Appendix B

2016/17 BETTER CARE FUND PLAN

Relevant Board Member(s)	Councillor Ray Puddifoot MBE Councillor Philip Corthorne
Organisation	London Borough of Hillingdon
Report author	Kevin Byrne, Administration Directorate Tony Zaman, Adults and Children and Young People's Services Directorate
Papers with report	**Appendix 1** - 2015/16 and 2016/17 BCF Plan Comparison Summary. **Appendix 2** - Supporting Narrative Document. **Appendix 3** - Detailed Scheme Descriptions. **Appendix 4** - Sample provider commentary templates. **Appendix 5** - Planning Template **Appendix 6** - Health Impact Assessment. **Appendix 7** - Equality Impact Assessment (inc. Carers).

HEADLINE INFORMATION

Summary	This report sets out the proposals for the 2016/17 Better Care Fund plan and seeks the Board's approval. The Better Care Fund is a Government initiative intended to improve efficiency and effectiveness in the provision of health and care through increasing integration between health and social care. The focus of Hillingdon's Better Care Fund plan is improving care outcomes for older people.
Contribution to plans and strategies	The Better Care Fund is a key part of Hillingdon's Joint Health and Wellbeing Strategy and meets certain requirements of the Health and Social Care Act 2012.
Financial Cost	The proposed total amount for the BCF for 2016/17 is £22,531k, made up of Council contribution of £4,629k and CCG contribution of £17,902k.
Ward(s) affected	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

1. **approves the 2016/17 Better Care Fund plan in principle for submission to the London Regional Assurance Team on 25 April 2016 as described in this report or with any amendments that it requires;**

2. **delegates authority to make any further minor amendments prior to submission, e.g., to reflect feedback from the London Regional Assurance Team and/or Policy Overview and Scrutiny Committees, to the Corporate Director of Adults and Children and Young People's Services, LBH and the Chief Operating Officer, HCCG, with final sign-off by the Chairman of the Board and the Chairman of HCCG's Governing Body; and**

3. **notes the content of the Health and Equality Impact Assessments (Appendices 6 and 7).**

INFORMATION

Strategic Context

1. The Autumn Statement on 25 November 2015 made it clear that the BCF would continue to be the vehicle for delivering integration between health and social care during the 2015 - 2020 Parliament. It was stated that each HWB area would be required to develop a plan for 2016/17 and then a longer-term plan to achieve 'full' integration by 2020. It is understood that guidance as to the definition of 'full' integration is expected to be published by the end of Q1 2016/17 and that the plan to get to 2020 will need to be agreed by the end of 2016/17.

2. The Autumn Statement also included an announcement about a requirement that every health and care system work together to produce a Sustainability and Transformation Plan (STP) covering the period October 2016 to March 2021. The purpose of this plan is to demonstrate how improved health and wellbeing, transformed quality of care delivery and sustainable finances across the health and care system will be delivered. The Better Care Fund (BCF) is seen as a mechanism for delivering on themes within the STP. The schemes in the proposed 2016/17 BCF plan are aligned to the emerging themes within the STP. The STP has to be submitted in June 2016.

3. For the 2015/16 BCF plan, both the Council and the CCG agreed to the minimum permitted value of £17,991k for the 2015/16 plan, which to minimise risk to both organisations for what was then a new initiative. The minimum required contribution for 2016/17 is **£20,015k**, an increase of 9.1%. If the Board approves the recommendations in this report the total value of the 2016/17 plan will be **£22,531k**, which would reflect an incremental progression towards integration between health and social care described in this report.

2016/17 BCF Plan Proposals

4. The 2016/17 BCF plan builds on the work undertaken as part of the 2015/16 plan. An assessment of the performance of the 2015/16 plan is considered in the 2015/16 BCF plan Q3 performance report, which is a separate item on the Board's agenda.

5. The proposals for 2016/17 include some logical extensions of activity undertaken in 2015/16 whilst simultaneously maintaining the cautious and incremental approach to integrated working and the pooling of budgets that minimises the risk to both the Council and HCCG. The proposals include:

- Extending existing schemes where benefits could be achieved for other adult client groups, e.g., development and management of the supported living market that will include all adults and extending the scheme on supporting Carers to all unpaid Carers;
- Adding funds to the pooled budget where this will have demonstrable benefits for residents/patients, e.g., specialist palliative personal care service for people at end of life;
- Extending scope of the plan to include new types of activities, e.g., dementia;

- Accelerating benefits through a greater ambition to integrate services across health and social care, building on progress made in 15/16, e.g., intermediate care; and
- Correcting anomalies from the 2015/16 plan, e.g., bringing the Council's budget for the community equipment contract into the pooled budget with that of the CCG so that the whole budget is under the same governance structure.

6. The intended outcomes of the 2016/17 plan include:

- A stable, cost effective care market that meets local needs.
- A better resident/patient experience of care.
- Reducing the number of emergency hospital attendances and admissions.
- Reducing the hospital readmission rate.
- Reducing the number of permanent admissions to care homes.
- Reducing the demand for on-going care.

7. **Appendix 1** provides a summary comparison between the 2015/16 plan and the proposed 2016/17 plan. Table 1 below shows the proposed schemes for 2016/17. The detailed scheme descriptions can be found in **Appendix 3.**

Table 1: Proposed BCF Schemes 2016/17	
Scheme	**Scheme Title**
1	Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.
2	Better care for people at end of life
3	Rapid Response and Integrated Intermediate Care
4	Seven day working
5	Integrated community-based care and support
6	Care home and supported living market development
7	Supporting Carers
8	Living well with dementia

National Conditions

8. The national conditions from 2015/16 have been rolled forward and two new conditions have been added. Table 2 below summarises the national conditions and the local response.

Table 2: Summary of National Conditions and Local Response		
Rolled Forward Conditions		
1.	There must be a jointly agreed plan approved by the HWB.	Dependent on the Board's decision.
2.	One or more pooled budgets must be established under section 75 of the NHS Act 2006.	Cabinet and HCCG Governing Body will be asked to approve a revised s.75 agreement in May.
3.	The provision of social care services must be maintained.	HCCG contribution includes 2015/16 protecting social care and Care Act new burdens allocation with uplift.
4.	An agreement for the delivery of 7-day services across health and social care must be in place.	There is a dedicated 7-day working scheme that includes actions to deliver this requirement. See **Appendix 3**.
5.	There should be better data sharing arrangements between health and social care.	Data sharing arrangements are in place and work in progress for

Table 2: Summary of National Conditions and Local Response		
Rolled Forward Conditions		
		further development.
6.	There should be a joint approach to assessments.	Most aspects of this condition are in place and dialogue is in progress about joint funding of care packages for older people.
7.	Agreement on consequential impact of changes within the plan on providers.	Providers, e.g. Metrohealth GP network, Hillingdon Hospital, CNWL and H4All will be asked to complete summary statements for final submission.
New Conditions		
8.	Agreement to invest in NHS commissioned out-of-hospital services	Already being met by the CCG and investment increasing in 2016/17 by £1.9m.
9.	Agreement on local action plan to reduce delayed transfers of care (DTOC).	Actions addressed in schemes shown in **Appendix 3**. A separate DTOC action plan will support the final submission.

Risk Share Arrangements

9. The Council and CCG agreed that for the 2015/16 BCF plan both organisations would manage their own risks. It is proposed that a similar approach is taken during 2016/17 except for two specific service areas and these are:

- *Community equipment* - It is proposed that the risks associated with under or over-performance would be shared proportionate to the financial contribution of each organisation; and
- *Specialist palliative personal care service* - It is proposed that the risks associated with under or over-performance should be shared on a 70:30 (CCG:LBH) split and with any under-performance would be shared proportionate to the financial contribution of each organisation.

10. The detail of these arrangements will be reflected in the section 75 agreement that Cabinet and HCCG's Governing Body will be asked to consider in June 2016.

11. During Q1 2016/17, it is proposed that the Council and CCG develop a risk share agreement that can then operated in shadow form for the remainder of 2016/17. The experience of the shadow period will help to inform the shape of any risk share arrangements to be included within the 2017/18 to 2019/20 plan.

12. The national BCF guidance encourages areas to develop risk share arrangements in respect of delayed transfers of care (DTOCs). This is not a requirement for Hillingdon as our performance for this metric is comparatively good. However, any future risk share arrangements could include other partners, such as Hillingdon Hospital and CNWL, in order to ensure a collective approach to managing the costs associated with the hospital discharge process and delayed transfers of care.

Measuring Success

13. The Board is asked to consider the following measures as key determinants of the success of the 2016/17 BCF plan.

14. **Progress towards a joint approach to a sustainable health and care system** - It is suggested to the Board that if agreement on the following areas is in place by the end of 2016/17 this would be a good indicator of success:

- The preferred integration option and procurement route for intermediate care services;
- The preferred integration option and procurement route for end of life services;
- The integrated brokerage and contracting model for care home placements;
- The model of wrap-around services for care homes and supported living schemes;
- An integrated approach to home care market development and management;
- An integrated outcomes framework for older people;
- An agreed understanding of the impact on health of the reduction by the Council in the use of residential care; and
- The risk and benefits share arrangements following a shadow arrangement in 2016/17.

15. **Performance against national metrics** - There were four metrics that were mandated by NHSE in 2015/16 and two locally determined, resident-focused measures. These six measures have been rolled forward in 2016/17 and are summarised in Table 3 below. The results of these metrics will be reportable to NHSE on a quarterly basis and will be reflected in the BCF dashboard that will also be reported to the Board and the CCG's Governing Body on a quarterly basis.

Table 3: National Reportable BCF Metrics 2015/16 and 2016/17

Metric	Target/Ceiling 2015/16	Projected Outturn 2015/16	Proposed Target/Ceiling 2016/17
1. 3.5% reduction in emergency admissions attributed to 65 + population.	- 388	- 556	- 663
2. Reduction in permanent admissions to residential & nursing homes (65 +).	150	145	150
3. Proportion of people (65 +) still at home 91 days of discharge from hospital to reablement.	95.4%	92%	93.8%
4. Delayed transfers of care (delayed days) 18 +.	4,790	4,335	4,117
5. Resident experience: how easy or difficult to access information and advice about support services and benefits.	73%	75%	75.5%

6. Social care-related quality of life.	19	18.4	18.6

16. The Board is asked to note the following about the proposed targets for:

- *Reduction in emergency admissions* - The proposed target reflects the contribution of the 2016/17 BCF plan to achieving the total emergency admissions reduction target in the CCG's 2016/17 Operating Plan. The BCF contribution relates, as in 2015/16, to the emergency admissions attributable to the 65 and over population;
- *Reduction in permanent admissions to care homes* - The proposed target takes into consideration demographic pressures arising from increased levels of frailty amongst the older people population and the limited availability of suitable alternative care settings until the delivery of two new extra care schemes in 2018;
- *Delayed transfers of care (DTOC)* - The Board can see from Table 4 that Hillingdon's DTOC performance for the period Q1 to Q3 2015/16 was significantly better than our North West London partners and other boroughs in our benchmarking family, e.g. Barnet and Croydon. However, improving our performance further is still necessary to minimise the unnecessary length of stay in hospital for residents/patients with all the implications that this has for loss of independence and pressures on the local health and care system. The proposed 5% reduction on the projected outturn for 2015/16 (a reduction of 217 delayed days) is based on the recognition that delivering on some of the causes of DTOCs will not be delivered until we are into 2016/17 and that therefore the impact of this will not be felt until later in the year. A key example of a cause of DTOCs is availability of local care home provision for people with challenging behaviours;
- *Resident experience* - The actual 2014/15 outturn was 74.8% and the provisional 2015/16 outturn figure is suggesting 75%. A similar rate of growth is therefore proposed for 2016/17 to give a target of 75.5%;
- *Social care-related quality of life* - The proposal for 2016/17 is to maintain this level of increase and set a target at 18.6, which recognises that the key area of performance that impacts on this metric is addressing social isolation. This is an area where the H4All's Health Wellbeing Service explained in more detail in scheme 1 (**Appendix 3**) has the potential to have an impact, as is also the case with the resident experience metric. This service is due to be operational in April 2016.

Table 4: Delayed Transfers of Care Performance Compared Q1 - Q3 2015/16

Area	Number of Delayed Days
Barnet	5,660
Brent	7,475
Croydon	4,305
Ealing	7,974
Hammersmith & Fulham	3,624
Harrow	4,274
Hillingdon	***2,909***
Hounslow	5,433
Kensington & Chelsea	3,829
Westminster	3,228

17. **Performance against scheme specific metrics** - The schemes detailed in **Appendix 3** contain a further range of metrics that will not be reported to NHSE but will be reported to the HWB and HCCG's Governing Body as part of the quarterly performance reports. These additional metrics will give a broader understanding of the successful implementation of the plan than the national metrics and will also be supported by specific testing of the service user experience by services. The following are examples of the additional metrics that will be reported:

- Utilisation rates for Connect to Support
- Number of falls-related emergency admissions
- Number of emergency admissions with a length of stay of between 0 and 2 days.
- Number of admissions a day avoided following a referral to Rapid Response by Hillingdon Hospital's Emergency Department.
- Average number of discharges supported home from Hillingdon Hospital wards by Community HomeSafe per day
- Number of referrals to Reablement per month.
- % of Reablement Team service users where there is no request for long-term support.
- Number of readmissions during a period of reablement.
- % of hospital discharges taking place before midday.
- Number of readmissions within 30 days.
- Number of Disabled Facilities Grants provided and value.
- Number of emergency admissions from care home.
- Number of emergency admissions from supported living schemes.
- Number of Carers' assessments completed.
- Number of Carers receiving respite or another Carer's service following an assessment.

Governance

18. The delivery of the 2015/16 plan has been overseen by the Core Officer Group comprising of the Council's Chief Finance Officer, the CCG's Deputy Chief Finance Officer, the Corporate Director of Adults and Children and Young People's Services (a statutory member of the HWB), the CCG's Chief Operating Officer and the Council's Head of Policy and Partnerships. This has worked well in 2015/16 and it is not proposed to make any changes to the governance arrangements in 2016/17.

BCF Plan Submission Timescales

19. The statutory BCF guidance was published on 23rd February with the following timescales for submission:

- *2nd March* - Submission of planning template setting out 2016/17 plan development progress and intended levels of contribution.
- *16th March* - Feedback from regional assurance team on first planning template submission
- *21st March* - Submission of revised planning template and supporting narrative document
- *11th April* - Feedback from regional assurance team on second planning template submission and supporting narrative document.
- *25th April* - Final submission of planning template and narrative document signed off by the Health and Wellbeing Boards and reflecting feedback.
- *13th May* - Confirmation of final assurance rating for 2016/17 plan.
- *30th June* - Deadline for section 75 agreements to be signed.

20. The first submission template was published on 24 February for submission on 2 March. This was submitted on behalf of the CCG reflecting the minimum contributions from both the Council and the CCG. Delays in confirming the proposed financial contribution arrangements for 2016/17 resulted in Hillingdon's second submission being delayed until April.

21. The final Hillingdon submission will comprise of the following documents:

- Supporting Narrative Document - *Appendix 2*
- Detailed Scheme Descriptions - *Appendix 3*
- Provider Commentaries - *Appendix 4*
- Revised Planning Template - *Appendix 5* (Updated template yet to be published)

Approval and Assurance Process

22. A more streamlined approval and assurance process has been introduced for the 2016/17 plan as described below:

- Narrative plans and template details to be submitted for regional moderation and recommendation to be made to NHSE. The London regional assurance team will comprise of the NHSE Director of Commissioning Operations, a representative from the London branch of the Association of Directors of Adult Social Services and a London local authority chief executive.
- Plans will be evaluated on the basis of quality and risk to delivery.
- There are three possible judgements arising from the assurance process and these are: '*Approved*', '*Approved with support*', '*Not approved'*.

Financial Implications

24. The minimum amount for the BCF for 2016/17 required by the Government for Hillingdon has been published as £20,015k. The proposed total amount for the BCF for 2016/17 is £22,531k, made up of Council contribution of £4,629k and CCG contribution of £17,902k. The increased funding above the minimum for 2016/17 is £2,516k and includes additional contributions from the Council of £1,172k and from CCG of £1,344k.

25. For 2016/17, the sum of resources identified within the BCF for Protecting Social Care (including Care Act new burdens) is £10,566k, an increase from 2015/16 of £2,608k. The total value of the NHS commissioned out of Hospital spend is set at £11,965k.

26. Table 5 below sets out each scheme showing funding by each partner.

Table 5: Financial Contribution to Schemes by Partner

Scheme	Funder-HCCG £000's	Funder - LBH £000's	Budget £000's
Scheme 1: Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.	390	657	1,047
Scheme 2: Better care for people at the end of their life.	106	50	156
Scheme 3: Rapid response and joined up intermediate care.	5,347	2,920	8,267
Scheme 4: Seven Day Working.	0	100	100
Scheme 5: Integrated Community-based Care and Support.	6,021	5,405	11,426

Table 5: Financial Contribution to Schemes by Partner			
Scheme	**Funder- HCCG £000's**	**Funder - LBH £000's**	**Budget £000's**
Scheme 6: Care Home and Supported Living Market Development.	83	150	233
Scheme 7: Supporting Carers.	18	899	899
Scheme 8: Living well with Dementia.		305	305
Programme Management.		80	80
Total	**11,965**	**10,566**	**22,531**

27. Monthly budget monitoring of the BCF will continue to be jointly undertaken by the CCG and Council with regular reports to HWBB on progress during the year.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

28. The recommendation will enable a Hillingdon BCF plan to be submitted in accordance with national guidance. The BCF plan will contribute to the development of a sustainable health and care system in Hillingdon that will support residents to regain or maintain their independence.

Consultation Carried Out or Required

29. Extensive consultation was undertaken as part o`f the development of the 2015/16 BCF plan, for which most of the proposals in the 2016/17 are a logical extension. There has been additional consultation with the Metrohealth GP network, Hillingdon Hospital, CNWL (community health and community mental health), the voluntary sector (H4All) and private residential and nursing care home providers through the Older People's Care Home Provider Forum. Residents have been consulted on the proposals through the Disabled Tenants' and Residents' Association and the Older People's Assembly.

30. A range of stakeholders across sectors and including Healthwatch have been involved in updating the Health Impact Assessment and Equality Impact Assessment, which can be found in **Appendices 6 and 7**.

31. A consultation programme as part of the development and delivery of the STP and the supporting three-year BCF plan (2017/18 - 2019/20) is currently being devised.

Policy Overview Committee comments

32. None at this stage. External Services Scrutiny Committee will be asked to comment on the proposed 2016/17 plan at a special meeting on 14 April 2016. Social Services, Housing and Public Health Policy Overview Committee will also be asked to comment at its meeting on the 20 April 2016.

CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

33. Corporate Finance has reviewed this report, noting that the financial impact of the proposed Better Care Fund plan is generally consistent with the Council's 2016/17 budget as approved by Cabinet and Council in February 2016. The proposed plan will maintain the risk share approach taken during 2015/16 for the majority of BCF activity, with each party being responsible for their own elements of the fund, for Community Equipment and Specialist Palliative Care new arrangements are proposed and detailed within this report.

Hillingdon Council Legal comments

34. Section 223GA of the NHS Act, 2006, provides the legal basis for the BCF and gives NHSE power to make any conditions it considers reasonable in respect of the release of NHS funding to the BCF. Where it considers that an area has not met these conditions, it also has the power, in consultation with the DH and DCLG, to make directions in respect of the use of the funds and/or impose a spending plan and impose the content of any imposed plan.

BACKGROUND PAPERS

- *Technical Guidance Annex 4: Better Care Fund Planning Requirements for 2016/17* (NHSE Publications Gateway Reference 04437 - February 2016)
- *BCF Planning 2016/17: Approach to regional assurance of Better Care Fund plans* (NHSE March 2016)

2015/16 Better Care Fund Plan and Proposed 2016/17 Plan Comparison Summary

Scheme Title	2015/16 Plan Scheme Summary	2016/17 Plan Proposed Changes
1. Proactive early identification of people with susceptibility to falls, dementia and/or social isolation.	• Training staff visiting people in their own homes on how to recognise risk factors. • Supporting people who fall and preventing recurrence of falls. • Keeping people active mentally and physically through Public Health, Library and Sports and Leisure Services initiatives. • Developing support from the third sector for people at risk. • Promoting telecare.	**<u>Rename to include stroke</u>** • Promotion and development of Connect to Support, e.g. access to information and advice. • Rolling out approach to Making Every Contact Count (MECC). • Promoting the H4All Health and Wellbeing Gateway as referral point for people identified as being at risk. • Reviewing the falls strategy to take a comprehensive view of the respective Council and CCG functions and funded services and how collectively with partners falls prevention can be supported. • Reviewing patterns of utilisation of third sector provision in response to Gateway interventions to inform how best to target current third sector capacity funded by the Council and/or CCG. in order to maximise the outcomes of supporting people to be independent in the community. • Developing stroke prevention approaches that will also address dementia, e.g. increasing physical activity, addressing excessive weight issues, smoking cessation and looking at early detection.
2. Better care for people at end of life.	• Developing shared care plans through care planning IT system, Coordinate My Care (CMC). • Developing processes to enable seamless care provision between health and social care. • Developing sources of information for professionals and residents.	Extend to cover delivery of first year of new joint (LBH & CCG) end of life strategy, including: • Improving identification of people at end of life. • Improving care and support planning. • Delivering a communications plan for professionals. • Establishing a joint specialist palliative personal care service. • Bringing social care spend for EoL into pooled budget. • Benchmarking 'best practice' for end of life care services with

		a view to commissioning a new integrated model of care with emphasis on shared outcomes and a seamless transition between providers. • Implementing outcome of review of support for carers of people at end of life.
3. Rapid Response and joined up intermediate care.	Achieve closer alignment between intermediate care services to speed up discharge process and prevent admission.	**<u>Rename to: Rapid Response and integrated intermediate care</u>** • Exploration of closer (structural as well as functional) integration options, including procurement choices.
4. Seven day working	• Identifying the services required for an 'ideal' 7-day discharge pathway • Mapping services currently available. • Prioritise commissioning and delivery of services required to close identified gaps.	• Accelerate advanced discharge planning on wards. • Developing the Integrated Discharge Team. • Addressing needs of people with severe mental ill health. • Developing the role of the third sector to support discharge and prevent readmission. • Use contractual levels to deliver seven day assessments in nursing homes. • Embedding earlier referrals to Hospital transport, e.g. before midday. • Changing practice to ensure early referral of patients showing signs of mental distress to the Psychiatric Liaison Service. • Embedding advanced discharge planning on wards through setting ward-specific KPIs and exploring standardisation of MDT process.
5. Review and realignment of community services to emerging GP networks.	• Realigning community health resources around GP networks. • Multi-disciplinary care team (MDT) approach to problem solving. • Establishing care planning and care coordination for people with long-term conditions.	**<u>Rename to: Integrated Community-based Care and Support</u>** • Expanding use of risk stratification tools to identify people those who may benefit from early support. • Rolling out the integrated model of care for older people across the borough. • Mainstreaming personalised care planning for older people

	• Promoting DFGs.	across the borough supported with IT through the Care Information Exchange. • Raise awareness within primary care of community service provision and access routes - Training to be provided to staff within primary care about the range of services provided by the Council to support the health and wellbeing of residents/patients in their own homes, including the provision of Disabled Facilities Grants (DFGs). • Bringing all funding for Medequip contract together and tendering for the service. • Re-launching the retail model for some items of community equipment to increase choice for residents/patients. • Develop an integrated approach to home care market development and management for all adults to reduce need for people to change provider where needs change and help manage risk relating to medication administration. • Development and delivery of a training programme on care standards for homecare providers. • Expansion of Personal Health Budgets.
6. Care home initiative.	• Provide support to care home staff from specialist clinical staff to prevent avoidable hospital admission. • Ensure that care homes implement robust environmental risk assessments and the dignity challenge. • Establish an escalation process between health and social care where there are safeguarding incidents or concerns.	**<u>Rename to: Care Home and Supported Living Market Development</u>** Remit extended to cover all adults in supported living, including extra care. Care homes continue as 65 + only. • Developing the model of care and support for extra care to maximise independence, prevent hospital admission and reduce demand on GP services. • Implementing preferred joint contracting options for care homes for older people. • Launching market position statements to set out medium and long-term needs for developers and providers of care homes and supported living schemes. • Addressing the gap in nursing home provision for people with behaviours that challenge.

		• Development of a menu of in-reach support for care homes and supported living schemes, including medical and clinical support.
7. Care Act Implementation.	• Implementing the Council's new responsibilities to carers through the following activities: - Improved access to information and advocacy; - Providing access to an assessment of need; - Meeting needs identified as a result of an assessment. • Implementing new statutory adult safeguarding requirements. • Implementing new market management and provider failure responsibilities.	**<u>Rename to: Supporting Carers</u>** Remit extended to cover all carers, e.g. young carers and adult carers. Deliver year 2 of the Joint Carers' Strategy: • Deliver a communications campaign to increase awareness and take-up of carers' support/services. • Reviewing assessment capacity across the borough • Implement carers' hub contract. • Deliver GP health checks and flu jab programmes for carers. • Implementing a carers' recognition scheme. • Deliver options to extend services for carers, e.g. extended carer cafes and winter activities. • Deliver an integrated engagement framework for carers. • Implement a range of social activities for young carers.
8. Living well with dementia	Not applicable.	**New scheme** • Implementing a single point of access (SPA) for crisis care that includes dementia. • Exploring feasibility of an integrated multi-disciplinary team that will have case management responsibility for people with dementia. • Developing a local dementia resource centre model. • Developing standardised training for providers. • Securing care home provision for people living with dementia with challenging behaviours. • Securing care provision for people living with dementia at end of life.