Appendix A

Medway draft Better Care Fund Plan 2022 - 2023

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Introduction

This plan has been developed by Medway Council (the Council) and the NHS Kent and Medway Clinical Commissioning Group (K&MCCG) within the footprint of the Medway and Swale Health and Care Partnership (M&S HaCP). It has been developed and agreed by the Joint Commissioning Management Group (JCMG). The final plan will be presented for endorsement by the Medway Health and Wellbeing Board.

The plan covers the joint Medway Better Care Fund proposals for 2022-2023 and the iBCF proposals.

The plan will need to be signed off by:

- The Lead Member for Children's and Adults' Services (Medway Council) Chair of the Medway Health and Wellbeing Board
- The Director of People (Children and Adults services) Medway Council
- The Director of Integrated Care Commissioning, Medway and Swale Integrated Care Partnership for NHS K&M CCG

The local vision and approach for health and social care integration

Medway Council and the KMCCG have a strong track record of joint working for the benefit of the population of Medway. We already have a joint commissioning team in place to ensure more integrated commissioning. The development of an Integrated Care Board (ICB) has further highlighted the opportunities that closer working between the Council and the KMCCG 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 a single commissioner model with shared provision. To realise this shared vision, we need to recognise the views of our wider stakeholders and ensure that our plans work across health and social care. In the year ahead, we will work towards realising this vision whilst focussing on developing people and processes. Good progress is being made to integrate health and care commissioning for adults and children.

Like all health and social care economies, Medway faces some significant financial challenges. Our BCF plan 2022-23 has been developed to ensure a close fit with the emerging Medway and Swale Integrated Care Partnership. A continued Medway-specific focus will ensure Medway can address the priorities identified in the Five Year Forward View, Medway Council Plan, and the Medway's People Strategy.

In Medway, shared leadership is demonstrated through the development of the M&S HaCP for delivering integrated care and wellbeing, with a focus on population health management. There has been significant system-wide engagement with social care

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and health providers, Councillors, GPs and the Acute Trust, to develop the partnership, which puts the needs of our residents before organisational need.

The health and social care system is being redesigned to reduce the number of trips to hospital made by people and increase the level of access to the support they require from 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 as well as better access to blood tests, dialysis or even chemotherapy closer to home. These changes will simplify and connect the often-confusing access to health across the Emergency Department, GP out of hours, minor injuries and illness services, ambulance services and 111 so that Medway residents know where they can get urgent help easily and effectively, seven days a week.

We have worked hard in Medway to understand the variation in health and social care outcomes across a wide range of indicators. Demographic profiles for the M&S HaCP have been developed by Public Health to ensure the work undertaken is data driven.

Background and Context

Medway Council was formed as a unitary authority in 1998 and consists of five main towns (Strood, Rochester, Chatham, Gillingham, and Rainham) and several 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 wards of Cuxton and Halling in the west.

Medway NHS Foundation Trust is a single-site hospital based in Gillingham. Medway Maritime Hospital serves a population of more than 427,000 people across Medway and Swale. The trust employs around 4,400 staff and provides a wide range of specialist and general hospital services to almost half a million patients a year. This includes more than 125,000 emergency department attendances, 88,000 admissions, 278,000 outpatient appointments and more than 5,000 babies born last year.

The Council and KMCCG have been involved in the development of the plan through the M&S HaCP which includes Medway Foundation Trust, representatives of the VCS, social care provider representatives and our health care community service providers.

Medway has a slightly younger population than the national average[1]. Population projections from 2018 suggest that from 2018-2028 those aged 65+ will increase by 15% to 51,007, and those aged 85+ will increase by 22% to 6,149[2] in Medway. This growth means an increase in support for older people will be needed with a wider range of services to support the breadth and complexity of needs.

[1] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

[2] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2

The number of people over 65 years with a limiting long-term illness is expected to increase significantly by 2023[3], which will impact on the demand for health services to manage long-term conditions such as dementia, heart disease and diabetes as the incidence of these conditions increases with age.

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[4].

Within Medway, the Slope Index of Inequality shows that the difference in life expectancy between the most and least deprived 10% of 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[5].

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

Average Medway life expectancy at birth is estimated at 82.6 years for women and 79.1 for men[6]. People aged 85 and over make up 1.8% of Medway's population (4,136 people according to 2010 estimates)[7] and NHS Digital data suggest that the recorded number of patients with dementia was 1,448 and the estimated number was 2,967 for Medway in the period up to January 2021.

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 2040, 20% of Medway's population will be aged 65 and over[8].

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.

In responding to the pandemic, the health and social care partners adopted a more collaborative approach to working. We intend to continue this level of collaboration through adaptable contracted services, meeting the current need and reflecting this approach in new commissioning activity.

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[3] https://www.poppi.org.uk/index.php?pageNo=331&areaID=8322&loc=8322
[4] https://www.poppi.org.uk/index.php?pageNo=330&sc=1&loc=8322&np=1
[5] https://analytics.phe.gov.uk/apps/segment-tool/
[6] https://fingertips.phe.org.uk/search/life%20expectancy
[7] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland
[8] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2

Medway Health and Wellbeing Board (HWB)

The HWB provides collective leadership to improve health and well-being across the local authority area, enabling shared decision-making and ownership of decisions in an open and transparent way, to:

- achieve democratic legitimacy and accountability, and empower local people to take part in decision-making;
- address health inequalities by ensuring quality, consistency and comprehensive health and local government services are commissioned and delivered in the area; and
- identify key priorities for health and local government commissioning and develop clear plans for how commissioners can make best use of their combined resources to improve local health and well-being outcomes in the short, medium, and long term.

The HWB is made up of Councillors, Medway Healthwatch, the Director of People (Children's and Adults), the Director of Public Health, the Assistant Directors for Children Social Services and Adult Social Services, the KMCCG Accountable Officer, the KMCCG Executive Director of Strategy and Population Health, the Senior Responsible Officer for M&S HaCP, the M&S HaCP Medical Director, Medway Community Healthcare, Primary Care Network representatives, NHS England, the Managing Director of Medway Community Healthcare and the Chief Executive Medway NHS Foundation Trust.

The HWB meets a minimum of four times a year with advisory sub-committees that may be set up to delegate the functions of the Board to a sub-committee or an officer.

The HWB has a Communications and Engagement Strategy that sets out how the board will engage with stakeholders and the public, involve them in the board's work and how communications will be managed.

Integrated Care System

In April 2020, KMCCG was formed by bringing together eight smaller clinical commissioning groups (CCGs). The creation of CCG lead to KMCGG is now recognised as an Integrated Care Board (ICB), with health and care organisations working together closely. Across the partnership there are:

- Forty-two primary care networks (PCN), of which seven are within Medway. The PCNs consist of groups of general practices working in partnership with community, mental health, social care, pharmacy, hospital, and voluntary services, offering a person-centred approach that coordinates health and social care for people living within the PCN.
- Four integrated care partnerships (ICPs), of which Medway and Swale are one. The M&S HaCP consists of acute hospital, community healthcare providers, the mental health trust, councils, commissioning colleagues and Healthwatch representatives.

- A single commissioning group for Kent and Medway that integrates the partnership's health and social care service commissioning functions through a pooled fund between the KMCCG and the Council.

The KMCCG executive team and governing body have an established set of CCG strategic priorities for the remainder of the year and the M&S HaCP aligns with these. Thus, further developing Medway as an integrated care partnership, enabling health and social care to work together with further autonomy to co-produce and deliver system wide changes. Within the footprint of a M&S HaCP collaborative joint commissioning takes place through the partnership commissioning function and is facilitated by the pooled fund s75 agreement.

Like all health and social care economies, Medway faces some significant financial challenges. The BCF plan has been developed to ensure a close fit with the M&S HaCP.

In April 2021 the M&S HaCP approved the HaCP Delivery Plan 2021/22 (the Plan). The Plan was developed in collaboration with system partners and is aligned to the organisational annual plans for partner organisations. The Plan sets out how local partners will work together over the coming year to achieve M&S HaCP 's aims to:

- Put local people at the heart of M&S . HaCP
- Listen to residents, service users, carers, staff, and other stakeholders to design and develop responsive, effective, equitable evidence-based care pathways.
- Deliver high quality health and care services across care pathways from home to specialist care provider (both physical and mental health).
- Shift the focus of care from treatment to prevention.
- Meet NHS Constitution standards, and a delivering sustainable financial position.
- Make the best use of health and care resources (people, money, estate, IT infrastructure etc.).

KMCCG has consulted with stakeholders in shaping its mission and vision for the future to build cohesion around the agreed focus for transformation in 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.

Other integration highlights:

- Both community services across Medway and Swale have a single point of access through their Clinical Coordination Centres. Referrals are triaged into the most appropriate service for the needs of the patient.

- Urgent response services provide a 2-hour response to patients in the community to support admission avoidance while primary care home visiting services provide visiting paramedic practitioners for housebound patients who require a same day GP appointment.

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- Neighbourhood Nursing Teams in Medway, focused around PCNs provide a team of nurses, therapists to provide holistic care to patients to complex needs – a model that will be reviewed with a view to rolling out across Swale. The team has direct access to MedOCC and improved access to primary care to support and develop relationships.

- PCN pharmacists provide support with structured medication reviews. Community navigators and social prescribers provide support with accessing health and social care support.

- To support those at end of life, a dedicated 24-hour Palliative Care Support Line is available to patients, family, carers and health professionals to prevent point of crisis. Night sitters are available to provide support to patients and families at end of life to provide support within the home, preventing an unnecessary hospital admission where appropriate.

- Health and social Care services work in collaboration to address clinical and social needs, assessing the persons needs to prevent hospital admissions and improve quality of life via the equipment contracts, enablement, reablement services, telecare, social prescribing. All carers are trained to advise service users/patients/families to support with adopting healthier lifestyles to improve their quality of life.

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. All partners involved in our Population health management programme are committed to addressing the wider determinates of health that impact negatively and positively (to share innovation) on an individual's health and wellbeing. Our approach should provide the ability to understand variation through benchmarking both measurable quantitative and the softer qualitative data and comparisons to improve clinical outcomes. It will help identify people who are currently well, but at risk of developing long-term conditions.

Through a population health management approach, the Medway and Swale system has created a data repository which identifies all statutory organisational data sets across our locality. We are in the process of extending this to include qualitative and quantitative data from the voluntary and community sector to create a richer source of local place-based intelligence. Once compiled, the data sets will be continuously analysed through the population health management steering group in order to identify the highest inequalities with an aim to build community resilience within neighbourhoods. All partners including wide agreement and contribution from the voluntary sector are included in the discussions and design.

We have developed a 'Local Memorandum of Understanding' - a written understanding between the Statutory, Voluntary and Community Sectors and other partners within the Medway and Swale locality about how we will co-operate. It will recognise the contribution Voluntary and Community groups make and acknowledge their independence, and also the moves in central government and wider society towards empowering the voluntary sector and communities.

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Medway and Swale HaCP recognise that it is crucial to the governance and wellbeing of communities in Medway and Swale work through engagement of volunteers, promotion of active residence, promotion of debate, questioning and new ideas, and providing services. If the Memorandum of Understanding is effective, it will support the development of Voluntary and Community sector capacity, to increase and improve the impact of the sector and benefit Medway and Swale residences. Community health resilience is the ability of a community to use its assets to strengthen public health and healthcare systems and to improve the community's physical, behavioural, and social health to withstand, adapt to, and recover from adversity and reduce inequalities. This is what we are setting out to do.

Some of the increases in demand for health services will focus on the management of long-term conditions such as dementia, heart disease, diabetes and respiratory as the incidence of these conditions increases with age, as does the risk of falls.

The Plan also sets out how M&S HaCP and local partners will work together to begin the recovery from the COVID-19 pandemic, to continue to support the delivery of the COVID-19 vaccination programme, and to prepare for any future surges.

Medway's Adult Social Care Strategy 2021 – 2025

The vision set for adult social care in Medway focuses on 'a shift from reactive to empowerment'.

The approach is based on four principles, which will only make a difference if they are part of the practice and culture of operational teams and through the work with partners.

- **Prevention**: A shared focus on learning and building on evidence-based interventions that can help to prevent avoidable demand on statutory health and care services.
- **Early intervention and recovery**: Working proactively 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.
- **Enablement:** Working 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 there is no alternative.
- **Safeguarding**: Placing the right of all adults to live their lives free from harm, abuse, and neglect at the heart of everything that is done.

By focusing actions and efforts on these key areas, and KMCCG's longer-term vision, the support and care provided to residents in Medway will strengthen and improve.

The focus in social care to embed the 'Three Conversation' approach, is a strengths-based practice to deliver more person-centred care and support as well as help prevent, reduce and delay the development of longer-term care needs. This 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**.**

Joint Commissioning Management Group (JCMG)

Robust partnership governance arrangements exist through the establishment of the JCMG, which comprises senior officers from the Council and KMCCG.

JCMG ensure appropriate prioritisation of resources and provide clear senior leadership across partner agencies to support the development and direction of integrated working, through oversight and monitoring of the BCF and the schemes within it.

JCMG has a set of core principles which include:

- Collaborative local leadership to develop a shared vision, culture, and values to support transformation to a shared vision and goals to improve health and wellbeing.

- A person-centred approach - All partners plan and deliver care and support with individuals and, where they wish, with their families, to achieve the best health and wellbeing outcomes.

- A preventative, assets-based population health approach that maximises health and wellbeing, independence, and self-care in or as close to people's homes as possible to reduce their need for health and care services.

- Proposals are only considered if they look to make a beneficial change to the wider health system within the footprint of the M&S. HaCP

- Proposals submitted to JCMG to consider may benefit one partner more if the proposal evidences the direct benefit to the wider health system.

JCMG Direction for 2022/2023

To assist JCMG decision making during 2022/23, it is recommended that the eligibility for access to funding from the BCF should be:

1. Improved discharges pathway from hospital
2. Prevention to hospital admission and support maximising care capacity
3. Addressing the pandemic's 'hidden' impacts on citizens and services:
    - Improving health/including mental health outcomes
    - Reducing health inequities in service delivery
    - Challenging inequalities (BAME, social deprivation, social isolation)

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- The impact on climate change, ensuring that Medway can address the priorities identified for through Medway's Joint Health and Wellbeing strategy and JCMG's core principles.
- Any unforeseen circumstances

BCF Plan 2022 - 2023

In 2021 – 22 the Council and KMCCG put several initiatives in place to deliver the BCF plan, resulting in:

- 100% of all commissioned Care Homes have NHS emails and taken up the digital inclusion opportunities offered by KMCCG.

- The roll out of Home First, the Intermediate Care and Reablement Services and the Medway Integrated Community Equipment Service (MICES) has shown that 7-day working is achievable and where appropriate 7-day working will be a key feature of BCF initiatives in Medway going forward.

- Bed days lost have been reduced through detailed and systematic examination and challenge to medically fit records to ensure delays where they happen are reduced to a minimum

In addition to developing approaches to provide integrated care for individuals already known to both health and social care services, the importance of prevention is recognised.

It is known that the key to managing demand and reducing pressure on the system is preventing 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.

As such, initiatives are introduced and built-on that identify individuals before they require services, or that prevent an individual's health from deteriorating further.

Patient Voice

Research and good practice highlight that residents value social care and support that focuses on the whole person, not merely their illness. Additionally, residents value support that is reliable and continuous, forms a trusting relationship, identifies workable strategies, and provides interventions to help people

Engagement with partners, residents, patients, and other stakeholders is embedded as illustrated in the engagement cycle below:

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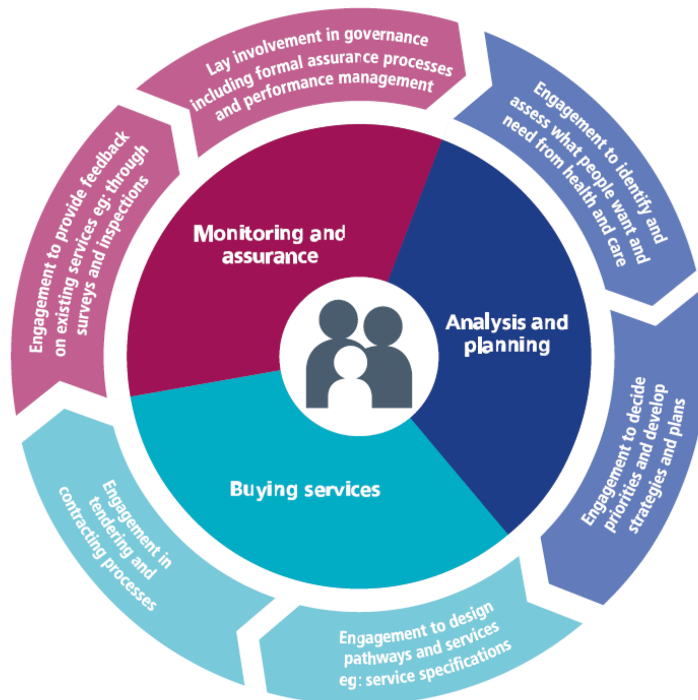

Diagram:Engagement cycle: Flyde Coast CCG

Examples are offered under National Condition 4, page 16 onwards. To ensure an unbiased approach, Healthwatch have been engaged to receive feedback and improve services.

Healthwatch Medway are contracted to:

- Promote and facilitate the involvement of Service Users, carers, and members of the public in decision-making concerning the Partnership Arrangements.
- Support the Council to in establishing the Local Healthwatch .
- Co-operate with the Council's Service Providers.

Focus on choice

Admission advice and information leaflets are now available for patients. The aim is 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.

Risk and performance monitoring

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

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Key:

JCMG: Joint Commissioning Management Group
LAEDB Local A&E Delivery Board
UEC: Urgent and Emergency Care Steering Group
IDS: Integrated Discharge System Executive Board
APC: Adults' Partnership Commissioning
ASC: Adult Social Care
KMCCG: Kent and Medway 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 to co-ordinate and integrate health and social care services, reducing the collective impact on improving outcomes for vulnerable residents.	2	4	8	• 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 UEC IDS AEDB
MFT is unable to reduce overheads linked to a reduction in activity from BCF impact, compromising their financial position	2	4	8	• KMCCG 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	JCMG

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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	3	4	12	• 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	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

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Most 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 with clearly stated outcomes and fully assessed risks. Business plans and Project Initiation Documents (PIDs) will be agreed by JCMG. These plans will include robust mobilisation plans for each project, including key milestones, impacts and risks.

Performance monitoring will take place quarterly at JCMG on an agreed set of metrics, which will evidence the impact of BCF implementation in Medway. These metrics are set nationally:

i). Avoidable admissions

Unplanned hospitalisation for chronic ambulatory care sensitive conditions

ii). Length of stay

Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for:

i) 14 days or more
ii) 21 days or more

iii). Discharge to normal place of residence

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence

iv). Residential admissions

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population

v). Reablement

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

National Conditions

National condition 1: jointly agreed plan

Governance of the BCF in Medway
JCMG was established to lead on all elements of joint commissioning, including BCF, and has allowed learning to be shared for informing local plans across the system, providing the flexibility to adapt to changes in need, performance, or circumstance.

Meeting every six weeks, JCMG has ensured the separate CCG and Council governance processes are fully informed such as the Health and Wellbeing Board, KMCCG's Governing Body, the Council's Health and Adult Social Care Overview and Scrutiny Committee, and Cabinet.

The M&S HaCP 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 ICB priorities. Every statutory body has a seat on the Local A&E Delivery Board (LAEDB) and has executive level representatives with the authority to commit to decisions on behalf of their organisation.

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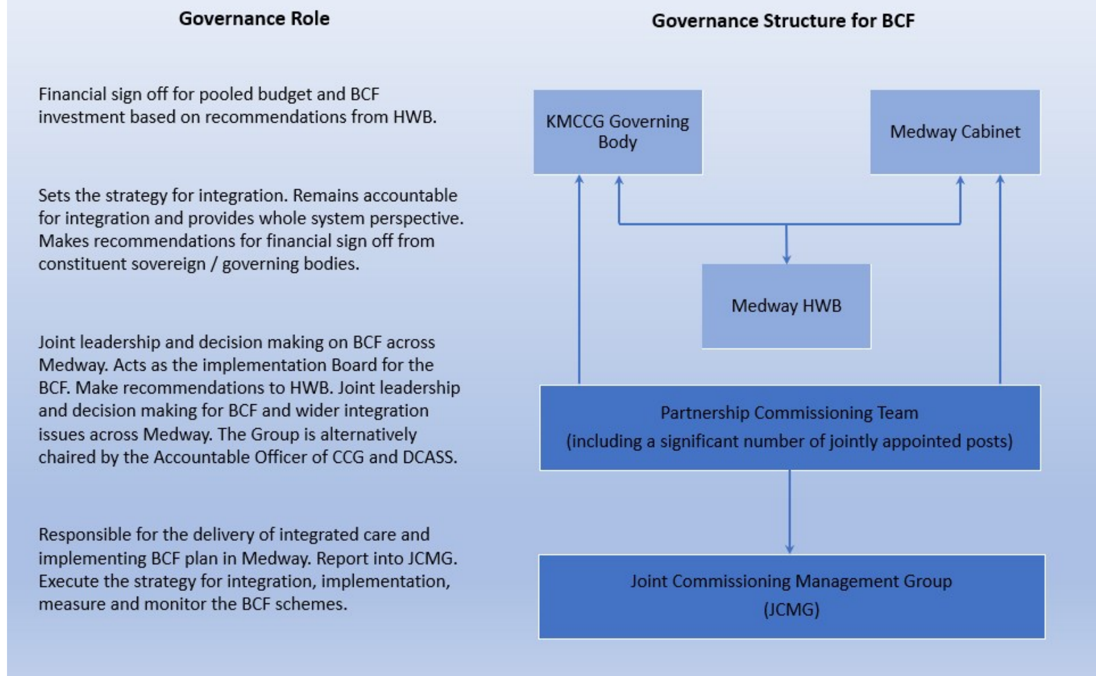

The LAEDB is responsible for leading recovery of performance against the national standard that 95% of patients will be seen and discharged within 4 hours of arrival at A&E at Medway NHS Foundation Trust. The A&E Delivery Board will also oversee the strategic direction and delivery of Unplanned Care,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

The overall BCF fund for 2021/22 was £29.907million with a new Section 75 agreement covering the governance and joint working. The funding includes provision for a joint commissioning team.

iBCF Funding
The BCF pooled budget includes the iBCF allocations for 2021/22.

iBCF funding will be used to address 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.

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

From 2021/22, a single Medway pool for transforming care was replaced with reimbursing costs as agreed by a wider Kent & Medway pooled budget. The only costs currently being forecast to be reimbursed are the cost of the Complex Care Co-Ordinator post employed by the Council.

All previous community infrastructure costs incurred by Medway Community Healthcare are now being delivered through Kent Community Health NHS Foundation Trust.

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Disabled Facilities Grant
The Better Care Fund provided an increase in funding for home adaptations and related opportunities to improve integration between health, social care and housing services to reduce hospital admissions and allow early hospital discharges.

Please see how the DFG Is utilised on page 22.

National condition 2: social care maintenance

Monthly provider forums have been created in Medway, which have excellent representation from residential and nursing homes as well as home care providers. Guest speakers attend and have 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 is led by thr Council and has representation from KMCCG, GPs, NHS Medway Foundation Trust and all other health partner agencies.

In response to the pandemic and the additional duties outlined in the Adult Social Care Action Plan, an interactive Medway Provider Portal was created for direct and continuous communication between the Care Sector and the Adults Partnership Commissioning service. Through the close monitoring of the National Tracker, provider's needs, capacity and outbreaks are met with a quick response. This is an embedded function that provides in-depth understanding and aids Care Market stability.

Fair cost of care fee uplifts

It is recognised that in Medway care providers have seen very little in the way of uplifts over several 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.
Since April 2020, government funds have been passported to the care sector and offered assistance during the challenging workforce crisis. Collaborative working with the ICB and Kent County Council (KCC) has delivered a co-created action plan to stabilise the care market.

Pathway redesign

Health partners and community providers have been actively engaged to embed the National Discharge and Community Support Policy and Operating Model. Significant in-roads have been made on improving handovers, patient information and advice, the use of reablement, and reducing long-term care packages.

Strategic planning and programme support

K&MCCG and the Council have a very close working relationship including a joint partnership commissioning team. The Council is a Unitary Authority which provides an advantage in the commissioning of services for Medway residents, as the responsibility for almost all local government actions sits within the one organisation.

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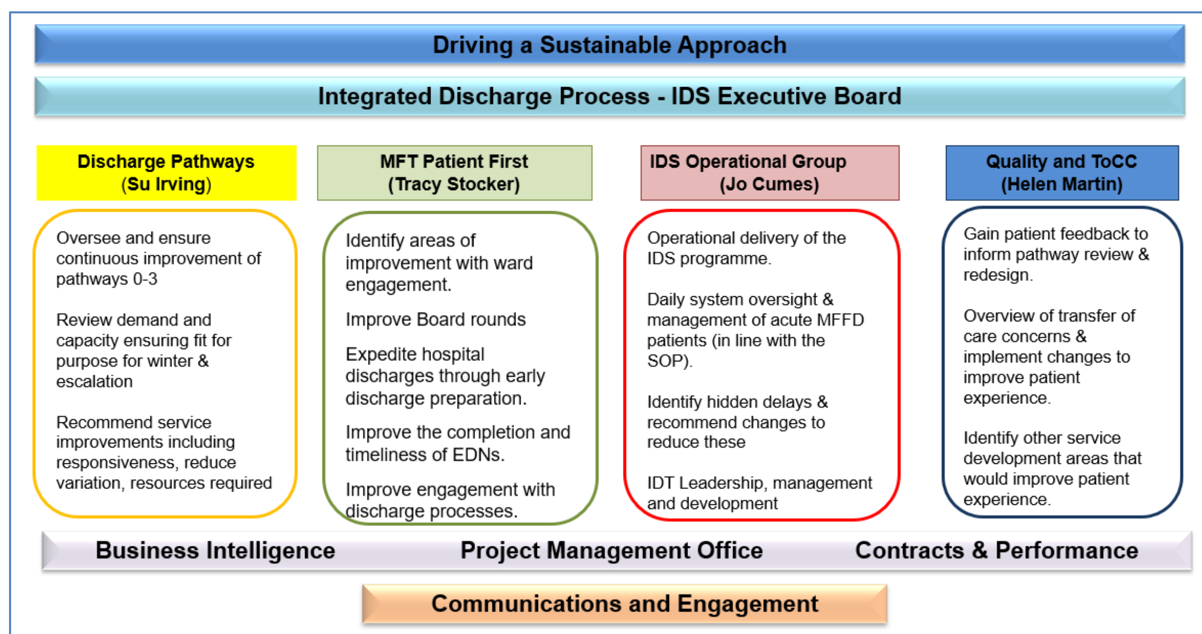
The Council and KMCCG will continue to develop and embed its partnership commissioning arrangements through the BCF.

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

Through the Integrated Discharge System programme, led by the Integrated Discharge System Executive Board, whole system partners are developing an action plan to implement the High Impact Change Model for Managing Transfers of Care.



Key areas of development include the commissioning of nine assessment beds in the community and the intermediate care and reablement service. During the pandemic additional care homes were commissioned with designated settings and a bridging service to assist all partners in the discharge delivery.

National Condition 4: Plans for improving outcomes for people being discharged from hospital

Medway leaders are prioritising effective hospital discharge planning. Guidance published to date has set the direction heavily for work within Medway by all system partners. The introduction of the 'discharge to access' pathway has seen a significant change in the number of people who experience a delayed discharge.

Hospital discharge in Medway remains a complex and challenging process for healthcare professionals, patients, and their carers. Particularly where the global pandemic has impacted so heavily on services and staff. The BCF facilitated several schemes highlighted below, which have helped to expediate an early response to the COVID-19 pandemic and support the earliest discharge and assessment at home possible.

We are working with our providers to ensure we are able to support patients needing ongoing care at home. The provider market is fluctuating greatly due to changes in

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demand for services and also the Government furlough scheme, which has impacted on the market considerably, particularly for domiciliary care. We are anticipating changes in demand for residential care as a result of Covid, which is reflected in our metrics, residential care demand is also impacted by the establishment of our discharge to assess pathway and our strategic approach to delivering more care and reablement in people's own homes where possible.

The Rapid and Urgent response teams comprise of nurses and therapists providing specialist care in the community, responding within two hours of a call to support admission avoidance, re-admissions and discharge to assess. The teams are supported by MedOCC GPs providing prescribing advice and guidance.

A Falls Response Car has been piloted in Medway since December 2020 with an excellent positive impact of 72% of attends resulted in non-conveyance of the patient to hospital with patients having wrap around services put into place at the time of the visit. Using the skills of both therapists and paramedics as an extension to the Urgent Response Service they are able to support fallers to stay at home instead of being conveyed to hospital. The pilot has been such a success, the pilot is continuing in Medway whilst a business case for a fully commissioned service is being considered by K&M CGG for the Falls Response Car to have extended hours and to roll out across Medway and Swale.

The SMART Team at Medway Hospital supports patients in their home on discharge who need to remain under close care of a hospital clinician during their recovery.

Patients discharging from an acute episode of care can be referred in to the MDTs/ILRs where appropriate. Members of the Integrated Discharge Team are attending these meetings to support discussions for those patients at risk of readmission.

The key to managing demand and reducing pressure on the system is to prevent people from becoming ill, ensuring that the system supports individuals to better manage their long-term conditions. The aim is to support people to live independently and well, for longer.

Support for patients requiring ongoing care at home is ensured through working with providers, particularly those in domiciliary care. The care sector is facing significant challenges partly due to an increase in demand. This is multi factored and wide ranging and on a national level, which has impacted particularly for domiciliary care.

The following BCF funded services support our system to effectively support safe and timely discharge from hospital.

Discharge to Assess

In 2019 a new pathway was established to facilitate a 'discharge to assess' approach in the community. This pilot was a success with no assessments were taking place in an acute setting by February 2020 and was then made permanent in March 2020 as part of the government's approach to discharge and expediated the Medway early response during the COVID-19 pandemic.

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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

Home from Hospital Pilot Service

The pilot service commenced on 1 November 2020 and due to its success has been extended to 31 March 2022, and to commission a longer-term service during 2022. The service supports patients for up to 8 weeks, who are aged over 50 and are awaiting discharge from an acute setting or residential reablement as well as assisting community patients to prevent admission into hospital. The aims of the service are:

- Preventing people from admission or re-admission to hospital
- Enhancing quality of life for people with short-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people are well-positioned for recovery at home following hospital admission
- Supporting people in a safe environment and protecting them from avoidable harm

Interventions include enabling micro living environments, facilitating hydration, nutrition, and warmth as well as social engagement as key factors in preventing ambulatory care sensitive conditions.

Patient voice:
"Just having a bit of company and help each week has restored my confidence and I no longer feel so isolated and down – [service co-ordinator] has been like an angle to me"

"Never did I think I would leave the house on my own, but now I am doing my shopping and enjoying going to the café sitting with a coffee and a paper".

"I really forward to our Friday chats and wish you could visit me for longer and more often".

"I am so very grateful for everything RVS had done and all the support that you have given my Mum during the lockdown when I was so far away and couldn't visit her"

The Homecare Bridging Service

The Homecare Bridging Service provides homecare to patients being discharged from Medway Hospital, for an interim period, whilst the search for a long-term provider continues. The service is provided at times of expected high demand for homecare services to ensure patient flow.

In response to the demand created by the pandemic, the bridging service has been flexed to accommodate continuous changing need. It has covered Pathway 1 (discharge to assess) consistently and were essential in the first surge when the homecare sector were without PPE, vaccinations, or testing.

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During the COVID-19 pandemic, the service provided rotas covering existing packages of care and take new cases on when the commissioned agencies and Home First were under significant demand pressures. The service continues to be available to Home First, Urgent Care (Rapid Response) to for a more effective discharge.

Intermediate Care and Reablement Service and Home First

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.

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 and has been extend to the 30 September 2023, and varied to accommodate the new health pathways.

Patient voice

An example patient experience is summed up in the following quote "I was in a sorry state when I first got home, barely able to do more than sit up in bed (and that only with assistance!), but from the very start getting a Home Visit from [worker] advising me on what assistance and aids were available to me – from daily care/enabler visits to get me washed and dressed, to providing equipment ranging from a perching stool to a humble urine bottle, to a visit from a physiotherapist – was an absolute lifesaver…

… All my dealings with all my helpers – carers/enablers/managers etc – were positive, and it was clear that everyone, absolutely everyone, was fully committed to doing their very best for me, and I really appreciated it."

Medway Integrated Community Equipment Service (MICES)

MICES was introduced during 2016 to bring together disparate equipment services into one integrated service. MICES has been vital in supporting the COVID-19 pandemic response as well as hospital discharge and people remaining at home with maintained independence for as long as possible. A new MICES contract commenced on 1 September 2021 and supports the increased demand of Pathway 1 (discharge to assess) discharges.

Patient voice
From the start of the MICES contract to August 2021, average customer satisfaction scores have remained in the 90th percentile for pre-delivery arrangements, equipment condition, delivery technician helpfulness and likelihood of recommending the servicer provided by Medequip to friends and family. There is room for some improvement for collection arrangements, which have an average score of 77.96%. This may be because the Medway contract allows for collection within 5 days regardless of the circumstances, whereas some other contracts allow for a 2 day emergency collection speed in the case of bereavements subject to authorisation.

Disabled Facilities Grant (DFG) and wider services

Medway Council understands how important support is to make sure vulnerable people can stay in their own home or find better accommodation to help them stay active and living independently. This may mean providing housing with support staff on site (supported housing) or having support staff visiting people in their home. Medway Council is currently reviewing whether there is the right type and right amount of housing related support and other help for people to stay in their homes for longer. The Housing Strategy 2018-2022 aligns with the Homelessness Prevention Strategy and links to a range of council plans and strategies.

It is predicted that there will be 22% more people living in Medway by 2037. There will be more households in all age ranges but especially those aged 65 and older. Medway Council will need to account for this in our future plans. An example of this is our current program of extra care schemes with future developments being planned in collaboration with our partners in Adult Social Care. Medway also recognises the changing needs of residents and aims to ensure that all new affordable housing developments include units which are accessible for people who use wheelchairs or have other mobility issues.

The Care Act 2014 shifted the focus to earlier intervention that offers a more preventative approach to supporting people. The principle of the DFG service for residents across Medway is to '*help me live in my own home, easily and with dignity with the right adaptation when I need it'.*

An established person-centred approach in place supports the needs of the person. The individual need is met through the DFG team or the MICES team dependent on that need.

In Medway, the MICES and DFG teams collaborate to meet the complex health and social care needs of residents.

The MICES supports the DFG and hospital discharge by providing community equipment to those with a temporary or permanent health need, or disability on a temporary or permanent loan basis.

Medway Wellbeing Navigation Service
The navigation service is part of social prescribing and supports patients on their journey through the health and social care system. The service supports those individuals who need assistance in locating and accessing the appropriate services for themselves and those they care for.

A Wellbeing Navigator is placed at Medway Foundation Trust to support discharge into the community, while supporting the individual needs of the patient to recover from ill-health and recurrent hospital admission.

Patient voice:
Wellbeing Navigation Service (WNS), from October 2018 to September 2020:

- 100% of service users were satisfied with using the WNS.
- Primary care attendances per patient after support through the WNS were reduced by 45%.
- Secondary care attendances per patient after support through the WNS were reduced by 45%.
- 95.5% of patients have not been readmitted to hospital within 28 days following WNS intervention
- There was a reduction of 94% in the use of 111 services, from a cohort of 196 patients who were frequently using the 111 prior to WNS intervention
- 1,595 service users report an average 16 points improvement in their wellbeing following WNS intervention (to a target of 6 points improvement)

Equality and health inequalities

The M&S HaCP footprint has some of the highest levels of deprivation in the UK, with some wards being in the 10 percent most deprived areas in the country. 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 will have implications for health and care services.

The pandemic has had an on-going effect on the way services are delivered in Medway. In addition to the changes required to inform discharge and funding of operations, there are signs of a trend in reduced demand for residential services and a shift towards supporting more people in their own homes. To be responsive to the pandemic and the demands on services, the Council is working with all health partners to understand and alleviate the pressures around hospital discharge and acute and community care.

In Medway, 23% more people have an unplanned admission for a chronic condition that could be managed out of hospital, compared to the national average.

Medway Joint Strategic Needs Assessment March 2021 states that deprivation has a major impact on shaping the physical and mental health and wellbeing. Life expectancy in Medway has been consistently below the England average, and in recent years:

- has increased for females however, females are more likely to spend a greater proportion of life in poor health than males
- just below the England averages by 0.7 years for males, and 0.8 years for females.

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The most deprived areas are more likely to have a lower life expectancy of up to ten years for a male and eight years for a female compared to the more affluent areas of Medway.

24% of children aged 4 to 5 years and 36% of 10- to 11-year-olds are classified as overweight or obese across Medway, with higher rates recorded in areas of deprivation. Nearly 70% of adults in Medway are classified as overweight or obese, which is significantly higher compared to England at 62%.

The number of people aged over 18 who smoke, is 4% higher than the national average. Smoking and obesity are known as the two key risk factors that contribute to morbidity and mortality across a range of conditions in adulthood. While smoking rates have fallen in Medway over the last decade, the prevalence remains high for manual occupations, and nearly half of adults with serious mental health illness smoke.

People with severe mental illness die on average fifteen to twenty years earlier than the general population, with smoking rates thought to be the largest contributor. In Medway, there is a higher rate of suicide, particularly in men, compared to the England average rate and a 2% higher prevalence of depression.
People with learning disabilities have shorter lives compared to the general population.

The one-year cancer survival rates are 5% lower in Medway than the national average. Cancer contributes to a greater extent in females (54.7%) than males (32.7%). Several areas in Medway have higher rates of death from cancer of approximately between 20% and 40% higher than the national average for England.

Addressing health inequalities in Medway

Medway's BCF Plan will ensure the initiatives the fund finances will focus on addressing the needs of those most vulnerable in the community. The aim is to proactively help people access the services, advice and care they need to maintain their physical and mental wellbeing.

Activities that look to address health inequalities are linked to the population health management programme (PHM). M&S HaCP I are the lead HaCP for the national programme. All levels of prevention are included: primary, secondary, and tertiary. A M&S HaCP health inequalities interactive map is being created and will include service provision and disease prevalence to calculate level of need and ensure equitable access.

The Joint Health and Wellbeing Strategy 2018-2021 links into several health and social care strategies and provides a high-level framework to improve the health wellbeing and health inequalities of the Medway residents. The focus is on five key outcomes:

- Giving every child a good start
- Enabling our older population to live independently and well
- Preventing early death and increasing years of healthy life
- Improving mental and physical health and well-being

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- Reducing health inequalities

The Joint Local Care Steering Group identified transitions as a priority area and recommended a proposal to JCMG to secure BCF funding for additional capacity to map health pathways, thresholds, and services for transition across a wider remit for the. HaCP

A Preparing for Adulthood Project Board has been established to improve the outcomes for service users transitioning from Children's Social Care to Adults' Social Care. This is to support people aged 16 and over with disabilities such as learning disabilities, autism, or physical disabilities. The objective is to develop a seamless process of transition to adulthood with clear signposting and information (such as education and providers) to young people, their families, and relevant stakeholders regardless of Care Act eligibility.

The BCF Plan facilitates the Psychotherapy for Tier 3 Children Service psychotherapy support programme, which commenced in 2021. The service is a weight management with psychotherapy to support and engage with children and young people who are above a healthy weight and higher than the 98th percentile. Over 2years the service aims to:

- increase understanding of a healthy lifestyle
- increase wellbeing and physical activity
- reduce the levels of overweight and obese within the cohort
- reduce the prevalence of long-term obesity related conditions
- reduce the use (and cost) of statutory services due to obesity related conditions
- improve family awareness and understanding of the impact of obesity

Other areas where the BCF Plan provides support to ensure equity of service and addressing the health inequalities are:

- Carers play an essential role in supporting the remain living independently of those being cared for by remaining in their own home. As the population increases, increasing the resilience of carers will also be a priority.
- Voluntary services have provided vital support to carers and health and social since the COVID-19 pandemic. Carers First provide carers information advice and guidance, a young carers and carers support payment service, and have actively supported carers throughout the pandemic by offering wellbeing calls, shopping and picking up medications for vulnerable carers. They also helped GPs to identify carers for the COVID-19 vaccination programme, and provided young carers with emergency continency planning and virtual support throughout the COVID-19 pandemic.

Partnership Commissioning sit within the wider directorate of Public Health which enables our BCF funded team to consider the latest research and guidance in relation to health and health inequalities and produce strategies and plans to address these. Our Market Position Statements will be reviewed in 2022/23 and will address the changes in the market and in needs locally.

A recent piece of work has been completed which is An Overview of the BAME Population in Kent and Medway. It notes:

- The outbreak of COVID-19 pandemic in March 2020 has highlighted the existing inequalities in the BAME population across England, and the need to investigate them and understand them better. A recent report published by Public Health England has shown that mortality rates from COVID-19 in some BAME population groups are nearly double than those in White British population.

- During the 2011 Census the majority of the BAME population in England, and also in Kent and Medway, was on average young, ageing between 20 and 39 years old. When compared with the SE region, the distribution of BAME population by broad age group in Kent and Medway was very similar. However, Medway on its own had a slightly higher percentage of BAME population aged 65-84 and 85+ years old, than the SE region and also Kent.

- The BAME groups with the highest number of social service users were Asian (690) and Mixed (492). Although the majority of service users were White British, Dartford, Gravesham, Maidstone, Shepway, and Thanet had a higher number of social service users from a BAME group.

- The largest BAME group in nursing and care home residents was Asian. Thanet (29%) and Gravesham (29%) had the highest percentage of BAME nursing and care home residents in Kent and Medway.

- The highest hospital activity rates in the BAME population in Kent and Medway were in Other ethnic group, which was higher than in White British. Hospital activity rates in Black and Other White population has been increasing over time and are currently higher than in White British population. It is very interesting how the rate of A&E attendances in Other White increased from 935 in 2018/19 to 1656 per 1,000 in 2019/20 which is very likely attributable to the outbreak of COVID-19.

Patient voice:
Carers Service in 2020, during the response to the pandemic:
In 2020:
- 95% of carers felt an improvement in their health and wellbeing because of using the service
- 92% of carers who felt better able to access support from health, social care, and welfare benefits system because of contacting the service.
- 100% of young carers who feel that the service has helped them to reach their educational goals
- 96% of carers felt that the service enabled them to have a meaningful break from their caring role, of which 23.3% were young carers
- 98% of young and adult carers who use the Carers service, feel that they are supported, and a Crisis is avoided

KMCCG are working with the Council and system partners to develop a Dementia Strategy in 2021 and 2022 to inform what further investment in dementia care.

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Work with providers will continue to build changes into the local market, which will deliver savings and improvements in service delivery.

Overview of funding contributions

Funding contributions for Medway's BCF in 2021/22 were 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 KMCCG and the Council. We await confirmation of funding details for 2022/23. For 2021-22, the BCF budget was £22.814 million (including DFG allocations). The BCF pooled budget includes the iBCF allocations for 2021/22 at £7.093million

The BCF expenditure plan is summarised in the following table and will be updated following confirmation of funding in 2022/23

No.	Scheme name	2021/22 expenditure
1	Joint commissioning infrastructure / programme support	£994,584
2	Telecare	£80,000
3	Intermediate care and reablement service	£4,264,420
4	Carers support services	£879,334
5	Dementia services	£202,032
6	Maintaining social care & managing demand including. community paramedic scheme	£3,350,169
7	Care home support	£279,949
8	Care Navigator Scheme	£440,230
9	Facilitating hospital discharge including new community discharge process	£2,778,215
10	Medway Integrated Community Equipment Service	£2,200,000
11	Disabled facilities grant	£2,470,674
12	Stabilising the care market, including care home placements, extra care, and fair cost of care fee uplifts	£3,454,116
13	Prevention/Early Intervention	£490,390
14	Managing Demand on Social Care	£2,950,165
15	STP/ICB costs	£80,000
16	Community nursing	£4,992,703
	TOTAL	**£29,906,981**

Conclusion

The BCF Plan enables Medway Health and Social Care Partners to actively collaborate to support innovation and address the changes in demand, discharge design and social care needs.

This style of working has been expedited as a system response to a global pandemic and has forged a systemwide partnership that is nationally recognised as best practice and is based on transparency and trust.

The BCF expenditure and narrative plan will be approved by JCMG and will be taken to the Health and Wellbeing Board for endorsement.

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