Appendix 2

Proposed Priorities 2018/19

Scheme 1: Early intervention and prevention.
• Relaunch and promote the online information system, Connect to Support and ensure linkages with the NHS Directory of Services. • Extend remit of Care Connection Teams to include adult mental health. • Review the model of voluntary sector support for older people funded by the Council and CCG to maximise the outcomes for residents aligned to the Accountable Care Partnership. • Explore the increased application of assistive technology to support the independence of residents in the community. • Develop a prevention strategy, including approach to delivering health checks.
Scheme 2: An integrated approach to supporting Carers.
• Secure partner sign-up to the Carers Memorandum of Understanding. • Develop the Carer Referral pathway for CNWL. • Identify a Carer's lead in all GP practice. • Deliver a communications campaign to schools to raise awareness of Young Carers so that teachers and staff are better placed to support them. • Develop a mechanism for reflecting the needs of Young Carers within existing assessment processes in Primary Care, Social Care and across all partners so that Young Carers are better supported in their role.
Scheme 3: Better care at end of life.
• Implement the Single Point of Access for End of Life Care. • Clarify the end of life model of care for people who wish to die at home. Links to schemes 4 and 5.
Scheme 4: Integrated hospital discharge
• Implement the Integrated Discharge Team. • Review Hospital Discharge Bridging Care Service and secure decision on model post

March 2019.

- Secure decision on Hospital Discharge Grant and implement if approved.
- Pilot the Housing/Mental Health Protocol.
- Deliver changes to the operation of the mental health funding panel process to expedite decision making.
- Model community-based service provision requirements to support discharge of people with complex mental health needs. Links to scheme 5.
- Seek organisational sign-up to the CHC, shared care and section 117 memorandum of understanding.

Scheme 5: Improving care market management and development.

Cross Cutting

- Develop and deliver a provider engagement plan.
- Review the provider failure policy and procedure.

Integrated Brokerage

- Complete co-location of teams.
- Embed integrated working of staff from LBH and CHC teams.
- Review outcomes to inform decision on longer-term model.

Integrated Homecare

- Review outcomes from pilot to determine procurement options to be undertaken in 2019 for delivery from Oct 2019.

Care Homes

- Implement specialist GP-led multi-disciplinary support service for care homes and extra care schemes.
- Explore feasibility of LBH being included within nursing home AQP and benefits of doing so.
- Embed training programme for care home staff on range of issues, including falls management, tissue viability, nutrition, medication and leadership for managers and/or aspiring managers.
- Develop a care home market position statement setting out requirements over next five years.
- Systemise provision of care home LAS conveyance and admission data to inform provider risk management process.

- Complete implementation of *'Red Bag'* scheme and monitor impact.

- Explore with HHCP opportunities for developing a career pathway for nurses as part of a workforce strategy to support nursing homes.

Extra Care

- Open Grassy Meadow Court and start implementation of fill strategy.

- Open Park View Court and start implementation of fill strategy.

- Continue to explore with partners opportunities to maximise the benefits of available resources at Grassy Meadow and Park View. Links to scheme 1.

Scheme 6: Living well with dementia.

- Deliver the Dementia Resource Centre.

- Develop community-based solutions to support discharge (or prevent admission) of people with challenging behaviours.