Appendix A

Integration and Better Care Fund

DRAFT Narrative Plan 2021 to 2022 – updates may be required in some areas, following receipt of planning and policy guidance.

Due to the Covid 19 response, areas were directed by Government to extend current BCF plans and arrangements to cover 2020/21 and any interim period in 2021/22

MEDWAY

Contents

Introduction

This plan has been developed by Medway Council and the Kent and Medway Clinical Commissioning Group.

It was approved by the Joint Commissioning Management Group at its meeting on xxx.

The plan covers:

- The joint Medway Better Care Fund proposals for 2021 - 2022
- Section75 Agreement which includes specific financial schedules for services within the BCF

The plan has been signed off by:

The Accountable Officer for Kent and Medway CCG:

The Director of People (Children's and Adults' Services):

Lee-Anne Farach

The Lead Member for Adults' Services (Medway Council)

And Chair of the Medway Health and Wellbeing Board

Cllr David Brake

Our joint vision and approach for health and social care integration in Medway

In Kent and Medway all the NHS organisations and the Kent and Medway local authorities have been working together as a sustainability and transformation partnership since 2016. During 2020/21 this joint working will be developed to further develop our integrated care system. This consists of:

1. Forty two **primary care networks** across Kent and Medway. A primary care network (PCN) consists of groups of general practices working together, and in partnership with community, mental health, social care, pharmacy, hospital and voluntary services in their local area, to offer more personalised, coordinated health and social care to the people living in their area.

2. Four **integrated care partnerships** drawing together all provider NHS organisations in a given area and working more closely with social care.

3. a **single commissioning group for Kent and Medway**, led by local doctors, to take a bird's eye view and look at where we can tackle shared challenges together such as cancer and mental health.

The Kent and Medway CCG executive team and governing body have established the following strategic priorities for the remainder of the 2020/21 financial year.

1. Further developing Medway as an integrated care system, enabling health and social care to work together with further autonomy to co-produce and deliver system wide changes. Within the footprint of a Medway and Swale ICP
2. Building and developing our relationships and ways of working with our people, our partners and our communities
3. Joint commissioning – building and developing our joint commissioning arrangements
4. Focus on system enablers – digital, workforce and estates
5. Ensuring we are resilient and continue to support and respond to Covid-19 and the EU exist response and winter pressures; with a particular focus on prioritising services and support for vulnerable people and individuals

Like all health and social care economies, Medway faces some significant financial challenges. Our BCF plan has been developed to ensure a close fit with the emerging ICP and will continue to provide a Medway-specific focus to that work, ensuring that Medway is able to address the priorities identified for Kent and Medway CCG and Medway Adult Social Care.

The national response to the Covid 19 Pandemic has also created pressures in the health and care system as a whole. At the time of writing this plan, we are working with uncertainties around the ongoing discharge funding and therefore our Better Care Fund spending plans will be finalised following the release of further guidance regarding this funding, which is currently only confirmed until March 2021.

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. It is also important to note the Medway Swale Integrated Care Partnership (MSICP) footprint also incorporates an large Swale, which has a population of around 148,000. Many Swale residents access services at Medway NHS Foundation Trust.

Although Medway currently has a younger age profile than the England average, the number of people living in Kent and Medway is predicted to rise by almost a quarter by 2031. This population growth has implications for health and care services.

The number of people over 65 years with a limiting long-term illness is expected to increase significantly by 2030. This increase will has the potential to increase demands on health services specifically related to the management of long term conditions such as dementia, heart disease and diabetes. The incidence of these conditions increases with age. Supporting people with complex dementia is a particular issue in terms of appropriate accommodation in Medway. We are working with providers to ensure the market is aware of the increasing need in this area.

Kent and Medway CCG report[1] the NHS locally spent just £86m (2%) of its budget supporting people to stay well and prevent illness, compared to £3.4 billion treating ill-health. The CCG note:

- People with a serious mental illness die on average 15 to 20 years earlier than the general population.
- If staffing was in line with the national average, there would be 175 more GPs in Kent and Medway.
- Over 50% of the practice nurses may retire in 10 years.

[1] https://www.kentandmedwayccg.nhs.uk/about-us/who-we-are/our-integrated-care-system

- Every day, about 1,000 people in Kent and Medway are not dischared from hospital in a timely manner.

The Covid 19 Pandemic has, and will continue to affect, the manner in which services are delivered in Medway. In addition to the changes required to inform discharge and funding of operations, there are already signs of a trend in reduced demand for residential services and a shift towards supporting more people in their own homes. In order to be responsive to the pandemic and the demands on services, Medway Council is working with all health partners to understand and alleviate the pressures around hospital discharge and acute and community care.

As the population is living longer and experiencing more complex physical and mental health issues there is an overall broader increase on health and social care services. The Medway Adult Social Care Strategy 2016 – 2020 "Getting Better Together" sets out our approach. This strategy will be refreshed in 2021 .

Our approach is based on four principles:

1. **Prevention:** we will focus on evidence-based interventions that can help to prevent avoidable demand on statutory health and care services.

2. **Early intervention and recovery:** we will proactively work with individuals, families and other agencies to help people who have experienced ill-health or crisis to recover as quickly as possible, reducing their ongoing needs and helping them return home.

3. **Enablement:** we will work on the assumption that people want to be enabled and supported to live independently at home and access employment when possible, ensuring that residential care is only used when it is clinically appropriate.

4. **Safeguarding:** we will place the right of all adults to live their lives free from harm, abuse and neglect at the heart of everything we do.

By focusing our actions and efforts on these key areas, along with the Kent and Medway CCG's strategic priorities, we will strengthen and improve the support and care provided to residents in Medway.

Medway's BCF Plan will focus on the needs of those most vulnerable in the community. This includes people living in areas of greatest deprivation, in particular those with a mental health condition. The aim is to proactively help people access the advice and care they need to maintain 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, but the complexity of the physical health and mental health problems that they are living with is also increasing. Currently there is too much dependency on residential care and the

Covid-19 Pandemic has caused changes in demand for these services, so we will need to be responsive and shift our commissioning intentions in line with demand and the changing views of the population.

The direction of travel in Medway is towards independence, reablement and recovery. We are already seeing the number of 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

Medway health and social care services recognise the importance of prevention. 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, we have created a community navigation service, to identify and support patients to navigate services in the community.

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 introduced a 'Three Conversation' approach to deliver a locality based support service to those contacting social care. This approach has now been extended to all teams in Medway.

To date, Medway have put a number of initiatives in place to deliver the BCF plans in previous years. As a result we have:

- Achieved compliance with use of the NHS number as key patient identifier
- Reduced Delayed Transfers of Care to meet and sustain the national target of 3.5%.
- 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 approach in Medway, funded from BCF, prior to the roll out of the new health pathways introduced in 2020 in response to the pandemic.
- Demonstrated that 7 day working is achievable, through the roll out of Home First, the Intermediate Care and Reablement Service and Medway's Integrated Community Equipment Service

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. Medway were invited to provide presentations of the development and delivery of Home First 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).

Our 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 of the contract.

Medway Integrated Community Equipment Service (MICES)

MICES was introduced during 2016 to bring together a number of equipment services into one integrated service. MICES continues to support hospital discharge and support people to remain at home and maintain independence as long as possible. The MICES contract was recommissioned in 2019/20 for best value and performance.

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.

The Medway system in 2016 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.

Medway continued to improve the low number of DToC and were recognised nationally for their improvements in this area. We continue to improve our discharge processes in Medway, as an active partner of the Integrated Discharge Service Executive Board and have recruited to a new senior role, a Head of Integrated Discharge.

Discharge to assess pilot 2019

A new pathway was established in 2019 to facilitate discharge to assess in the community. This pilot was a success and by February 2020 zero assessments were taking place in an acute setting. This enabled us to make the pathway permanent in March 2020 as part of the government's approach to COVID discharge.

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 2021 - 2022

This section is based around existing national conditions and areas of focus within the High Impact Change Model which supports NHS and Social Care efficiency.

Effective Hospital Discharge Processes

Medway leaders are prioritising effective hospital discharge planning. Guidance published to date has heavily influenced the work already carried out in Medway, which has seen a significant change in the number of people who experienced a delayed discharge. This change is sufficiently well documented within the whole system in specific performance reports.

Hospital discharge in Medway remains a complex and challenging process for healthcare professionals, patients and their carers. Particularly in the current times, where the global pandemic has impacted so heavily on services and staff. However, the move to establish our discharge to assess pathway in 2019 facilitated our early response to covid, with the pathway already in place to support earliest discharge and assessment at home.

Regular Multi Agency Discharge Events (MADE) take place in Medway. Both planned and ad-hoc events take place to support effective discharge planning and performance and deliver continued learning and improvements.

Seven-day services

All services in Medway are considered for 7 day working and commissioners would reflect this in their procurement processes. There are areas of services where 7 day working remains a challenge, for example in the transfers of care to residential and nursing homes, however we work closely with our partners and the patient is always prioritised.

Trusted assessments

Our aim is to establish a system where all patients needing to be assessed for ongoing care, receive that assessment in the community. As part of this, the BCF in Medway has funded additional support to Care Homes through enhanced primary care and pharmacist reviews of medication. We have also aligned GP provision to care homes in their locality.

A trusted assessment model operates in our BCF funded assessment beds and operates successfully.

Focus on choice

Admission advice and information leaflets are available for patients.
We will continue to monitor choice as a component of delayed transfers of care (DToC). The DToC categories are reported to the Urgent Care Organisational Group as a regular item to maintain momentum around DToC and reduce further delays related to patient/family Choice, which impact on our DToC performance.

iBCF Funding

Additional funding 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 2019-20. The risks will be reviewed on a monthly basis, with oversight by the Joint Commissioning Management Group on a through reporting on our 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 resulting in an inability to co-ordinate and integrate health and social care services, reducing the collective impact on improving outcomes for vulnerable residents.				• Robust partnership governance arrangements via JCMG • 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.	JCMG UCOG
MFT is unable to reduce overheads linked to a reduction in activity from BCF impact, compromising their financial position				• K&M 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).	UCOG
Shifting of resources to fund new joint interventions and services will destabilise current providers across the health and social care system				• Review individual risk assessments ensuring intended as well as potential consequences are assessed • Contingency plans put in place	JCMG
Day-to-day operational pressures				• Commissioners will work closely with providers	APC

on providers prevents them from making the required changes to develop a long-term integrated vision				throughout the process and ensure that they have the necessary support and resources to deliver the required changes in the timeframe required	JCMG
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	SRG JCMG
Preventative services will fail to translate into the necessary reductions in acute, nursing home /residential care home activity, impacting the overall funding available to support core services and future schemes				• Partnership Commissioning will ensure that activity is monitored 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	APC JCMG
Sustainability of financial planning assumptions				• 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.				• 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				• 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 every six weeks at the Joint Commissioning Management Group, on an agreed set of metrics which will evidence the impact of BCF implementation in Medway.

National Conditions

This section has been updated following the issue of new BCF guidance for 2021/22. The new National Conditions are:

National condition 1: jointly agreed plans

National condition 2: social care maintenance

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

National Condition 4: Plan for improving outcomes for people being discharged from hospital (former condition - reducing delayed transfers of care)

The changes in national conditions for this financial year are minor and the BCF narrative plan contains a focus on these areas throughout.

Overview of funding contributions

A pooled budget for the Better Care Fund is administered in accordance with a Section 75 agreement between the CCG and the Council. The proposed pooled BCF budget for 2021-22 is to be confirmed.

Our BCF expenditure plan will be detailed fully in the BCF Planning Template, submitted separately.

Approval and sign off

This plan has been jointly agreed by Medway Council and Kent and Medway CCG. The plan will be presented to the Medway Health and Wellbeing Board at its meeting on 18 November 2021.