major issue with 33% of over 65s expected to fall once per year, increasing to 50% for over 80s. Fractured Neck of Femur (NoF) is commonest on the 3rd or 4th fall.

At the time of prioritisation (and the Falls vehicle model being agreed) the following data (below) was evidenced

For falls activity. Key points are:

- There were 2,596 calls between April 2012 and March 2013 received by SECAmb for falls.
- 85% of these patients were over the age of 50.
- More than 50% of falls are between 8am and 6pm – highest rate for the over 50s is between 7am – 9am.
- Response rate was 95% and conveyance rate 39% which means 1,515 patients were not taken to hospital and 962 patients were. Medway has the second lowest conveyance rate in Kent for falls.

More recent data from SECAmb is being supplied to further inform the new model. The project has been slightly delayed due to delays obtaining the data. This has now been received and will be used as a baseline to contribute to the development of an alternative model.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Not clear at this stage, to be identified following further analysis.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
As above.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
This will be determined as part of the model development, expected outcomes include - Reduction in the number of falls related ambulance conveyances, and ED attendances Improved patient experience by non-conveyance. Increase support for older people supported with falls management Improved care for patients by providing falls avoidance support. Enabling patients to stay in their own home, with support from health and social care. Reduction in falls related fractures, including NoF. Improve access to community equipment to prevent admissions Key Performance Indicators will be established to monitor achievement against outcomes.
What are the key success factors for implementation of this scheme?
Stakeholder engagement in the model and approval of the business case, expected to be submitted in October 2014.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	
Name of Provider organisation	
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	