Appendix A

Integration and Better Care Fund

Narrative Plan Template 2017/19

Better Care Support Team

MEDWAY

Contents

Introduction

This plan has been developed by Medway Council and Medway Clinical Commissioning Group. It has been approved by the Joint Commissioning Management Group and Medway Health and Wellbeing Board at its meeting on 12 September 2017.

The plan covers:

- the joint Medway Better Care Fund proposals for 2017 – 2019
- the iBCF proposals for 2017-18
- the Transforming Care Plan for 2018-20
- Section75 Agreement which includes specific financial schedules for both the iBCF and Transforming Care Programme budget proposals

The plan has been signed off by:

The Accountable Officer for Medway CCG:

Caroline Selkirk

The Director of Children's and Adults' Services:

Ian Sutherland

The Lead Member for Children's and Adults' Services (Medway Council)
Chair of the Medway Health and Wellbeing Board

Cllr David Brake

What is the local vision and approach for health and social care integration?

Medway Council and Medway CCG have a strong track record of joint working for the benefit of the population of Medway. We already have in place a joint commissioning team to ensure more integrated commissioning. The development of a Kent and Medway Strategic Transformation Plan (STP) has further highlighted the opportunities that closer working between the Council and the CCG would bring to the residents of Medway, including further joint work across a larger Kent and Medway footprint when it makes sense to do so.

Our vision is to move toward the Medway Model, a single commissioner, with shared provision. However, we need to recognise the views of our wider stakeholders and ensure that our plans realise a shared vision across health and social care. In the year ahead we will work towards realising this vision, focussing on developing people as well as processes. In children's health and care services, we have already achieved an integrated commissioning model across Social Care, Public Health and the CCG with our ambitious children's health tender. Good progress is being made to integrate adult health and care commissioning.

Our five key priority areas for integration in 2017 are:

1. Local model of care – implementing the next stage of delivering the Medway Model

2. Rationalisation of estate –consider the co-location of our frontline and back office teams and the need for flexibility in how we use our locations and buildings

3. Joint commissioning – building and developing our joint commissioning arrangements

4. Digital roadmap – recognising the huge enabling potential of information management and technology in supporting development of the Medway Model

5. Communications and engagement – creating a compelling, shared narrative and agreeing practical actions to support communications across Medway

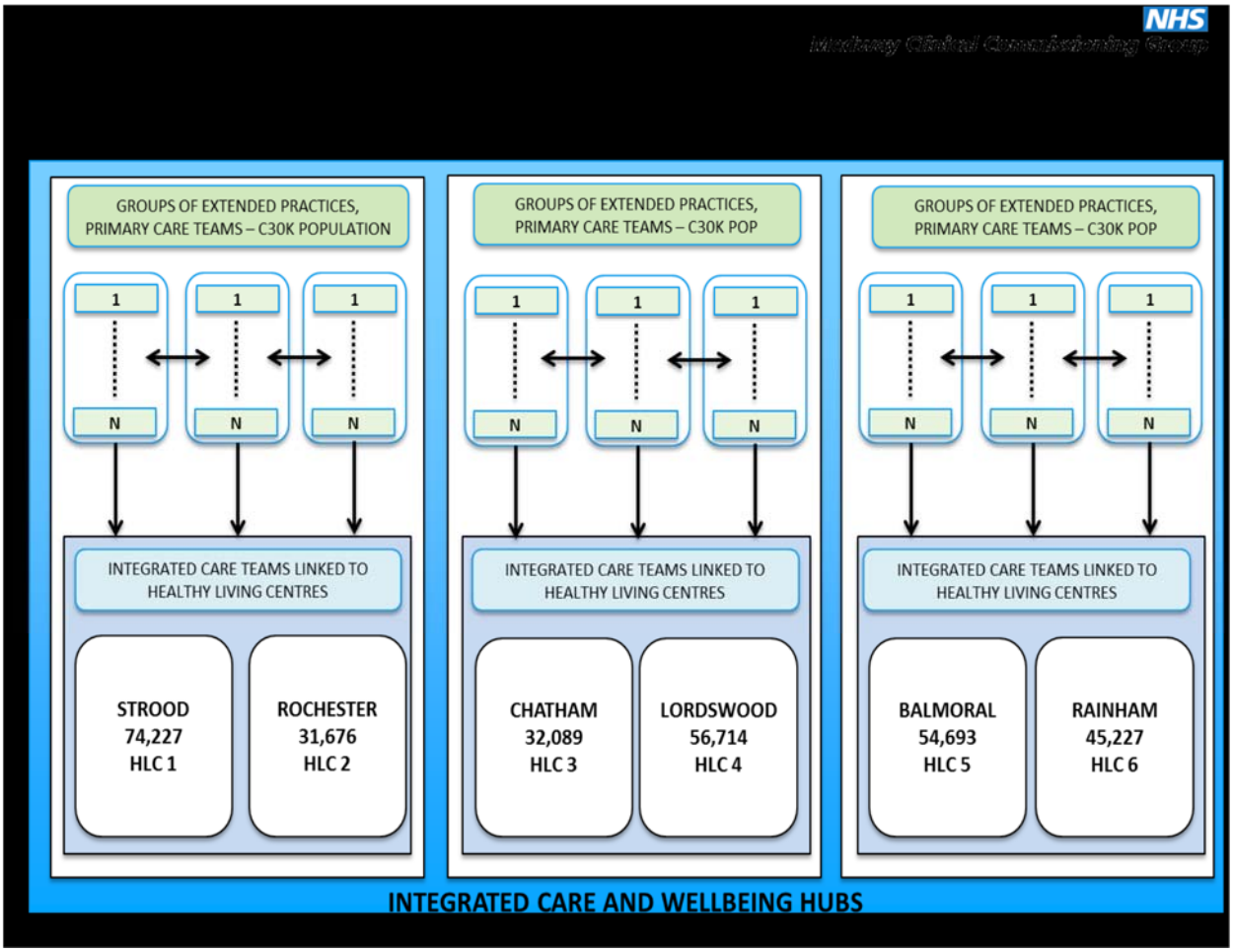
Like all health and social care economies, Medway faces some significant financial challenges. Our BCF plan 2017 – 2019 has been developed to ensure a close fit with the emerging STP and will continue to provide a Medway-specific focus to that work, ensuring that Medway is able to address the priorities identified in the Five Year Forward View and the Council's plan

In Medway, shared leadership is demonstrated through the development of the new Medway Model for delivering integrated care and wellbeing. There has been significant system-wide engagement with providers (both health and social care), Council Members, GPs and the Acute Trust, in developing this model. The Medway Model puts the needs of residents before organisational need and is a key response to the Kent and Medway STP.

The Medway Model is based around six local geographies, building groups of extended practices and focuses care in each of these through a Healthy Living Centre (HLC), each with a population of between 30,000 and 50,000.

The health and social care system is being redesigned, so that people will need to make fewer trips to hospital and instead access the support they need at more specialist clinics provided in local surgeries. This will allow people to have one point of call for family doctors alongside teams of community nurses, social and mental health services, and better access to blood tests, dialysis or even chemotherapy closer to home. These changes will also join up the often confusing array of A&E, GP out of hours, minor injuries clinics, ambulance services and 111 so that Medway residents know where they can get urgent help easily and effectively, seven days a week.

The Medway Model



We have worked hard in Medway to understand the variation in health and social care outcomes across a wide range of indicators. Detailed analysis has been done for each of the groups of extended practices within the Medway Model. This analysis is data-driven and drawn from work undertaken by Public Health.

Background and context to the plan

Medway Unitary Authority ("Medway") was formed in 1998 and consists of five main towns (Strood, Rochester, Chatham, Gillingham, and Rainham) and a number of smaller towns and villages, now contained within 22 electoral wards. While the towns are densely populated there are larger, much more sparsely populated rural areas in the Hoo Peninsula to the north of Medway, and the ward of Cuxton and Halling in the west.

There is one Acute Trust, Medway NHS Foundation Trust, serving around 300,000 people resident in Medway, according to figures produced by the Office for National Statistics in 2015.

Even though Medway has a slightly younger population than the national average, projections from 2015 to 2025 suggest that the number of people 65 years of age or over will increase by 24% to 53,000 and the number of people over 85 years will grow by 44% to 6,900. This growth will mean both an increase in support for older people will be needed, as well as a wider range of services to support a wider, and maybe more complex range of needs.

The number of people over 65 years with a limiting long-term illness is expected to increase significantly by 2030, which would have an impact on the demand on health services for the management of long term conditions such as dementia, heart disease and diabetes as the incidence of these conditions increases with age. The summary of Medway's JSNA can be found here:

http://www.medwayjsna.info/jsna-summary.html

These changes in need will inevitably put additional demands on health and social care services in Medway. There are already signs of a trend in increased numbers of people with additional support needs and the Medway system reflects the national shortage of available specialist resources outside of the acute setting. In response to this, Medway will develop a system-wide response, removing traditional barriers across Health and Social Care - the Medway Model outlined above.

Within Medway, the Index of Inequality shows that the difference in life expectancy between the 10% most and least deprived in the population is 9.4 years for men and four years for women. The main disease contributors to the life expectancy gap are the same as the major causes of death, with circulatory disease and cancer contributing the most to the life expectancy gap.

The challenges of public sector funding as well as increased demand will mean that Medway Council and Medway CCG will need to deliver significant efficiency savings to achieve agreed outcomes, such as enabling the older population to live independently and well for longer; preventing early death; and increasing years of healthy life.

Medway has many challenges facing it over the next five years, not least the predicted rise in people aged over 65, and, with this, the potential for higher levels of morbidity and demand for care. Alongside this are a range of indicators which show that significant health inequalities still exist, which, if not addressed, will also increase the pressure on an already pressurised health and care system.

- Average Medway life expectancy is estimated at 81.7 years for women and 77.6 for men[i]. People aged 85 and over make up 1.6% of Medway's population (4,136 people according to 2010 estimates)
- An estimated 6,300 people of working age in Medway live with a moderate disability
- An estimated 6,700 people in Medway live with sight loss
- An estimated 6,400 people of working age in Medway live with moderate or severe hearing loss, meaning they require a hearing aid or support with different forms of communication such as lip reading or the use of British Sign Language.
- An estimated 2,727 people over 65 live with dementia in Medway.

Demand on health and social care is rising as the population is living longer, and experiencing more complex physical and mental health issues as they live those additional years. By 2035 over one fifth (21%) of Medway's population will be aged 65 and over, up from 15% in 2014.[ii]

NHS Medway Clinical Commissioning Group (CCG) has consulted with stakeholders in shaping its mission and vision for the future that builds cohesion around the agreed focus for transformation in both the most effective clinical models of care and in the underpinning enabling strategy to develop strong provider networks with flexibility to adapt to changing need.

Medway CCG's 5 year vision focuses on:

- Maximising health gain and reducing inequalities
- Securing sustainability and resilience through integration - to secure a seamless transition between providers where patients need the support or intervention of community care, secondary care, social services or the voluntary sector.
- Improving productivity and clinical effectiveness across all providers

Some of the increases in demand for health services will focus on the management of long term conditions such as dementia, heart disease and diabetes as the incidence of these conditions increases with age. With the increasing rise in the older population, will also come a risk of an increase in falls.

Medway's Adult Social Care Strategy 2016 – 2020 "Getting Better Together" sets out a vision for adult social care in Medway based on 6 strategic priorities:

1. Prevention
2. Personalisation
3. Partnership
4. Integration
5. Innovation
6. Safeguarding

By focusing our actions and efforts on these key areas, and the CCG's 5 year vision, we will strengthen and improve the support and care that we provide to residents in Medway.

One of the key areas of focus in social care for 2017-18 is the development of a 'Three Conversation' approach which will deliver more person centred care and support as well as help prevent, reduce and delay the development of longer term care needs. The implementation of this new model links directly into the system-wide activity to reduce delays to discharge, reduce 91 day re-admission rates and increase the amount of home-based care people receive.

Improving health and reducing reliance on health and social care for an increasing number of older people will require greater focus on early intervention, greater self management and better care coordination.

Medway's BCF Plan, aligned to the delivery of the Medway Model, will target those most vulnerable in the community including people living in areas of greatest deprivation and in particular those with a mental health condition, to proactively help them access the advice and care they need for both their physical and mental wellbeing.

Increasing the resilience of carers will also be a priority, with proactive support for people in their own homes to enable people to live independently.

In terms of social care, needs increase significantly over the age of 85. Not only are the numbers of older people growing in Medway, as stated earlier, the complexity of the physical health and mental health problems that they are living with is also increasing. Currently there is too much of a dependency on residential care. This needs to change.

The direction of travel in Medway is towards independence, reablement and recovery. Over the next few years, Medway will make a significant shift from expenditure on traditional institutional style services such as care homes and day centres into services delivered in people's own homes and in local communities.

For example, we are already seeing the amount spent on reablement services delivered at home increase. We will now work towards a reduction in the amount spent on residential care homes unless there is a specific, specialist need to provide care in those settings which cannot be accommodated at home.

Progress to date

Between 2015 -2017 Medway Council and Medway CCG put a number of initiatives in place to deliver the BCF plan. As a result we have:

- achieved 98% of the service users registered on our social care systems having an NHS number. We have worked with adult social care to retrospectively apply NHS numbers to all live cases. This has involved close working with the national records team

- reduced the DToCs to the national target of 3.5%. To support the delivery of the DToC target Medway has an integrated, multidisciplinary DToC process which provides weekly senior challenge. The contribution of this effort was recognised by the CQC Inspection of Medway Foundation NHS Trust in 2016 which noted ''*Medway has one of the lowest delays to transfer of care in the country*"

- reduced bed days lost by nearly 30% through detailed and systematic examination and challenge to medically fit records to ensure delays where they happen are reduced to a minimum

- introduced a “discharge to assess” service, Home First, which has helped over 2500 people home from hospital

- demonstrated that through the roll out of Home First, the Intermediate Care and Reablement Services and MICES that 7-day working is achievable and 7- day working will be a key feature of BCF initiatives in Medway going forward.

In addition to developing approaches to provide integrated care for individuals already known to both health and social care services, we recognise the importance of prevention. To achieve that we continue to build on, and introduce initiatives that identify individuals before they require services, or that prevent an individuals’ health from deteriorating further, for example, in 2017/18 we will focus on reducing the number of conveyances to hospital from residential and nursing settings, through the frailty work being led by Medway and Swale Centre of Excellence (MASCOE).

We know that the key to managing demand and reducing pressure on the system is to prevent people from becoming ill in the first place, or ensuring that the system supports individuals to better manage their conditions, thus maintaining their health and well-being wherever possible. Medway Council is piloting a ‘Three Conversation’ approach to deliver an improved service to those contacting social care for advice and support. It is anticipated that this approach will be rolled out in 2017-18 across the health and care system.

Home First Discharge to Assess

Medway has an established service to deliver assessment and reablement at home. Home First is a multiagency response service that supports hospital discharge for people who are medically stable and have reablement potential. The significant difference with this model is that the assessment and reablement is delivered in the service user’s home setting and not, as has traditionally been done, in a hospital ward or community bed.

Medway’s Home First service has been highlighted at regional and national BCF network events and by the Emergency Care Improvement Pathway (ECIP), which supported its development, as good practice and Medway has been invited to provide presentations of the journey to its creation and delivery as part of the national programme of Masterclasses as well as to information sessions run by the Association of Directors of Adult Social Services (ADASS).

The new Intermediate Care and Reablement Service (IC&RS), which was developed from the learning of the original Home First trial, commenced on 1 October 2016 with Home First as an embedded part. This new service aims to extend the reablement opportunity to people requiring additional non-acute support to get them ready to go home.

Home First provides reablement in people's own home. There is capacity for up to 35 people a week to go home via this route. The IC&RS is a bed based service. People referred to the IC&RS discharge pathway spend, on average, 21 days receiving support. During this time progress towards independence is constantly monitored and if the multi-disciplinary team providing the reablement identify there is an obvious need for additional on-going support once the person returns home, this is organised while they are still receiving reablement. The average length of stay is around 28 days.

In total over 2500 people have either gone home or had their care transferred earlier through the Home First / Intermediate Care and Reablement pathways since this service was commissioned.

Medway Integrated Community Equipment Service (MICES)

MICES was introduced during 2016 to bring together a number of equipment services into one integrated service. The service now operates from three "satellite" stores and provides quick response times, especially to Home First patients who receive their equipment within 24 hours of it being ordered.

In its first year of operation, June 2016 – June 2017, the new service dealt with 12874 orders, which involved the loan of 31747 pieces of equipment. In that same time-frame 14973 items were recycled back into the system for reuse.

Reducing delays to transfer of care (DToC)

Even before DToC was introduced as a National Condition to the BCF programme, Medway had identified, as part of the work with the Emergency Care Improvement Programme (ECIP) that bringing down DToC numbers and understanding the blockages that led to DToC was a crucial issue.

When the DToC work started, the Medway system was ranked in the third quartile for performance and was averaging losses of 774 bed-days each month. In the first quarter of 2017 the bed-days lost averaged 475 and Medway system's performance is now in the top quartile and almost reaching the stretch target of 2.5%.

Dementia

In the last 2 years there has been a concerted effort across Medway to increase dementia awareness across a range of organisations and the local community, as a way of improving the care and support that people living with Dementia and their carers receive. A number of areas including crisis management, dementia diagnosis, support in care homes and post diagnostic support have been addressed.

Amongst these initiatives has been the introduction of a Dementia Support worker role that has integrated into existing workers role across a number of organisations including Carers First, Alzheimer Society, IMAGO (care navigators), Age UK and is being supported by Admiral Nurses from KMPT and MCH. Practically this means that in addition to Admiral Nurses there a number of dementia trained workers that

can visit individuals in their own homes to provide specific support and advice to them and their carers.

This collaboration has led to the development of multi-disciplinary drop in clinics which run alongside dementia cafes. This increasing cross organisational co-ordination of support for individuals is leading to increased satisfaction with services and support.

BCF Plan for 2017-2019

Community Discharge Process

Medway leaders are aware of the plentiful evidence of the benefits for patients, carers staff and organisations of effective hospital discharge planning. Guidance published to date has heavily influenced the work already carried out in the borough and as a result, Medway has seen a change in the number of people who are reported as a delayed transfer of care. This change is sufficiently well documented within the whole system in specific performance reports.

Yet despite the number of “good practice” guides and the demonstrable local achievements, hospital discharge in Medway remains a complex and challenging process for healthcare professionals, patients and their carers. Hospital staff, and therefore their community health and social care partners, remain under constant pressure to discharge patients from the ward as quickly as possible.

A number of proposals and tests will be considered over the coming months in order to develop a new community discharge process in Medway. By January 2018 we will have collated information about the impact from our trials and will be able to implement the agreed approach across Medway.

Delays to Transfer of Care (DToC)

A delayed transfer of care (DToC) trajectory has been agreed for Medway in 2017 with 16.56 as the agreed target for daily delays.

Medway will continue to work in a focused, multi-disciplinary way to monitor the system delays, provide solutions to the challenges and deliver the ambitious DToC target.

A separate DToC Plan on a Page is detailed in Appendix 1, and accompanies this BCF plan with specific actions and key performance indicators (KPIs).

Seven-day services

Plans to move to 7-day working continue to be developed. Some services, such as Home First, Intermediate Care and Reablement, IDT and the proposed Community Assessment Hub are already focused on 7-day working.

As a restructure of Adult Social Care takes effect from the autumn of 2017, new contracts and rotas for health and social care staff are being drawn up and negotiated. Negotiations will also take place with care providers to assess and restart care at weekends. Hospital departments have plans in place to extend their operational hours into evenings and weekends to enable greater discharge planning over 7 days.

Trusted assessments
Medway plans to roll out a single assessment process through the Community Discharge process. The service is being developed around the principle that people will receive one assessment which is accepted across the health and social care system.

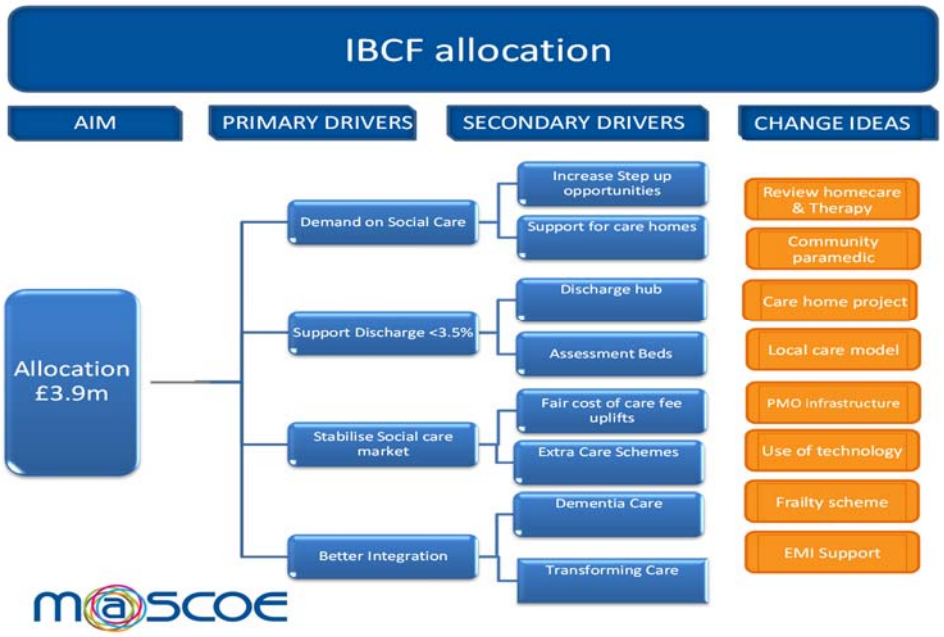
We will ensure people are upskilled to undertake an appropriate level of assessments as part of the Three Conversation's model. Once the reorganisation of Adult Social Care is embedded in the third and fourth quarters of 2017/18, we will move away from making long term decisions in a crisis situation.

KPIs will be developed with social care to ensure progress is maintained and can be documented.

Focus on choice
Admission advice and information leaflets are now available for patients. We aim to increase the visibility of information about the "patient pathway" through the hospital and increase the understanding of the "choice" policy. This is being monitored through the A&E Delivery Board.

We will continue to monitor choice as a component of DToC. The DToC categories are reported to the Urgent Care Organisational Group as a regular item and the DToC plan contains KPIs relating to maintaining momentum and reducing those categories, like Patient Choice, which impact on the DToC performance.

iBCF Funding
The following diagram demonstrates our intended approach in relation to the management of iBCF funding. This additional funding will be used for addressing demand on social care; facilitating hospital discharge; stabilising the social care market and enhancing integration. Although the iBCF is reported separately, the funds will be incorporated into the overall Section 75 which covers BCF.



Risk and performance monitoring

The Risk Register detailed below for the Medway Better Care Fund provides an overview of the top risks identified for 2017-18. The risks will be reviewed on a monthly basis by the BCF Programme Lead, with oversight by the Joint Commissioning Management Group on a quarterly basis through a performance dashboard.

Key:

JCMG:	Joint Commissioning Management Group
AEDB	A&E Delivery Board
UCOG	Urgent Care operational Group
APC:	Adults' Partnership Commissioning
ASC:	Adult Social Care
CCG:	Clinical Commissioning Group

There is a risk that:	**Likelihood**	**Potential impact**	**Overall risk factor**	**Mitigating Actions**	**Ownership**
Breakdown in partnership working results in an inability	2	4	8	• Robust partnership governance arrangements via JCMG	JCMG UCOG AEDB

to co-ordinate and integrate health and social care services, reducing the collective impact on improving outcomes for vulnerable residents.				• Prioritisation of resources and clear senior leadership across partners to support the development / direction of integrated working • Continued focus on building and maintaining strong relationships between partners through formal and informal routes.	
MFT is unable to reduce overheads linked to a reduction in activity from BCF impact, compromising their financial position	3	3	9	• CCG and MFT are working closely together to ensure detail of plans aligned and impact understood. Annual review of target involving commissioners and provider(s).	AEDB
Shifting of resources to fund new joint interventions and services will destabilise current providers across the health and social care system	3	4	12	• Review individual risk assessments ensuring intended as well as potential consequences are assessed • Contingency plans put in place	JCMG
Day-to-day operational pressures on providers prevents them from making the required changes to develop a long-term integrated vision	3	3	9	• 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	APC JCMG
Inability within the timeframe required to address the cultural and competency requirements across the whole workforce to enable integrated working to be successful	4	3	12	• 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	SRG JCMG
Preventative services will fail to translate into the necessary	3	4	12	• Partnership Commissioning will ensure that activity is monitored	APC JCMG

reductions in acute, nursing home /residential care home activity, impacting the overall funding available to support core services and future schemes				and report any deviation from planned trajectory to the Joint Commissioning Management Group who will put in place remedial action in a timely fashion. Contingency plans inline with risk sharing agreement in s75	
Sustainability of financial planning assumptions	3	4	12	• Close monitoring against the Better Care Fund metric to secure shift in patient flows out of hospital. To continue to review financial planning assumptions against progress and adjust plans accordingly.	JCMG
Better Care Fund schemes will increase demand for community based services, which could lead to higher waiting times for community care assessment.	2	3	6	• Commissioners will work closely with providers to ensure appropriate monitoring tools are in place to manage any increase in demand. • Contingency plans put in place including further investment of community services.	APC JCMG
Scheduling of change is complex with risk of potential gaps if acute services are reduced before community capacity is in place	2	3	6	• Transition planning and co-design will be critical. Close transition management and creative contract negotiation processes underpin better planning and commissioning.	JCMG

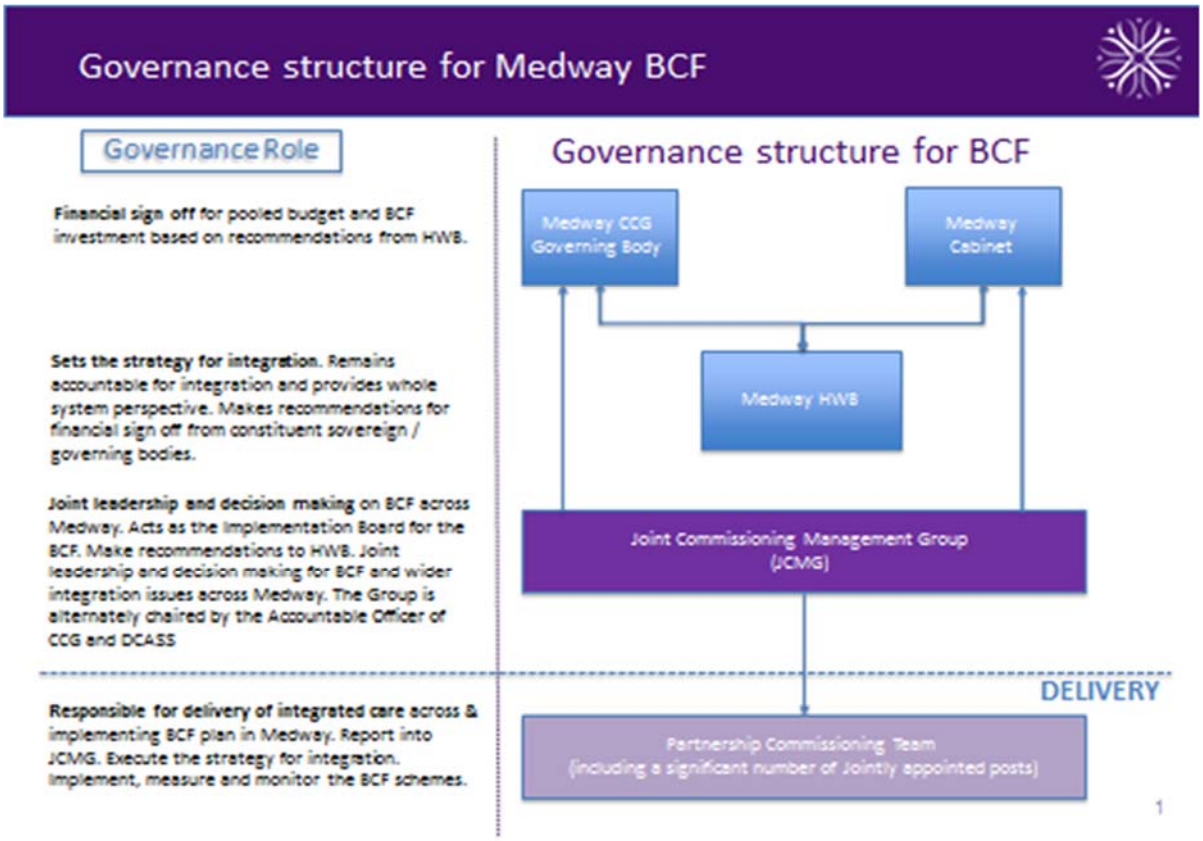
The majority of services within the BCF Plan are currently operational, and the risks already assessed and owned. In the case of new services or major variations to existing services, business cases will be developed to ensure that they are fully costed, outcomes clearly stated and risks fully assessed. Business plans and Project Initiation Documents (PIDs) will be agreed by the Joint Commissioning Management Group. These plans will include robust mobilisation plans for each project, including key milestones, impacts and risks.

Performance monitoring will take place quarterly at the Joint Commissioning Management Group, on an agreed set of metrics which will evidence the impact of BCF implementation in Medway.

National Conditions

National condition 1: jointly agreed plan

The diagram below describes Medway governance processes:



The Joint Commissioning Management Group (JCMG) which was established to lead on all elements of joint commissioning, including BCF has enabled us to share our learning to inform local plans across the system, providing us with the flexibility to adapt to changes in need, performance or circumstance.

Meeting every six weeks, the JCMG has enabled us to ensure the separate CCG and Council governance processes are fully informed e.g. the Health and Wellbeing Board, Medway CCG's Governing Body, Medway Council's Overview and Scrutiny Committee and Cabinet.

The overall BCF fund for 2017 – 2018 is £22,677,366.00 and for 2018 – 2019 is £24,350,408.00 with the existing Section 75 agreement covering the governance and joint working. The funding includes provision for a joint commissioning team.

The BCF pooled budget includes the iBCF allocations for both years, which are £3,962,308.00 for 2017 – 2018 and £5,151,562.00 for 2018 – 2019. The BCF budget will also include the funding for the Transforming Care Programme once this has been finalised. All of these elements will be covered by one Section 75 agreement.

The BCF expenditure and narrative plan has been approved by the Joint Commissioning Management Group which represents the Council and CCG, and will be taken to the meeting of the Medway Health and Wellbeing Board on 12 September 2017 for endorsement.

National condition 2: social care maintenance

We have created a monthly provider forum in Medway, which has had good representation from our residential/ nursing homes as well as home care providers. We have invited guest speakers and have had themed and solution focused discussions, resulting in an action plan for improvement. Updates on progress are given at each provider forum and sent out electronically. The provider forum has representation from Medway Clinical Commissioning Group, GPs, NHS Medway Foundation Trust and all other health partner agencies and is led by Medway Council.

In order to stabilise the local care market our iBCF will focus on:

Fair cost of care fee uplifts:
It is recognised that in Medway care providers have seen very little in the way of uplifts over a number of years. Medway has one of the lowest unit costs for residential and domiciliary care provision in the South East and this is a contributing factor to many struggling to deliver the level of service expected by the Council.

There is agreement across the health and social care system that an amount of £962,000.00 will be allocated from the iBCF funds in 2017 – 2018 and increased further in 2018 – 2019. This is reported in the NHSE BCF planning template.

Pathway redesign:
We are redesigning our care pathways to reduce hand overs, improve information and advice, improve use of reablement, reduce long-term care packages, increase take-up of direct payments, introduce a strength based approach to social care and implement a 'Three conversations approach' to social care delivery.

Our trial of the 'Three Conversation Model' in Medway has shown some improvements to client satisfaction and outcomes and we intend to roll this approach out across our social care teams. Through this, we will remove the traditional 'assessment for services' approach and create a new culture where practice is based on three conversations. We are currently concluding a staff reorganisation to better support and implement the new model.

Strategic planning and programme support:
Medway CCG and Medway Council have very close working relationships including a joint partnership commissioning team. The co-terminosity with Medway Council and its Unitary Authority status provide a real advantage in the commissioning of services for Medway residents. Medway Council and CCG will continue to develop and embed its partnership commissioning arrangements through the BCF. Funding has been allocated through iBCF to increase dedicated finance support for the BCF programme in 2017/18.

Micro-commissioning:
This project is about developing and embedding streamlined decision making, placement finding and payment pathways to achieve tighter controls on spend. It will also develop a strong and efficient Access to Resources team whose remit will be to

source better value from all residential, nursing, supporting living, extra care and homecare provision.

National condition 3: NHS commissioned out-of-hospital services

Medway CCG, Medway Council and Medway NHS Foundation Trust are developing an action plan to implement the High Impact Change Model. We have previously worked with ECIP on our BCF programme and we are keen to identify and implement best practice models. We are also looking at fast track assessments for CHC to ensure that at least 85% of CHC assessments are undertaken outside of the acute setting.

Key areas of development include: the new Community Discharge process, the commissioning of nine assessment beds in the community and the commissioning of an intermediate care and reablement service.

Through the High Impact Change Model self-assessment we have identified key areas for improvement. These relate primarily to integrated assessment and budgets and this will largely be addressed through the creation of a new community discharge process, remodelling assessment beds so that we will be able to ensure that at least 85% of CHC assessments are eventually undertaken outside of the acute setting.

In partnership with Kent, Medway has established a 24/7Crisis Resolution Home Treatment Team (CRHTT). CRHTT is made up of Psychiatrists, Psychiatric Nurses, Pharmacists, Social Workers, Occupational Therapists and Support Workers, all of whom work together to resolve the mental health crisis. The service was set up to respond to and support adults who are experiencing a severe mental health problem which could otherwise lead to an inpatient admission to a psychiatric hospital. The main aims are to help someone manage and resolve a crisis through assessment and treatment in their home environment as an alternative to going into hospital. They also support people being discharged from psychiatric hospital, enabling them to continue recovery at home.

The Medway Liaison Psychiatry Service aims to provide mental health support to people admitted to Medway Maritime Hospital. The service works very closely with staff at Medway Maritime Hospital to allow patients' mental health to be treated effectively alongside any physical health problems. The service is available to anyone over the age of 18, regardless of address, who attends an emergency department or is an inpatient at Medway Maritime Hospital and needs advice, assistance or a mental health assessment.

Kent and Medway STP plans have highlighted a range of actions relating to mental health, acknowledging that mental health is as important as physical health and planning a range of actions:

- Work to deliver integrated mental and physical health services
- Deliver rapid access to individuals and their families to give expert advice, guidance and support during their first episode of psychosis

•Implement a CORE 24 model of liaison psychiatry in all acute emergency departments

•Transform children's emotional and wellbeing services and improve transition between children's and adult services

•Improve prevention and early intervention, help and support

•Deliver screening, assessment, intervention, training and support across the physical and mental health journey for women, babies and families.

We have already:

•Reduced our use of private beds to zero
•Secured funding for a Core 24 Liaison Service
•Developed and implemented a Peer Supported Open Dialogue service
•Secured additional funding and procured a provider for mother and infant mental health services
•Launched two new Street Triage services in Thanet and Medway.

In addition to the cross-organisational dementia work highlighted earlier in this report, a project funded by the BCF in 2017 will be extending our work with care homes in order to improve staff knowledge, understanding and support for those people with Dementia. Clinical staff will visit care homes to undertake initial assessments of clients who are as yet undiagnosed but displaying symptoms. This increased diagnosis then leads to improvements in care as detailed in current research and best practice. Dementia crisis management is also being addressed through work with Med OCC and MCH on developing pathways to manage and avert carer breakdown as reported through the dedicated helpline.

Along with other systems we are embracing the challenge provided by 7-day working and it is a feature that all future BCF initiatives will be delivered across 7 days. We have plans in place to meet our targets in this area, however this is an area that will require specific focus over the next year alongside the development of demand and capacity plans.

Finally, Medway CCG and Council have expressed an interest in BCF Graduation for 2017/18 and we await the result of this submission. We are moving towards a mature BCF, and the Council and CCG share a vision to create one commissioning organisation, with shared provision. In the year ahead we, therefore, need to make plans that move us towards realising this vision, focussing on developing people as well as systems and processes.

National Condition 4: Managing Transfers of Care

In relation to reducing delayed transfers of care, we have committed to the following actions:

- We will review and amend patient pathways to reach our targets around delayed transfers of care.

- We will develop a Community Discharge process which will be delivered as a test for change from October 2017, as well as establish 9 assessment beds which are already operational

- We will increase the availability of clinical support available to care homes to reduce transfers to hospital and hospital admissions. This will be supported in part through the creation of a community paramedic scheme

- We will focus on the patient journey and flow through the system, reducing transfers of care and improving the patient experience. We have funded additional assessment beds to improve the patient experience, and enable the ongoing assessments of people with complex care needs following hospital discharge

- We will make reablement available to all those who can benefit from it and monitor effectiveness, particularly for those with complex needs

- We will invest in dementia care, to increase the availability of EMI beds and reduce out of area placements

- We will work with providers to build changes into the local market which will deliver savings and improvements in service delivery. We will provide an uplift in fees in order to achieve this

- We will invest in Extra Care housing to reduce our existing block contracts and reduce residential care costs in the longer term

- We will fund a complex care coordinator and project officer support for our Transforming Care Programme

The Medway and Swale Health and Social Care Economy A&E Delivery provides whole system oversight and leadership to drive improvement in A&E performance, and ensure high quality Urgent Care Pathways for patients in the context of the Sustainability and Transformation Plan (STP). Every statutory body has a seat on the A&E Delivery Board and is represented at executive level with the authority to commit to decisions on behalf of their organisation.

The A&E Delivery Board is responsible for leading recovery of performance against the national standard that 95% of patients will be seen and discharged within 4 hours of arrival at A&E at Medway NHS Foundation Trust. The A&E Delivery Board will also oversee the strategic direction and delivery of Unplanned Care as defined by the STP and the outcome of the Urgent and Emergency Care Review.

Overview of funding contributions

Funding contributions for Medway's BCF have been agreed and confirmed, including agreement on identification of funds for Care Act duties, reablement and carers breaks from the CCG minimum.

A pooled budget for the Better Care Fund is administered in accordance with a Section 75 agreement between the CCG and the Council. For 2017–2018 the proposed BCF budget is £22,677,366.00 and the proposed pooled BCF budget for 2018–19 is £24,350,408.00.

The BCF pooled budget includes the iBCF allocations for both years, which are £3,962,308.00 for 2017 – 2018 and £5,151,562.00 for 2018 – 2019. iBCF funding is allocated to the following areas:

Stabilising the Care Market	**Developing community infrastructure**	**Managing demand on social care**	**Facilitating hospital discharge**
Fair cost of care fee uplifts Pathway redesign Strategic planning and programme support Micro-commissioning - developing and embedding streamlined decision making, placement finding and payment pathways	Extra care GP support in care homes Community paramedic scheme	Dementia care Transforming Care / complex care coordination Placements Transitions - improving the seamless approach to transitions and the outcomes for individuals and their families	Additional assessment beds commissioned to improve patient flow Integrated community discharge process is being developed to improve discharge

Our BCF expenditure plan is summarised in the following table and detailed fully in the BCF Planning Template, submitted separately:

No.	**Scheme name**	**2017/18 expenditure**	**2018/19 expenditure**
1	Joint commissioning infrastructure / programme support	£835,000	£835,000
2	Telecare	£80,000	£80,000
3	Intermediate care and reablement service	£3,955,515	£3,955,515
4	Carers support services	£879,335	£879,335
5	Dementia services	£202,032	£202,032
6	Maintaining social care & managing demand including. community paramedic scheme	£3,612,815	£3,732,815
7	Care home support	£550,930	£550,930
8	Care Navigator Scheme	£224,886	£224,886

9	Facilitating hospital discharge including new community discharge process	£1,635,114	£1,835,465
10	Medway Integrated Equipment Service	£2,200,000	£2,200,000
11	Disabled facilities grant	£1,854,496	£2,017,933
12	Transforming care programme	£387,350	£387,350
13	Stabilising the care market, including care home placements, extra care, and fair cost of care fee uplifts	£1,808,129	£2,997,383
14	Community nursing	£4,451,764	£4,451,764
	TOTAL	**£22,677,366**	**£24,350,408**

Approval and sign off

This plan has been jointly agreed by Medway Council and Medway CCG. The plan will be presented to the Medway Health and Wellbeing Board at its meeting on 12 September 2017.

[i] Medway's Market Position Statements

[ii] 2014 population projections http://www.medway.gov.uk/pdf/Population%20Projections%202016.pdf

Appendix 1

Medway DToC Plan 2017 - 2019

Focus Areas	Action	Outcome	KPI	Lead	Timeframe
DATA – UNDERSTAND ISSUES	AGREE METRICS FOR PLAN AGREE TRAJECTORY BENCHMARK PERFORMANCE REPORT TO UCOG	BETTER UNDERSTANDING OF ISSUES LEADING TO DToC ACROSS SYSTEM UCOG ABLE TO TRACK PERFORMANCE AND HOLD TO SYSTEM TO ACCOUNT		AD COMMISSIONING,BUSINESS & INTELLIGENCE	MONTHLY REPORTING TO UCOG QUARTERLY MONITORING VIA BCF STOCKTAKE
GOVERNANCE – WHOLE SYSTEM RESPONSE	WHOLE SYSTEM MDT APPROACH ESTABLISH DToC DATA GROUP to DELIVER TARGET	REDUCTION IN DToCs • KMPT • MFT (Medway Residents) • WHOLE SYSEM / OTHER STAKEHOLDERS	ACHIEVE AGREED REDUCTION MOVE TOWARDS 3.5% NATIONAL TARGET >4/100,000 POPULATION REDUCTION IN SYSTEM DToC DELAYS DUE TO ASC	AD COMMISSIONING BUSINESS & INTELLIGENCE	AGREEMENT VIA UCOG TBA
BUILD CAPACITY	DEVELOP COMMUNITY ASSESSMENT HUB INCLUDE CHC BROKERAGE PROCESS AND PATHWAYS DEVELOP TRUSTED ASSESSMENT PROCESS RECONFIGURE BROKERAGE FUNCTION	REDUCTION IN DUPLICATION – ENSURE RIGHT CARE, RIGHT PLACE, RIGHT TIME ALL PROCESSES DELIVER A CO-ORDINATED DISCHARGE PLANNING BASED ON JOINT NEEDS ASSESSMENT PROCESSES AND PROTOCOLS, ON SHARED / AGREED RESPONSIBILITIES DELIVERING GOOD OUTCOMES FOR PATIENTS	TO BE ESTABLISHED AS PART OF THE CAH BUSINESS PLAN SET KPIS AROUND LENGTH OF STAY / DISCHARGE DESTINATION	HEAD OF ADULTS' PARTNERSHIP COMMISSIONING PROGRAMME MANAGER - PMO PROGRAMME MANAGER - PMO UCOG	HUB OPERATIONAL FROM OCT 17 NOVEMBER 2017 SEPTEMBER 2017 SEPTEMBER 2017
COMMUNITY SERVICES	MOBILISE COMMUNITY ASSESSMENT HUB ART INTEGRATION CARE HOMES INTEGRATED INTO WHOLE HEALTH AND SOCIAL CARE COMMUNITY AND PRIMARY CARE SUPPORT REVISE SERVICE SPECIFICATION AND CONTRACT T&Cs TO IMPROVE RESPONSE TIMES ENSURE SUPPLY IN MARKET MEETS DEMAND	PATIENT CARE IS DELIVERED IN COMMUNITY RATHER THAN IN AN ACUTE SETTING IMPROVE RESPONSES FOR REQUESTS FROM RESIDENTIAL / NURSING HOMES NO UNNECESSARY ADMISSIONS FROM CARE HOMES / CLOSER LIASON WITH COMMUNTIY GERIATRICIAN PATIENTS ABLE TO ACCESS RIGHT SERVICE IN RIGHT PLACE	REDUCTION IN COMPLEX DToCs REDUCTION IN THE NUMBER OF DToC IN COMMUNITY BEDS REDUCTION IN THE NUMBER OF PROVIDERS THAT RECEIVE AN INADEQUATE / REQUIRES IMPROVEMENT CQC RATING	PROGRAMME LEAD HEAD OF ADULTS' COMMISSIONING HEAD OF ADULTS' COMMISSIONING HEAD OF ADULTS' COMMISSIONING	MOBILISE CAH OCT 2017 NOVEMBER 2017 MARCH 2018 REVIEW OF PROGRESS ON WINTER OUTCOME
WORKFORCE DEVELOPMENT	ASC PROCESSES TO MEDWAY MODEL OF DELIVERY REVIEW CAPACITY / SKILL SET IN COMMISSIONED SERVICES TO ENSURE UPDATED PROVISION OF SERVICES SCOPE POTENTIAL FOR INCREASED POOLED RESOURCES INCLUDING CHC	ASC WORKFORCE UNDERSTANDS PROCESSES THAT SUPPORT EARLY DISCHARGE REDUCTION IN DUPLICATIONS / DELAYS / UNNECESSARY ADMISSIONS TO HOSPITAL PATIENTS TO HAVE SINGLE ASSESSMENT	IN LINE WITH THE EXPECTATIONS OF MEDWAY MODEL / STP	HEAD OF SERVICE SOCIAL CARE PROGRAMME LEAD - CCG PROGRAMME MANAGER - PMO	JANUARY 18 REVIEW POST WINTER 2017 TBA

Focus Areas	Action	Outcome	KPI	Lead	Timeframe
VOLUNTARY AND COMMUNITY SECTOR	REVIEW AND BUILD CAPACITY OF VOLUNTARY SECTOR ORGANISATIONS TO ENGAGE IN DISCHARGE TEAMS TO SUPPORT PEOPLE HOME FROM HOSPITAL	REDUCTION IN SOCIAL ISOLATION AND COMMUNITY RESILIENCE	REVIEW TARGETS FOR 2017/18 PR	PROGRAMME LEAD ADULTS' COMMISSIONING / PUBLIC HEALTH	MARCH 18
	SUPPORT COMMUNITY INITIATIVES (SUCH AS DERIC / MEGAN) TO BECOME INTEGRATED WITHIN THE DEVELOPMENT OF A NEW HEALTH AND SOCIAL CARE MODEL	VOLUNTARY SECTOR FULLY INTEGRATED AS PART OF THE HEALTH AND SOCIAL CARE TEAM BOTH WITHIN THE ACUTE TRUST AND IN THE COMMUNITY			
CHOICE	IMPLEMENT THE NEW NATIONAL GUIDANCE ON PATIENT AND FAMILY CHOICE	REDUCTION IN DTOC DAYS RELATING TO CHOICE IN LINE WITH ACTION PLAN	REDUCTION IN NUMBER OF PEOPLE / BED DAY DELAYS ON CHOICE	PROGRAMME LEAD ADULTS' COMMISSIONING	MARCH 2018
	IMPLEMENT A TRIAL TO PROVIDE TAILORED INFORMATION, ADVICE AND GUIDANCE FOR THOSE IDENTIFIED AS REQUIRING SUPPORT	INCREASED SUPPORT FOR PEOPLE ON CHOICE	ACHIEVE 3.5% REDUCTION AND LESS THAN 8 BED DAYS LOST DUE TO SOCIAL CARE	PROGRAMME LEAD ADULTS' COMMISSIONING / HEAD OF SERVICE SOCIAL CARE	
	CHOICE PROTOCOL USED PROACTIVELY TO CHALLENGE PEOPLE				
DIGITAL ROAD MAP	DEVELOPMENT OF STRATA WITH SYSTEM PARTNERS	INCREASED INTEROPERABILITY	INCREASED USAGE OF TECHNOLOGY SNABLED CARE SERVICES (TECS)	PROGRAMME LEAD ADULTS' COMMISSIONING	MARCH 2017
		BETTER UTILISATION OF TECS AS BOTH A PREVENTATIVE MEASURE AND DISCHARGE FACILITATION		PROGRAMME LEAD ADULTS' COMMISSIONING	MARCH 2017