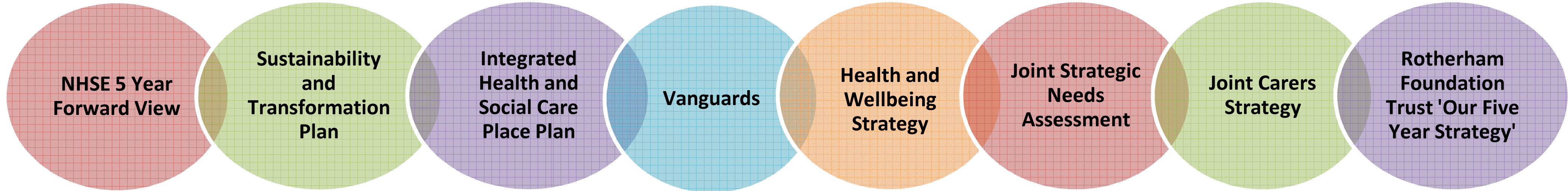
Appendix 2



BETTER CARE FUND – INTEGRATING HEALTH AND CARE

Prevention and Early Intervention	Integrated Care for People with Long Term Conditions	Hospital Discharges and Reablement	Joint Commissioning Arrangements
▪ The development of a single point of access into health and social care services; including the Integrated Rapid Response service. ▪ The development of preventative services that support independence eg 'Shaftesbury House Short Stay Project' and the introduction of the 'I Age Well Tool'. ▪ A review of all community therapy services including remodelling of Community Occupational Therapy (COT), ICES (integrated Community Equipment Service) and Wheelchair service. ▪ Continued expansion of the Social Prescribing programme. ▪ Implement actions in the Joint Carers Strategy	▪ The development of integrated health and social care teams – The Health Village Project. ▪ The development of a single health and social care plan for people with long term conditions. ▪ The improvement of quality of care through a joint approach to care home support – Enhanced Health in Care Homes. ▪ The provision of dementia support services to promote independence. ▪ The Commissioning of sheltered housing to promote the independence of people with learning disabilities.	▪ The reconfiguration of the home enabling service to support hospital discharges seven days a week. ▪ The consideration of a specialist reablement centre incorporating intermediate care. ▪ Further review and reconfiguration of intermediate care to include trusted assessor approach to referrals. ▪ Build strong links with care home sector to enhance health in care homes – trusted assessor, enhanced skills for staff, health quality officer. ▪ Implement High Impact Change Model	▪ To have a shared approach to delayed transfers of care (DTOC). ▪ The development of joint commissioning around fee setting of domiciliary care, residential, nursing home and CHC placements. ▪ The development of a joint medication administration policy for people receiving care at home. ▪ The increase in uptake of people with personal health budgets, Integrated Personal Commissioning Plans and direct payments. ▪ The reduction in the cost of learning disability high cost care packages. ▪ Clear governance and accountability arrangements for new models of care – Accountable Care System

What are the outcomes?

To reduce the number of permanent admissions to residential and nursing care homes.	**To increase the number of older people still at home 91 days after hospital discharge.**	**To reduce the number of delayed transfers of care from hospital.**	**To reduce the total number of emergency admissions and readmissions to hospital.**

TO IMPROVE CARE