Medway's Better Care Fund Plan

Bodies involved strategically and operationally in the production of this plan:

Medway Council via Health and Wellbeing Board (HWB) and Cabinet; Public Health; NHS Kent and Medway Integrated Care Board (ICB); Medway and Swale Health and Care Partnership (HCP), members of the Joint Commissioning Management Group(JCMG), Medway Integrated Discharge Team; Medway Community Healthcare; Strategic Housing and DFG Services; VCS Sector via the Better Together Consortium; Medway Foundation Trust; Kent County Council

How have you gone about involving these stakeholders:

We have established a Steering Group to support regular and ongoing engagement with key stakeholders and internal and external partners around BCF Planning and commissioning activity for the Better Care Fund. This group includes those listed above as stakeholders and supports co-production of BCF plans and the wider programme of our Partnership Commissioning Team. We have also engaged with our Health and Wellbeing Board, both to input views into the draft BCF Plan and in their agreement of the final version. We are recommissioning many of the key BCF funded services in 2023-2025 and officers follow the established best practice commissioning cycle with engagement supported, wherever possible, by Medway Healthwatch, to ensure our engagement plans are robust and the voice of service users and carers is represented.

Partnership Commissioning is a function that was developed to commission health and social care services and is dedicated to specifically support the BCF, utilising BCF funds. Officers are senior commissioners and programme leads who work across Health and Social Care and are a key part of the Public Health Directorate within Medway Council. Our location as a function, working alongside Social Care, supports regular engagement and collaborative working.

Utilising the intelligence and needs analysis developed by Public Health enables our BCF plan to have a focus on prevention while supporting the priorities of Health and Social Care services through a population health management approach. Officers within Partnership Commissioning are jointly appointed by NHS Kent and Medway and Medway Council and work closely to integrate both organisational objectives though the development of BCF plans. Partnership Commissioning also commission and directly contract manage many of the services that are funded, including Intermediate Care, Equipment Services, Carers Services, Healthwatch, Voluntary Sector Infrastructure Support, Home Care, Supported Living, Telecare, Residential and Nursing Care. Commissioners have regular and ongoing engagement with service providers through regular contract monitoring meetings, and also attend many strategic Health and Social Care meetings, engaging regularly with our HCP and ICB.

The HCP have developed a Voluntary and Community Sector Framework - a written understanding between the Statutory, Voluntary and Community Sectors and other partners within the Medway and Swale locality about how we will support each other. This recognises the contribution Voluntary and Community groups make to support residents and statutory services and makes a commitment for statutory services to work with the VCS on an equal footing.

Governance

Our Joint Commissioning Management Group (JCMG) was established to lead on all elements of joint commissioning, including BCF, and provides direction and leadership. Attended at Director Level for Social Care, Public Health and Medway ICB, the JCMG in Medway has allowed learning to be shared across the system, providing the flexibility to adapt to changes in need, performance, or circumstance.

Meeting every six weeks, JCMG has ensured the separate NHSKM and Council governance processes are fully informed such as the HWB, NHS KM ICB's Governing Body, the Council's Health and Adult Social Care Overview and Scrutiny Committee, and Cabinet.

The M&S HCP provides whole place-based system oversight and leadership to drive improvement in Emergency Departments performance and ensure high quality Urgent Care Pathways for patients in the context of the ICB priorities. Every system partner attends the Local A&E Delivery Board (LAEDB) and has executive level representatives with the authority to commit to decisions on behalf of their organisation.

We have also established a Partnership Commissioning Steering Group to support engagement around development of our BCF plan and our commissioning activity. This group have supported various programmes of commissioning including Wellbeing Navigation, Voluntary and Community Sector, Carers Support Services, Supported Living and Intermediate Care and Reablement. We work closely with our local Healthwatch Service to design and produce engagement materials to support our commissioning activity, ensuring the patient voice is captured and that we consider accessibility and protected characteristics.

Executive Summary

This should include:

- **Priorities for 2023-25**
- **Key changes since previous BCF plan.**

The Medway Better Care Fund Plan 2023-2025 has been created with reference to our local strategies which aim to deliver better outcomes for our local population. It aims to harmonise key priorities set out in partnership strategies at national and local level. These include Social Care, NHS, Public Health, Disabled Facilities Grant and wider for example the Medway Joint Local Health and Wellbeing Strategy and the Kent and Medway Integrated Care Strategy

Priorities for the BCF in 2023 - 2025 are:

1. Improved discharge pathways from hospital to realise the best health outcomes for our residents

2. Prevention to reduce hospital admissions and improve the availability of acute or statutory services

3. Improving health and mental health outcomes through a population health management approach

4. Reducing health inequality in relation to service delivery. The specific focus is to address disparity amongst ethnic minority communities, focussing on our most disadvantaged and socially isolated communities. The BCF programme is also tailored to help deliver the local ambitions to support those underserved in our communities. It aligns to the Levelling Up agenda and implementation of the Core 20+5 programme which is a specific NHS focus to address inequalities in the 20% of the English population who are most deprived.

5. The wider cost of living and health and social care workforce crisis

6. Housing related initiatives to support effective hospital discharge

Our JCMG oversee the development of BCF plans and allocation of BCF resources, ensuring we are adaptable to system or population changes and can make amendments to contracts or planned activity as needed.

Our priorities in the last year have been on recovery from the impact of COVID 19 by reframing discharge pathways and the retention and recruitment of Social Care and Health Workforce.

In 2023-2025, an additional focus will be on the recommissioning of a large number of key services that are crucial in delivering on the BCF aims and objectives, including Intermediate Care and Reablement, Supported Living Accommodation, Residential and Nursing Placements, Wellbeing Navigation and a consortium model of Voluntary and Community Services.

Effective contract management ensures regular communication takes place between our commissioners and service providers. These include Medway's VCS and Healthwatch, this supports the effective alignment of resources and development of our BCF Plans. The Population Health Management Model is key to the targeting of our resources. It will be a feature within all contracts. This will ensure providers identify and develop actions to address health inequalities in service delivery.

We recognise that housing related issues can be a barrier to effective discharge. Working with colleagues to facilitate issues associated with housing is another key intention of our BCF plans for 2023-2025. Working closely with our Housing and Disabled Facilities Grant (DFG)Team, we aim to develop a new housing officer role, resourced from the DFG budget, aligned to our Integrated Discharge Team. This role will develop an action plan to address the most common housing related issues that

delay hospital discharge in Medway. This role will enable us to respond quickly to housing needs in a way that supports effective and timely hospital discharges.

The changing landscape and challenges arising from the Covid-19 pandemic and related cost of living crisis has led to a significant impact on social care and health services. These services are having to deal with some of the highest costs of providing care that commissioners have ever seen. The scale of this demand is yet to be fully understood. The Fair Cost of Care exercise we undertook with our providers shows there is considerable work to do to meet the required contract costs for residential care. On this basis we are working closely with providers to create a long-term plan to address this issue, while continuing to deliver services within current budgets. We know that in Medway we must focus our limited resources in the most effective way to meet immediate needs and at the same time, invest in preventative services that delay the need for costlier statutory services. We will ensure our approach to commissioning is of the highest standard. We have in place robust governance processes to enable us to invest in services to improve the health and resilience of our population. In the current financial crisis, there is a need for new ideas and concepts. Our approach to coproducing our service specifications follows the best practice commissioning cycle. It utilises the latest public health intelligence and needs analysis data. There is full engagement with service users, carers and other stakeholders to facilitate the tackling of health inequality, through the design of services that meet the needs of the population and deliver against the strategic aims for health and social care.

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person-centred health, social care and housing services including:

- **Joint priorities for 2023-25**
- **Approaches to joint/collaborative commissioning**
- **How BCF funded services are supporting your approach to continued integration of health and social care.**

Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

The Medway Better Care Fund Plan 2023-2025 has been created with reference to our local strategies for the Peoples Directorate, Social Care, NHS, Public Health, Housing/Disabled Facilities Grant and wider. It is crucial to the governance and wellbeing of communities in Medway and Swale that we work collaboratively through engagement of volunteers, promotion of active residence, promotion of debate, questioning and new ideas, and providing appropriate services at the right time.

In Medway, shared leadership is demonstrated through the development of the M&S HCP for delivering integrated care and wellbeing, there has been significant system-wide engagement with social care and health providers, voluntary and community sector, Councillors, GPs and the Acute Trust, to develop the partnership, which puts the needs of our residents before organisational need.

We work diligently to understand the variation in health and social care outcomes across a wide range of indicators. Demographic profiles for the M&S HCP have been developed by Medway Public Health, as part of the Joint Needs Assessment to ensure the work undertaken is data and evidence driven.

The COVID-19 pandemic necessitated the introduction of an interim allocations approach to ensure that systems had sufficient resource to respond to the pandemic. From 2022/23, the allocations methodology will be reset to move systems back towards a fair share distribution of resource at the levels affordable within the SR21 settlement which confirms the Long Term Plan (LTP) funding settlement, provides additional resources for elective recovery and to reflect the impact of COVID-19, and extends the settlement period to 2024/25.

Our JCMG, as described earlier in this narrative, oversee the development of BCF plans and programmes, ensuring we are adaptable to system or population changes. Commissioners also regularly report on outcomes from the key contracts funded. The Partnership Commissioning Team are embedded as part of the Public Health directorate and this provides the opportunity to collaborate widely in the development of plans, with provider and operational engagement taking place regularly through contract management processes.

2023-2025 will see our main areas of focus being the ambitious programme of recommissioning that we have planned, which includes key services that are crucial in delivering the BCF aims and objectives, including Intermediate Care and Reablement, Supported Living Accommodation, Residential and Nursing Placements, Wellbeing Navigation and a consortium model of Voluntary and Community Services which include Medway's Carers Services. The development of the service specifications for each service will involve extensive engagement with stakeholders, providers, service users, carers and statutory services and the development of Equality Impact Assessments. Governance of commissioning activity is extensive, being in the first instance overseen by JCMG and supported by Medway Council's Procurement Service, which ensures we meet robust commissioning standards. This is then scrutinised by a Procurement Board, with final decision making through Medway Council's Cabinet of elected members. Officers then manage the contracts for services throughout their term, building on successes and tackling any gaps in service delivery and ensuring the best outcomes. Regular reports are made to JCMG on the performance of contracts and any changes or variations to service delivery over the term.

National Condition 2:

Use this section to describe how your area will meet BCF objective 1: Enabling people to stay well, safe and independent at home for longer.

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- **steps to personalise care and deliver asset-based approaches**
- **implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches**

- **multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake**
- **how work to support unpaid carers and deliver housing adaptations will support this objective.**

The health and social care system in Medway has been designed 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. These changes 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.

The key to managing demand and reducing pressure on the system is to prevent people from becoming unwell while ensuring that the system supports individuals to better manage their long-term conditions and prevent deterioration. The aim in Medway is to support people to live independently and well, for longer. Our BCF funded Wellbeing Navigation Services, Carers Services and our wider work as a joint commissioning team that supports this ambition with greater collaboration and effective joint working between providers and commissioners. We have systems in place to ensure we commission effectively and as demonstrated during the pandemic, can be flexible and adaptable to changing needs and demands. The national workforce crisis and rising cost of living will impact on health and further inequalities in Medway. We will need to balance the immediate demands on services with investment in preventative care, to support those with needs.

Medway NHS and Medway Council also fund a number of separate initiatives which provide preventative services including our Public Health Services for healthy weight management, smoking cessation services, exercise and health education programmes. Identifying and addressing the wider determinants of health is our Public Health priority and Medway's strategic leadership through JCMG helps balance our approach.

Through our commitment to 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. It will include qualitative and quantitative data from the voluntary and community sector to create a richer source of local place-based intelligence. The data sets will be continuously analysed in order to identify the highest inequalities with an aim to build community resilience within neighbourhoods. All partners, including contribution from the voluntary sector, are included in the discussions and design.

The Voluntary Sector Framework developed in 2022/23 will support the development of Voluntary and Community sector capacity, to increase and improve the impact of the sector and benefit Medway and Swale residents. It is our intention that community health resilience will be developed through this approach. The BCF in Medway funds a VCS infrastructure contract which has been very effective in delivering support to the sector, as well as generating income for the VCS sector which represents a return on investment of around £13 for every £1 spent on the contract. We will be recommissioning this contract within a consortium model which

will focus on improved outcome monitoring for the five lots within the contract, to commence in January 2024.

Medway Council's Social Care services operate on a locality basis, working closely with our Benefits Team as well as other Council services such as Housing and Disabled Facilities Grant teams to address identified housing issues that are affecting health and wellbeing or delaying hospital discharge. This supports us to identify areas which require different approaches, such as with our the more remote areas of Medway, including the Peninsular, where locality-based community services such as Whoo Cares are having a positive impact on social isolation and supporting residents to access services.

Medway Council and Kent and Medway NHS recognise the essential contribution that carers make to maintain and improve the health and wellbeing of Medway residents. The Medway Joint Carers' Strategy aims to support Medway carers to carry out their valuable role, which is key to maintaining a balanced and person-centred health and care environment. In the recommissioning of Medway's Carers Services during 2023/24, we will be looking to build on the good practice already established. The development of a new specification in partnership with our service users, providers and key partners will ensure we identify where the priorities for the next 3-5 years need to be focussed.

The DFG budget funds three Occupational Therapists in the Adult Social Care service and one in Children's Social Care. These posts work specifically on adaptations and assist with identifying those that would benefit from adaptations to their homes to enable them to continue living in their home and maintain independence. The DFG budget also provides £200,000 to the MICES budget each year to contribute towards the supply and fitting of support aids for the elderly and disabled.

Medway's Wellbeing (Care) Navigation Service has been in operation since October 2018 and was recommissioned with a new service specification and objectives in 2023. The service is based on the Care Navigation: A Competency Framework[1] and operates a three-tier level of support defined as follows:

- Low (Essential): Telephone support, offering Information, Advice and Guidance (IAG), Signposting, and Recourse Information Pack
- Medium (Enhanced): Face to face / home visit, offering IAG, signposting, form filling, multi-agency work
- High (Expert): Home visits, offering assessment of complex multiple needs, IAG, signposting, form filling, multi-agency work

The Wellbeing Navigation service is embedded within the system and works with the Integrated Discharge Team and is fully integrated within the seven Primary Care Networks and all General Practice surgeries (GPs). There are Wellbeing Navigators in place within hospital discharge at Medway Foundation Trust. The service is intrinsically linked to prevention and avoidance in the use of statutory services, including the Primary, Secondary, Urgent and Emergency Care, Adult Social Care, Housing and Benefits. Our commissioned provider is also an affiliated member of the

[1] https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf

Medway VCS Better Together Consortium Strategic Leadership Board. The service supports those aged 18+ and as well as taking referrals from community sources, the service directly supports hospital discharge by placing Wellbeing Navigators within the integrated hospital discharge team.

National Condition 2 (cont.)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e., where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g., admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

The Urgent Community Response (UCR) service in Medway provides urgent care to people in their homes (including care homes) which helps to avoid hospital admissions and enable people to live independently for longer. The service is delivered by Medway Community Healthcare and offers older people and adults with complex health needs who urgently need care, fast access to a range of health and social care professionals within two hours. This includes access to physiotherapy and occupational therapy, medication prescribing and reviews, and help with staying well-fed and hydrated, as well as short-term packages of care to help people remain at home, if appropriate.

The service operates seven days a week, from 8am to 8 pm in line with national guidance. On average, the service receives 271 referrals each month with most referrals being sent by General Practitioners and the ambulance service. There is already close joint working in place with South East Ambulance service and plans to further strengthen this partnership involve co-locating clinicians from both services in a community hub to identify callers (generated from 999/111 calls) who are suitable for UCR teams to respond to. Patients who meet the UCR eligibility criteria will be pulled out from the ambulance stack and re-directed to UCR teams, thereby helping to ease pressure on South East Ambulance services and increase the number of 999/111 referrals into the UCR service.

Data from the service demonstrates that the main reasons for referral are attributable to patients requiring further clinical observations, acute disease, blood tests and

unexplained falls. Additional funding was allocated in 22/23 for the purchase of lifting equipment to assist the team when responding to fallers. Additional funding for assistive technology i.e., falls detectors is also being sought by the team, to enable additional support to be offered to fallers, and to help reduce subsequent falls.

The UCR team work with other care teams such as reablement services and community nursing to provide ongoing support post the two-hour response to prevent delays in ongoing care. As other workstreams come online in 23/24, they will link in with virtual wards (that prevent and monitor deterioration) and community diagnostic centres to ensure direct access to diagnostic testing if required.

The provision of an UCR team is nationally mandated as set out in the NHS Long Term Plan, and funding to commission the service is allocated via Ageing Well monies. To date the service has been commissioned at a local Health and Care Partnership level. During 23/24, Kent and Medway ICB plan to re-procure community services and UCR services will be part of that procurement. The procurement is currently in design phase so it is unclear, what if any, impact this will have on the service going forward.

The service provides monthly performance reporting but there is no formal method of monitoring capacity and demand currently. In order to ensure the UCR team is directing resource appropriately, there is a need for this data and processes to better inform the Better Care fund Planning process.

In 2021/22, providers, commissioners and systems took important actions to improve the capacity and responsiveness of existing UCR services to deliver care within two hours in line with national roll-out of the two-hour standard.

National Condition 2 (cont.)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- **unplanned admissions to hospital for chronic ambulatory care sensitive conditions**
- **emergency hospital admissions following a fall for people over the age of 65**
- **the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.**

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.

Patients discharging from an acute episode of care referred to the Multi-Disciplinary Integrated Discharge Team are supported with referrals for Wellbeing Navigation or to our Carers Service, where appropriate. This can help support the ongoing care in the community and support preventative actions to reduce the likelihood of a readmission. The SMART Team at Medway Hospital supports patients in their home on discharge, where they need to remain under close care of a hospital clinician during their recovery.

Admissions for chronic ambulatory conditions is an identified area which requires improvement in Medway. We have seen increased admissions in Medway and we are undertaking further analysis to target resources most effectively. The Kent and Medway ICB recognises the challenges and welcomes the Core 20+5 programme, to ensure effective management of long-term conditions through NHS services, where there may have been changes to services due to the pandemic.

Working with our PH colleagues, we are analysing data in this metric to identify priority areas within the overall metric. That intelligence will feed directly into commissioned and other health and wellbeing services that operate in the community, to support the better management of the most relevant long-term conditions. Working within the acute on specific discharges, and also working alongside and within Medway's PCN's, Wellbeing Navigators are well placed to identify and support the management of those ambulatory conditions that have required a hospital admission. The consideration of this and the other BCF metrics, will be consistent areas of focus for all our BCF commissioned services. We will also be engaging with Healthwatch, as part of the VCS Consortium model, to consider how we can improve this metric.

Medway operates a Falls Prevention Team which is part of the community rehabilitation team which is made up of Physiotherapists, Occupational Therapists and Rehabilitation Assistants whose advanced skills provide comprehensive multifactorial assessments to patients in Medway with a history of falls or who are at risk of falls.

The specialist assessment consists of:

- Cognition as well as ability to plan to carry out daily tasks
- vision
- sensation and proprioception (joint and movement sensation)
- flexibility
- weakness and co-ordination
- posture, balance and walking ability
- Home environmental assessment

Self referrals can be made to the service as well as referrals from other healthcare professionals and the community. The new Falls related BCF metric for 2023-2025 will support us to further develop our understanding of falls related admissions and any gaps in the current services that are available to residents. We know for example that there can be long waits for ambulance attendances where there has been a fall at night, particularly during winter and other times of system pressures. We will work jointly through our commissioned community care providers and our telecare and equipment services to identify the opportunities for improvement. We have already a large number of Care Homes with lifting equipment to help manage falls within the home.

We work closely with our providers to develop new strategies and approaches to support people to remain at their normal place of residence for as long as possible. Wellbeing Navigators can support to identify and address falls hazards when working

in a person's home and Falls will be a theme that we ask our VCS Consortium and Wellbeing Navigation Services to focus on for 2023/25.

Our discharge pathways include provision for those patients with a non-weight bearing diagnosis for patients who are not able to be supported by usual services, where it may cause a delay to discharge. We have residential and home-based support in place, with the patient overseen during their recovery in the community by the SMART team at Medway Hospital.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: Provide the right care in the right place at the right time.

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.
- how additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.
- implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

Our strengths-based, locality approach to adult social care ensures that we take the right actions based on the needs of the person at the time. For anyone experiencing a crisis, we will take immediate action to support that need, with planning for the longer-term taking place when the crisis is averted.

For most people, long term support will be the exception rather than the rule. Adult Social Care aim to provide just enough support to assist people to build on their current strengths and develop their abilities to look after themselves without becoming overly dependent on social care support. We will work with partners to ensure that people have the right access to housing, health, and community services so that they can have a good quality of life and make a positive contribution to their communities. Our aim is for people to have access to work, housing, and social networks which support them to be independent, improve their wellbeing and reduce isolation.

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.

Adult Social Care Discharge Funding in 2022/23 supported a number of effective schemes, many of which became a new addition to contracted activities and others

that we will be considering for ongoing investment, utilising the additional discharge funding confirmed as part of the BCF planning process 2023 – 2025.

Enhancing home care services will be a key area of investment for additional discharge funding in 2023/2025, replicating successful schemes from 2022/23. We will also be expanding support to care homes to support dementia and avoid crisis and hospital admissions. Extra workforce schemes and increasing bed capacity will also be priorities for the ongoing additional discharge funding.

National Condition 3 (cont.)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- **learning from 2022-23 such as**
  - **where number of referrals did and did not meet expectations**
  - **unmet demand, i.e., where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)**
  - **patterns of referrals and impact of work to reduce demand on bedded services – e.g., improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);**
- **approach to estimating demand, assumptions made and gaps in provision identified - planned changes to your BCF plan as a result of this work.**
  - **where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?**
  - **how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.**

The Intermediate Care and Reablement Service is currently being re-procured. The recommissioning process follows our established collaborative process with key partners. The procurement focuses on providing two types of support for the discharge from acute hospitals through Pathway 1 (home-based intermediate care with reablement) and Pathway 2 (bed-based intermediate care with reablement) in line with the national discharge model. The service is provided for a maximum of six weeks, depending on the individual's rehabilitation needs.

The service sits between the demand from acute hospitals referring into the service and, potential, referrals out of the service to the Adult Social Care. It provides packages of care for those patients who have the same, or reduced, or new levels of care. The aim of the service is to prevent, reduce or delay the need for a long-term package of care.

The ICRS contract is a vital part of the discharging of patients, but it is only one part. The discharging of patients is an intricate process and reflects the complexity of each individual's needs leaving hospital. Therefore, the process is ever changing.

This contract is a stable point in that process. The specification design captures the lessons learnt from the pandemic and the current contract and enables this contract to flex to accommodate future requirements and need to change.

Currently the Health and Social Care system is looking to procure 15 step-down beds to discharge people into before their final residential setting.

Two wards at Medway Foundation Trust (MFT) are focussed on rehabilitating/preventing deterioration of patients' condition whilst they await their discharge home.

There is an on-going block contract with Strode Park Foundation (SPF) to provide 16 beds for rehabilitation at Platters Farm Lodge (Platters). There is a forthcoming opportunity to agree a reconfiguration of the number of beds that are provided for rehabilitation, respite, dementia respite and dementia. The re-configuration could come into effect from 1 October 2024.

At the end of June 2022, there were 32,075 patients waiting to start treatment at MFT. Commissioners have not had access to plans for how the elective backlog is to be addressed nor the predicted level of demand to come from MFT.

It should be noted that the contract will also receive referrals from Out of Area (OOA) acute hospitals and NHSKM will have no influence on discharge policy in this instance.

A discharge dashboard has been developed for the M&S HCP, that captures an overview of discharge activity and a comparison of the discharge pathways from MFT, as the local acute hospital.

There is no formal method of monitoring capacity and demand placed in Medway, however the following narrative outlines our approach and lessons learned.

Data collection

The collection of data to support the Demand and Capacity Data process has been a beneficial challenge. With this second round, council officers and contracted providers have a better core understanding of how services are aligned and the available data sources. While the data is not a level whereby meaning planning assumptions can be made based on the demand and capacity information, it is now possible to understand where data gaps and accuracy issues occur so that plans on how to address these, and agreements on which datasets are to be used, can both be made.

The revised format of the Demand and Capacity data collection is welcomed and is now much more meaningful for Medway as well as flexible for the reporting needs of individual local authorities.

Hospital Discharge

Deep cleans and other home preparations prior to discharge account for a large part of the demand for the Social Support (including VCS) services. These are key services for facilitating discharges for both Pathway 0 and Pathway 1, particularly when dealing with multifactored discharges (as opposed to clinically complex cases).

Reflecting on the data from last year's C&D planning, there was a good balance between the capacity and the realised demand for both Pathway 0 and Pathway 1.

The flow of patients discharged through Pathway 1 is often affected by issues with long term packages, co-ordinating with family and friends and preparing homes. Anecdotally, if Pathway 1 is looked at, minus those challenging and multifactored cases, then it is averaging at around 2.5 days No Criteria to Reside.

Pathway 2 experiences similar issues for people flowing out of the bedded reablement provision as the hospital does. As such, it is difficult to say whether there are sufficient beds available if it were possible to release beds.

As Pathway 3 contains the most complex cases it is also harder to find onward care. In some cases, up to 75 care homes have been contacted without a successful placement. It is always hardest to find placements for higher end care and nursing. Workforce issues contribute to this. The recommissioning of residential and nursing care will support the market and secure the required provision for Medway.

Future Action

The pathway allocation is dependent on referrals and recommendations from the referring acute hospital. Difficulty occurs when there is a need to balance reablement potential against the triaging of resources. For example, there may be occasions where, to support the patient flow through discharge, a patient that is best suited for Pathway 1 is discharged to a Pathway 2 bed because this is a better placement for the patient than remaining in hospital. In these circumstances, the patients are quickly “stepped-down” to the Pathway 1 provision. At present, it is not a simple task to capture where there is an interim use of a pathway, as better than hospital, or to enable flow. There is an aim to ensure clear communication when being flexible or utilising a less appropriate pathway.

There is the potential to look at 24hr at home care for Pathway 3 as well as increasing efforts to prevent high levels of care with more care hours to reduce Pathway 3 admissions.

The nationally commissioned Voluntary Responders scheme was announced after Medway had committed to a new contract which has doubled the VCS capacity in Medway hospital. We will need to consider:

- Ease of access to Voluntary Responder’s data to support future BCF Capacity and Demand submissions.
- Equity of service for patients that received the Medway-commissioned wrap around service vs the Voluntary Responder scheme.
- Competition between the Voluntary Responder scheme and the existing Voluntary and Community Sector infrastructure in Medway for volunteers.
- Competition for physical space in acute hospitals.

Community

Calculating demand for community services is significantly difficult because it is not linked to a prior process controlling the level of referrals that come through; such as the elective waiting list for acute hospitals.

Additional factors that can affect referrals to community services include:

- Weather extremes
- Awareness of the service by primary care services and the public
- Perceptions of A&E delays by the public
- School holiday patterns

The main referral sources are from GPs and South East Coast Ambulance Services NHS Foundation Trust (SECAmbs). The current Urgent Community Response contract has evolved over time. While there was a drop in referrals from SECAmbs, the provider has been working with them on CAD work. It is now imagined that this will now increase back to previous levels.

Future services development may include further work with community hubs regarding 999 and 111 calls as well as looking at whether it would be possible to divert lifeline telecare calls to the urgent response service from SECAmbs. Kyndi (Medway Council's Telecare Provider) may be receiving around 100 calls per month that could be supported through the urgent response service, leading to lower demand on SECAMBS and fewer hospital admissions.

National Condition 3 cont.

Set out how BCF funded activity will support delivery of this objective with reference to changes or new schemes for 2023-25 and how services will impact on the following metrics:

- **Discharge to usual place of residence**

Funded by the BCF, our Integrated Discharge Team are an embedded part of Medway Maritime Hospital, the acute hospital for Medway and Swale residents. They work across agencies and in close collaboration with Health and Kent County Council colleagues who are aligned to the team. The IDT work to a jointly agreed specification and provide regular monitoring reports and attend system calls which take place daily and allow collaboration on complex discharges.

The Hospital Discharge Protocol also ensures joint working with key services, including the Housing Options service. The protocol ensures early identification of those in hospital who may require intervention from a range of services to provide a joined-up approach to planning their discharge, limit hospital stays and support people to maintain their independence. Our Wellbeing Navigation Service also has a physical location at the hospital and supports with hospital discharge and in cases where a patient may need some ongoing support and advice to help them stay well and prevent them needing emergency or statutory services if possible.

We are looking to further increase our responsiveness to addressing housing related issues in 2023 – 2025 through the establishment of a new officer post which will be funded from the DFG and directly support the IDT to complete assessments where there are identified housing needs. Crisis grants are also available for those who may need essential housing repairs or temporary accommodation while larger repairs take place.

For care home readmissions, our Integrated Discharge Team work closely with our brokerage team to support the care home to plan readmissions, as well as ensuring dedicated Primary Care support to Care Homes to manage patients on discharge.

The Medway BCF funds the Intermediate Care and Reablement Service, the Integrated Community Equipment Service as well as the VCS contracts that support people getting home from hospital or working in the community to avoid admission to the acute.

National Condition 3 Cont.

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas of improvement identified and planned work to address these.

We have reviewed the High Impact Change Model and actions are included within our commissioning plans for 2023-2025. The key areas of focus are:

Early discharge planning

We already have a multi-disciplinary approach to planning discharge, which starts at admission. Our plans to increase support around housing related issues, as well as expanding the support at the acute from Wellbeing Navigation, will support this objective.

Monitoring and responding to system demand and capacity

There has been extensive work with our Home/Domiciliary Care sector to ensure we have adequate resources in place and that it can be increased at times of system pressure. We have seen improvements in delayed discharges in relation to home care and we had a number of successful schemes in operation over Winter 2022/23 which we will replicate with the ongoing additional discharge funding.

We are using the BCF capacity and demand planning process, linked closely to our recommissioning of intermediate care and reablement, to plan effectively for discharge. The social care and health workforce crisis and cost of living impacts are significant factors for Medway and we will need to work creatively to balance identified demand with available budgets, particularly as costs are rising at a significant rate.

Digital Transformation

Kent and Medway ICB in partnership with the Kent and Medway Local Authorities, are pursuing a digital strategy that supports and enhances patient care. This will transform how we approach and deliver our care such as patient wearables and a Kent and Medway care record.

Multi-Disciplinary/Multi agency teams

Our integrated discharge service ensures a multi-agency approach to discharge, with resources aligned from Wellbeing Navigation and the Medway Carers Service to ensure practical support for patients discharging and ongoing community support for up to 12 weeks. As noted previously, we will be increasing the wellbeing navigation resources available at the acute, particularly focusing on direct work with wards, where patients discharge with no further input from IDT or statutory services.

Assistive Technology

Kyndi is our in-house Telecare provider and work closely with the Integrated Discharge Team in Medway Foundation NHS Trust to support hospital discharges. Patients are discharged with traditional telecare services such as Lifeline, with wearable devices and pendants providing alerts of falls or other emergencies to a contact centre operated by Kyndi. Urgent Response and Home First services can also prescribe a range of smart assistive technology such as motion sensors, smart medication dispensers, pressure mats etc as well as key safes.

Home First

We have an established Home First approach in Medway. Actions to improve this further are captured within the recommissioning of intermediate care and reablement which is currently within the tendering process.

Flexible working patterns

We ensure that services are commissioned to support effective hospital discharge and operate flexibly to allow working patterns to both maximise recruitment and retention of staff, while meeting the needs of service users. We work closely with our providers to ensure residential services are available to support hospital discharge of both new and existing residents, however we do also recognise the need for those providers to manage their own resources effectively and ensure there are protected times for residents to have less disruption and allow a protected time for visitation. Ongoing collaboration in the planning of services ensures we balance organisational need with the needs of our residents.

Trusted Assessment

The recommissioning of our Carers Service will explore the potential for the commissioned provider to undertake statutory carer assessments in a trusted assessor model. We will be working closely with adult social care to shadow in the first stage and develop a proposal to deliver assessments based on a full understanding of the current process and Care Act obligations.

Engagement and choice

Choice is an embedded approach within our NHS Acute Service, we also ensure that our commissioned Wellbeing Navigation service can support effective hospital discharge as well as ongoing support to the individual and family to look at a holistic assessment of need, maximise entitlement to benefits and financial support, as well as identifying actions to improve wellbeing and condition management, linking into resources in the community as well as healthcare and statutory services.

Improved discharge to Care Homes

As noted previously, our discharge schemes over winter 2022/23 included enhanced support to care homes, which we will be able to effectively replicate in Winter 2023/24 due to the additional discharge funding. We hold regular provider engagement meetings which supports us to identify where we need to provide additional support and this was vital during the pandemic, when there were specific challenges for care home. We have utilised the close working developed during this period, to ensure ongoing dialogue identifies any challenges.

Housing and related services

Housing is a key area of development for our BCF plans in Medway. We recognise housing related issues can be the barrier to effective hospital discharge and will be ensuring there is enhanced housing support aligned to our IDT through recruitment to a new role in 2023-2025. Housing related issues and falls hazards will also be identified by our Wellbeing Navigation Service, both where they support hospital discharge and from community referrals.

National Condition 3 Cont.

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered.

Adult Social Care Discharge Funding in 2022/23 supported a number of effective schemes, many of which became a new addition to contracted activities and others that we will be considering for ongoing investment, utilising the additional discharge funding confirmed as part of the BCF planning process 2023 – 2025.

Considering the rapidly increasing cost of care and availability of care hours, we focussed some activities on investment to deliver training and equipment that supports some patients to move from double handed to single handed care. Evaluation of the scheme supported a local decision to include the new equipment and training resources as permanent additions to our equipment service, funded by the BCF.

Support to enhance our home care services will be a key area of investment for additional discharge funding in 2023/2025 as this was successful during winter 2022/23. We will also be expanding support to care homes to support dementia and avoid crisis and hospital admissions. Extra workforce schemes and increasing bed capacity will also be priorities for the ongoing additional discharge funding.

The Additional Discharge Funding schemes for 23/24 will reflect the learning and successes from the ASC Discharge Funding schemes of 22/23.

The ICB allocation will mainly be funding step down beds. There is a small allocation to enable therapy on acute wards to prevent deterioration to patients waiting for a long-term care placement.

The ASC allotment will be used as winter surge money from October 23 – March 24. This will enable the purchase of additional nursing and complex beds, supporting the care sector workforce, increase the capacity to offer assistive technology, and an increase in agency work to ensure we have capacity to meet the demand.

iBCF funding is focussed on delivering the Care Act outcomes, stabilising the care market, ensuring fee uplifts to address increasing costs and workforce issues; increasing bed capacity and placements as well as supporting integrated care functions such as the Integrated Discharge Team and providing staff to support effective and timely assessments both in the acute and in the community, supporting transitions of care from Health into Social Care.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Medway Council and Kent and Medway NHS recognises the essential contribution that carers make to maintain and improve the health and wellbeing of Medway residents. The Medway Joint Carers' Strategy aims to support Medway carers to carry out their valuable role, which is key to maintaining a balanced and person-centred health and care environment.

Carers FIRST are the commissioned provider in Medway, delivering all adult and young carers services. Working to a coproduced specification for Medway, they also bring a wealth of knowledge and expertise as one of the national organisations supporting Carers. We ensure carers are helped through a holistic assessment. And close joint working with health and social care to make sure that the person the carer is caring for has proper support in place. They help young carers to access community and school-based activities that help to reduce the long-term impact on young carers' development. Outcomes from our contract are met or exceeded and in 2022 we have shared a case study focused on a young carer's journey, which has been used by the BCF team as a national good practice example.

In the recommissioning of Medway's Carers Services during 2023/24, we will be looking to build on the good practice already established. The development of a new specification, coproduced with our service users, providers and key partners, will ensure we identify where the priorities for the next 3-5 years need to be focussed.

- The State of Caring 2022 by Carers UK [2]reports:
    - there are around 10.6 mil carers within the UK, with carers support valued at £530 million per day during the pandemic, or £193 Billion in a full year – exceeding the value of the NHS
    - The cost-of-living crisis has increased pressure on Carers finances, with 77% saying the cost-of-living is one of their main challenges over the coming year
    - Many carers are struggling with poor mental and physical health. A fifth said their physical health was bad or very bad (21%) and 30% said their mental health was bad or very bad.

We need to focus our resources as effectively as we can in Medway, looking at improving outcomes through a population health management approach, focusing on the most deprived locations and communities. Our commissioned carers service will be working to a coproduced specification and KPI's will be focussed on improvement of health and wellbeing, following a holistic approach to support adult and young carers and identify 'new' or 'hidden' carers.

Our commissioned carers service provides 24hr support via phone and online as does Adult Social Care as we know it can be difficult for carers to access out of hours support in times of crisis. Contingency planning conversations take place with carers to help them understand the technology, support or services which are available in times of crisis and emergencies to avoid unnecessary hospital admissions and carer breakdown.

In 2023/24 one of our key areas of focus will be exploring the potential for our commissioned carers service to carry out statutory carer assessments under a trusted assessor model. Currently, Social Care spend £1.6m on Direct Payments for Carers in support of identified needs.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

Our approach is that works funded by means of DFG will be the simplest and most cost-effective adaptations that will meet the client's assessed needs.

Wherever the council judge it to be a practicable and realistic option, the re-ordering and/or change of use of existing rooms will be the preferred solution and will take precedence over the construction of extensions.

[2] https://www.carersuk.org/media/p4kblx5n/cukstateofcaring2022report.pdf

Additional financial support will also be offered via the new Financial Assistance Policy which will be offering Grants and/or Loans to support owner occupiers and families to remain living in their own homes without fear of disrepair.

These Grants and Loans currently in use are:

- Disabled Facilities Loan – to assist applicants with additional funding on top of the maximum, eligible DFG.

- Moving Home Grant – to assist applicants to move home to a more suitable/adaptable property. This grant assists with moving and legal fees.

- Emergency Repairs Grant – for applicants to access funding for essential repairs, such as roof, electrics and heating.

- Homeowner Improvement Loans – to bring properties to a safe standard, with consideration to electrical installation, heating, kitchen facilities, bathing, in line with HHSRS category one hazards.

Our intention once the policy is approved and in place is to also offer the following:

- Contribution Based Grant – to assist grant applicants with their assessed contribution, where there are affordability issues and applicants would be put into hardship.

- Discretionary Adaptations Assistance Grant – to assist with funding where the adaption is in excess of the maximum grant eligible (£30,000).

- Discretionary Stairlift Grant – to allow all grant applicants to have access to funding without being means tested.

Works funded via the Homeowner Improvement Loan or Emergency Repairs Grant will be the most cost-effective works to remedy issues identified under the Housing Health and Safety Rating System (HHSRS).

Grants are available for people who are disabled and meet the criteria set out in s100 of the Housing Grants, Construction and Regeneration Act 1996 Act and for eligible works that includes the following:

- facilitate access by the disabled occupant to, from and within the dwelling (for the purpose of this grant a dwelling includes park homes).

- provide essential facilities and amenities within the dwelling; and

- facilitate access to and from a garden by a disabled occupant or making access to a garden safe for a disabled occupant.

The DFG budget funds three FTE Occupational Therapists in the Adult Social Care service and one FTE in Children's Social Care. These posts work specifically on adaptations and assist with identifying those that would benefit from adaptations to

their homes to enable them to continue living in their home and maintain independence.

The DFG budget also provides £200,000 to the MICES budget each year to contribute towards the supply and fitting of support aids for the elderly and disabled.

Outside of the DFG funding there are also several other streams of work that are being completed by the service to enable people to maintain their independence and remain in their homes, these include providing floating support services commissioned by the housing service to provide housing related support, including assistance with budgeting, support through the DFG/housing application processes and ensuring that they have appropriate support services in place to meet their needs. Some of these services are funded through a commitment of HRA funds.

To ensure that those that are leaving hospital are discharged in a timely manner, with adequate support and into an appropriate property, we have established a Hospital Discharge Protocol that ensures joint working with the services, including the Hospital Discharge Team and the Housing Options service. The protocol ensures early identification of those in hospital that may require intervention from services to provide a joint up approach, limit hospital stays and support people to maintain their independence.

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG Funding for discretionary services? (Y/N)

We allocate funds from the DFG budget to support applications for Crisis Grants (for essential repairs), Moving Home Grants (to assist with the cost of moving to a more suitable home where future adaptations can be carried out and supported with funding from the DFG applications) and Disabled Facilities Loans to assist where schemes are in excess of the £30,000 max. In addition to applicants having the maximum eligible grant allowance (subject to the Means Test) any fees incurred for supporting the application such as architects, surveyors, utility companies and agents (such as HIAs) will be funded from the DFG budget, allowing all eligible funding to be allocated to the required and supported adaptation.

If so, what is the amount allocated for these discretionary uses and how many districts use this funding?

Medway is a unitary authority. There is no fixed allocated amount for this as it is dealt with on a case-by-case basis. The budget is under constant review to ensure that there is available funding, sufficient for all applicants that require the additional support. The spend per annum for Medway Residents is currently in region of £25,000.

Equalities and Health Inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- **Changes from previous BCF plan**
- **How equality impacts of the local BCF plan have been considered**
- **How these inequalities are being addressed through the BCF plan and BCF funded services**
- **Changes to local priorities related to health inequality and equality and how activities in the document will address these**
- **Any actions moving forward that can contribute to reducing these differences in outcomes**
- **How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.**

The M&S HCP 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. We also have a growing population of single person households, which can increase the likelihood of current or future reliance on statutory services. Our population growth and other population changes will have implications for health and care services. Medway welcomes the release of the Core 20+5 programme which aims to address health inequalities in the 20% of most deprived populations and the guidance will be used alongside our population health management approach and the levelling up agenda, to inform our future commissioning activity, which will have an increasing focus on addressing inequalities. Some of the planned actions from the PHM Steering Group which operates on an HCP footprint and therefore includes Swale, are:

Childhood Asthma –recognised as a key priority within the Population Health Management Programme and a new role has been funded through Health Inequalities Funding, to support PCN's and conduct asthma reviews. This operates across Medway and Swale. A new asthma app is in development to support children and young people to engage with asthma management.

Community Health Catalyst Programme - led by the voluntary sector and engages with groups within the Core 20+5 programme, utilising health inequalities funding. The scheme is establishing trusted relationships with those identified and aims to build initiatives that address the identified need for those people or communities. Funding is available for these initiatives through a 'community chest' scheme open to the VCS, to support community resilience.

Making Every Adult Matter (MEAM) - funded by Big Lottery as a national programme to work with people with multiple disadvantages and ultimately, reduce avoidable deaths. In Medway and Swale, we have secured additional HCP funding and established a senior programme manager to lead the work, supported by two coordinator posts. The programme is supported by the VCS in Medway as a key partner in delivery.

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 increasing costs of care and 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. Our key goal will be to ensure a whole system collaborative approach to adopting Population Health Management (PHM) approaches across the NHS, council services including public health and social care, the voluntary and community sector and the communities and neighbourhoods of Kent and Medway, to design new models of proactive care and deliver improvements in health and wellbeing which make best use of our collective resources.

All our BCF commissioned services are managed under the leadership of JCMG. Commissioners take a PHM approach in planning the delivery of services, utilising the data and intelligence from our Public Health teams, and more widely, to develop targeted commissioning plans and maximise the outcomes from our investment. The PHM programme and analytics group also utilise JSNA data and then deep dive into it to get a greater depth of intelligence to inform our system priorities.

Service specifications for commissioned services are based on good practice examples and coproduced with service users, utilising their expertise as people of experience, as well as providers and other stakeholders. Contract monitoring is robust and takes place routinely, with KPI's based on targeting inequalities and groups who may be underrepresented currently, e.g., specific carer projects targeted at men, who are less likely to recognise themselves as carers or seek support.

Emergency admissions to hospital are more common in areas with higher levels of deprivation. Research also shows that individuals from more deprived communities are less likely to engage in preventative programmes, such as immunisations, screening, dental check-ups and eye tests, when facing no immediate discomfort or disability. People from deprived areas are more likely to present to health care providers at a later stage of illness. Services are often poorest in the areas that need them most - an issue known as the "inverse care law". It is hard to attract and retain high quality clinicians to areas with high deprivation and needs. The work may be harder due to the high needs of the local people. There may also be more VCSE services in more affluent areas where it is easier to attract volunteers. A strategic approach to tackling inequalities in Medway will need to address these issues. Our commissioning process sits within Public Health and adheres to the Medway Council Governance processes, with senior member and leader oversight.

The NHS Long Term Plan sets out an ambitious mental health service model, taking more action on prevention. The Kent and Medway Mental Health Learning Disability and Autism Provider Collaborative Board (MHLDA PCB) brings together all the mental health and wellbeing partners with those with lived experience to design a new way of working, integrate service models and develop a shared accountability for improving the mental health and wellbeing of our communities. Through the community mental health framework, Mental Health Together, we are implementing an entirely new service model to support people with complex mental health

difficulties. It will provide a person who is living with serious mental illness care that is centred around them, their family and local community, by joining up support from different services that can help. The model focusses on supporting mental ill health in the context of someone's whole life, for example how debt, relationships and employment can impact someone's mental wellbeing, as well as how physical health can impact them too.

The Kent and Medway system are using their system capital allocation to improve the care delivered to the residents of Kent and Medway whilst also improving population health outcomes and reducing health inequalities. Kent and Medway NHS and Social Care Partnership Trust have begun work on a new, purpose-built inpatient facility for older adults with functional mental health needs. The £12.6m investment is part of a drive to eradicate 'dormitory' style wards in inpatient mental health facilities. It will ensure that Kent and Medway residents have access to the highest standards of inpatient mental health care.

As noted earlier, changes to our BCF plan and delivery of services will be realised through our recommissioning of key services in 2023-2025, which will have a population health management and equalities focus through our approach to commissioning, focusing resources in areas of most need and inequality. This will also be built into contracts as a requirement for providers to develop their own targeted operational plans to deliver services that identify and address key areas of deprivation and inequality.

BCF Metrics, National Conditions and Policy Objectives

National Condition 1:
Jointly Agreed Plan.

National Condition 2:
Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer.

National Condition 3:
Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time.

National Condition 4:
Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services.