APPENDIX

BCF SCHEME DESCRIPTION	EXPECTED OUTCOMEs
Locality Community Model	
The Locality / community model scheme will provide a phased and structured approach for reviewing, aligning and integrating community services for the population of the Isle of Wight. The benefits of this change will increase the level of innovation and deliver truly integrated teams which are based upon skills needed as opposed to services currently delivered. It will also deliver system wide efficiencies and better outcomes for people. This scheme is being undertaken by the My Life a Full Life programme, Transforming Community Services. There are already three integrated locality teams which are providing the foundation to delivering co-ordinated care and early intervention and prevention. New roles have been developed and piloted including care navigators and Locality area co-ordinators. The next phase is for services and staff to be aligned with locality and a new operating model put in place to support full integration. The key outputs for the TCS workstream include, but are not limited to: • Implementation of locality governance and organisational structures including focus on safeguarding and the vulnerable. • Implementation of integrated locality services • Implementation of case management of those at risk • Review of existing co-ordination provision in each locality • Development of community resilience and community assets in each locality • Development whole system business model and new way of contracting for community services e.g. Alliance contracting. • Development and implementation of MH Crisis Cafés	• Improved Quality and satisfaction of care for people, through clear service navigation and easy access to integrated coordinated services closer to home. • Improved case management which prevents and, where possible, avoids deterioration and crisis leading to non-elective admission to hospital, or admission to residential care. • Commissioned services will be sustainable, provide value-for-money and meet the needs of the Isle of Wight population. • Multidisciplinary teams supporting people with complex needs, including community health and social care, mental health and voluntary services. • Reduced complexity of services. • Services that offer an alternative to hospital stay. • Services wrapped around primary care and the individual. • Power of the wider community is harnessed.
Hospital to Home	
By improving discharge planning and patient flow, and by investing in capacity to care for patients in more appropriate and cost effective settings we will ensure that no patients stays longer in acute, community or mental health bed based care, than their clinical condition and care programme demands. The scheme will ensure that every patient has an integrated Discharge Plan, informed by their presenting condition and known social circumstances where complex needs are identified early in their journey and appropriate support models are in place to prevent readmission, reduce length of acute spells and minimises patient decompensation. The scheme will use the 8 High Impact Change self-assessment tool to determine the system baseline and will agree a time bound trajectory to move those areas forward. The scheme is further supported by iBCF additional funding of a for change/project management lead who will drive, implement and monitor the improvement plan.	• DTOC reduction achieved as per agreed trajectory based on national target. • Reduced delayed bed days by improving Home first: Discharge to Assess/ Trusted Assessment system-wide processes • Reduced long term bedded care through implementation of Home First/Discharge2Assess • Improved reported patient and carer outcomes/ experience • Reduce excess bed days across the system • Reduce acute readmissions with same condition (trajectory to be determined)

BCF SCHEME DESCRIPTIONS

Promoting Independence (Equipment)	Outcomes
The Promoting Independence Scheme will comprise of a number of different services all aimed at supporting people to remain independent for longer by providing a structured and integrated community service for the people of the Isle of Wight. The Scheme will comprise of the following services: • Community Equipment Service • Wheelchairs Service • Independent Living Centre and User Led Organisation • Assistive Technology • Disabled Facility This BCF Scheme will incorporate the iBCF TEC Scheme which covers a number of different areas including: • Transformation of Wightcare Service • Cultural change (INTERNAL) • Culture Change (External) • Investment in additional equipment • Technology Training • Technology enabled care • Secondment opportunity for suitably qualified and experienced person with a background in rolling out Tec The iBCF proposal is focused on the use of assistive technology to meet specific needs of individuals. It is anticipated that this will enable faster discharge from hospital with less traditional care being put in place at the point of discharge. Ultimately some people may be able to return home without needing a care package and with assistive technology providing the support assessed as being required. The greater use of assistive technology should help providers to streamline their business models and better distribute their workforce.	• Building Individual & Community resilience by forming part of a holistic approach to supporting people to remain independent at home • Developing, Regaining and Sustaining Independence by providing resources and equipment to enable people to develop their personal resilience and build confidence • Living as Independently as Possible by providing help and support to those who need that help and support to remain independent at home • Earlier discharge form hospital • Ability to for a person to return home to convalesce with 24/7 support where the only other alternative may have been short stay nursing/residential placement
Rehabilitation, Reablement & Recovery	**Outcomes**
All the services included within this Better Care Fund Scheme aim to ensure that people can achieve maximum independence with their activities of daily living with the aim of remaining in their homes as long as possible, thus decreasing the need for long term care. Synergies in provision may enable these services to work more closely together, driving efficiencies in the system through integrating and simplifying pathways. **Specific Actions 2017/19:** • Procure new Community Rehabilitation beds • Mobilise new Rehabilitation Service • Enable implementation of iBCF Reablement Scheme • Integrate Rehabilitation Service with Reablement Service	• Prevention of unnecessary care placements • Supporting people to live independently for longer. • Increase in proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. • Enhanced domiciliary care services with ability to undertake reablement

This BCF Scheme will incorporate the iBCF Proposal for a Specialised Homebased Reablement Team which will be developed to ensure that people with complex reablement needs can receive a service which is currently not available. The Team will include Occupational Therapists, Physiotherapists and support workers who will focus on the needs of people who need double-handed carer support and also those who are in Reablement beds in the Adelaide and Gouldings. People will be able to remain in their own home longer without the need for costly domiciliary care packages. By using assistive technology as part of the main social care offer we will promote independence and maintain independence for those we serve for longer. • Promotes independence • Helps people to maintain their independence Ability to for a person to return home to convalesce with 24/7 support where the only other alternative may have been short stay nursing/residential placement	The iBCF Proposal for a Specialised Homebased Reablement Team would expect the following outcomes: • Increased throughput of people in in Reablement beds with decreased lengths of stay • Increase in the number of people with complex needs who can be supported by domiciliary care, if a face-to-face care package is required • Decrease in the number of people requiring a face-to-face care package because they can be supported by Technology Enhanced Care (TEC)
Integrated Mental Health Provision	Outcomes
An integrated primary, secondary health, social care and third sector mental health system built around need of individuals. The priority is to improve people's mental health and wellbeing by supporting the shift in services from hospital to community and ensuring the delivery of a more integrated model of support that recognises wider social networks and the importance of physical wellbeing, resilience and recovery. Deliverables: • Review and reconfiguration of mental health reablement / rehabilitation pathway (Woodlands). • Review of Mental Health Day Service Provision. • Service specifications with recovery based outcomes developed through co-creation (health, social care and third sector)	• People with a mental health problem will receive personalised care that is focused on recovery including employment and housing support. • People with mental health problems will be able to easily find information, advice and guidance; this will ensure that they feel supported to manage their own condition. • People with mental health problems will be supported to maintain independence.
Learning Disability Transforming Care Programme	Outcomes
In November 2015 NHS England published *Building the right support*, a radical plan to develop more community services for people with a learning disability and/or autism who display behaviour that challenges support provision. Locally we will: • Co-create with people with a learning disability, their family, carers and other stakeholders both on the Island and across Hampshire, the Sustainable Transformation Plan which locally defines and implements new models of care to enhance quality of life for all people with a learning disability living on the Island and those placed out of area. • Refine the process to prevent unnecessary admission to specialist hospitals and lengthy hospital stays	**Personalisation -** To promote and develop self-directed strengths based support and approaches to personalisation that reflect the individual's preferences and aspirations, balancing this with the need to ensure resources are used cost effectively. Building individual and family resilience, reducing the need for formal support. **Choice and Control –** To increase the choice and quality in the local market for health and social care services to ensure people with a learning disability across the island have access

for individuals by supporting those in crisis via implementation on the Care Treatment Review process. o Review of current Isle of Wight respite provision o Build workforce to develop competent, confident, critical thinking staff • Review and develop current local accommodation and support provision to ensure it meets the current and projected future needs for people with a learning disability.	to a diverse range of high quality options to choose from, that are local to where they live, enhance quality of life and represent good value for money. **Quality -** Improved quality of support provided for people with a learning disability and their families, in particular ensuring that services are continually improving on person centred planning, approaches to communication and are developed with the full involvement of the people being supported. **Information -** Improve information and advice available to people with a learning disability in order to empower them to make more informed choices about the options available to them. To improve the information available with regard to population and needs to ensure intelligent commissioning strategically co-created with people with a learning disability.
Employment Support	Outcomes
In February 2016 NHS England Published the Five Year Forward View for Mental Health. Integral to this strategy is the need for alignment of an Employment Support offering across the health and care system for: • People with mental health problems • People with a learning disability • People with physical disability • People with a combination of the above. Nationally and locally, the employment rate for adults with mental health problems remains unacceptably low: 43 per cent of all people with mental health problems are in employment, compared to 74 per cent of the general population Deliverables for the BCF 17 /19 scheme through alignment of existing provision: • We will increase access to psychological therapies for people: living with common mental health problems, in order to support them to find or stay in work. • We will increase access to individual placement and support programmes for people: living with severe mental illness, living with a learning disability, living with physical disability in order to support them to find and or maintain employment.	• People with learning disability will receive timely access to individual placement and support programmes in order to facilitate them to maintain or find employment through IPS mode • People with physical disability will see an improvement in their quality of life through increased opportunities of access and or maintaining employment through IPS model • People with common mental health problems and or severe will receive timely access to psychological therapies to support them to find and or maintain employment • People with common and severe mental health problems will see an improvement in their quality of life through increased opportunities of access and or maintaining employment through IPS model, including living as independently as possible.
iBCF SCHEME DESCRIPTION	EXPECTED OUTCOMEs

ASC DELIVERING CARE CLOSE TO HOME	
It is recognised that that the current model of delivery for ASC is neither efficient nor cost effective: it does not lend itself to delivering person centred care and is resulting in a significant over reliance on residential and nursing care. To address this, there is a new strategy for Adult Social Care entitled Care Close to Home. This is predicated on 7 pillars: three core delivery pillars; and four enabling pillars. The Strategy represents a wholesale programme of reform and transformation. It is predicated on the vision, principles and priorities set out in My Life a Full Life and reflect the imperatives described in the Sustainability and Transformation Programme for Southampton, Hampshire, the Isle of Wight and Portsmouth. The four enabling pillars comprise the focus of this bid and comprise: a. competent, confident critical thinking staff; commissioning for value and impact; person centred professional practice and care; and partnerships and integration. Underpinning each of these four pillars are key work streams whose full implementation will secure more effective use of resources, a remodelling of practice, culture and systems and delivery of the community services element of My Life a Full Life. Underpinning this programme is a series of key work streams: • Direct Payment Delivery Redesign • PA Market Development to support direct payment recipients providing a flexible delivery model • Pre-Paid Cards Phase two – full implementation of the pre-paid card programme for DP recipients • Non Res Charging changes – Under take a two month public consultation to consider taking into account the Higher rate of disability benefits as prescribed in the Care Act 2014 • Home Support –Implement full Individual Pricing Model • Fully implement and embed Residential/Nursing Dynamic Purchasing System • Fully implement and embed Learning Disability Dynamic Purchasing System • Explore models around effective “off island” placements as a viable alternative • Implement a robust and transparent Resource Allocation System (RAS) • High Cost Reviews ensuring best use of resource whilst delivering person centred services • S117 Review • CHC review	• Create a robust and sustainable ASC system • Maximise best use of resources • Reduce costs where possible ensuring value for money • Create a diverse and robust market place • Underpin the Care Closer to Home Strategy • Reduce DTOC’s by creating a sustainable diverse marketplace, facilitating effective and swift discharges • Create a viable Personal Assistant (PA) marketplace to support direct payment recipients • Implement a system that supports self-funders to become empowered consumers using *adam* Life (Life co.)

BCF SCHEME DESCRIPTIONS

SUPPORT FOR PROVIDERS	Outcomes
The purpose of this bid is to provide support to all market sectors. This scheme includes the following areas: • Commercial provider secondment opportunity • VCS secondment opportunity • Sector led Safeguarding training • Sector led specialist dementia training • Provision of an Independent Chair (and administrative/co-ordinator support) for the local associations • Health and Social Care Market Day • Grant funding to nominated provider to lead on programme of improvement across all market sectors • Analysis of CQC report and findings across all market sectors to identify themes and trends	• Improving quality across all market sectors • Increasing the learning and development offer available to providers • Increasing commissioning capacity and capability • Improving provider engagement • Building strong and sustainable relationships between commissioners and providers
VOLUNTARY & COMMUNITY SERVICES (PREVENTION AND EARLY INTERVENTION)	**Outcomes**
The Living Well project has 4 elements for maximum impact supporting: • Older people • People living with learning disability • People living with mental health conditions • Carers Element 1: Creation of a VCS Living Well team working across the hospital, as well as being based in the community through local VCS organisations and Integrated Locality Service. Element 2: Recruitment of a specialist Learning Disability Worker, working with Social Care to alleviate pressure on ASC, reduce use of residential care and where relevant support improved transfers of care between hospital and home. Element 3: Creation of a hospital based carers support service, and GP champion role, to complement community based services. Element 4: Creation of a VCS Brokerage Scheme, helping people live well independently. Collectively, the Living Well Project will reduce pressure on ASC and support the high impact change model to better manage transfers of care between hospital and home; specifically early discharge planning, joint assessment as part of an MDT, supporting Home first/discharge to assess, trusted assessment and enable choice as well as reduce/delay the need for residential care.	A Living Well project within the VCS that will: • Support a reduction in delayed transfers of care through contribution to the high impact change model • Create community capacity to divert demand for Adult Social Care, particularly those ineligible for statutory funding (42% of enquiries) • Support people to increase their ability to self-care, live well and retain their independence • Help to reduce/delay the need for emergency admissions and a move to residential care