The Kent Better Care Fund
First Draft Submission

Contents:

Owner: The Kent Health and Wellbeing Board

Date: 12 February 2014

Version No: 1.0 First Draft Submission

The Kent Better Care Fund
First Draft Submission

1. Introduction

Health and social care integration in Kent is about improving outcomes for our 1.5million population through supporting independent living, empowering people and placing a greater emphasis on the role played by the citizen and their communities in managing care.

Kent will continue to be bold in developing new and different solutions to the challenges facing health and social care and as Integrated Care and Support Pioneers continue to work through partnerships that support integrated commissioning and deliver the provision of integrated services. The Kent approach has been to look at whole system integration; rather than working in one area and then moving on to others we have developed a comprehensive programme which supports integration across the entire health and social care economy.

To reflect the complex picture of health and social care within Kent the Better Care Fund is built from a local level, with 7 area plans, across 3 care economies – giving a complete Kent plan.

We will use the Better Care Fund to continue provide us with the opportunity to go further faster and start the longer programme of transformation provided by being a Pioneer. It will drive forward our integration programme, developing more community based services alongside the re-design and commissioning of new systems-wide models of care that ensure the financial sustainability of health and social care services; a proactive, rather than a reactive model that improves outcomes for people and means the reduction of hospital and care home admissions.

"They want to keep us in our home, we want to stay in our own home – and we're going to be!"

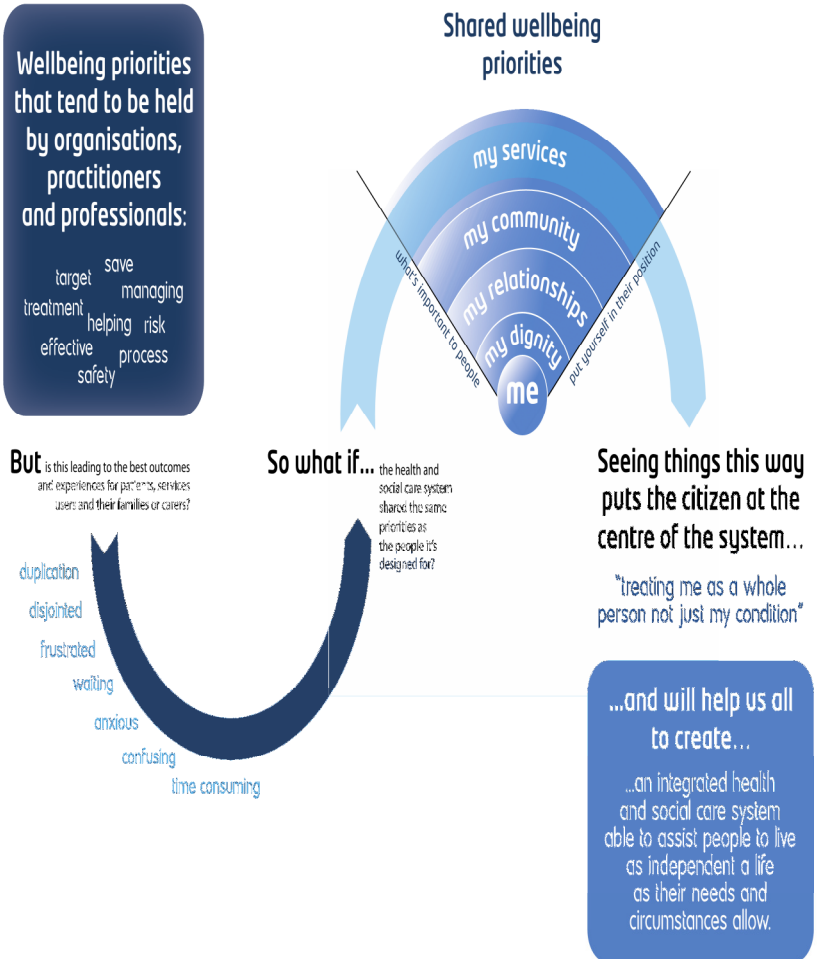
2. Our Vision

Kent supports the vision as outlined by The Narrative in Integrated Care and Support, Our Shared Commitment, May 2013:
"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

By 2018 we want to achieve an integrated system that is sustainable for the future with improved outcomes for Kent's 1.5 million population and includes the Kent £ across the entire health and social care economy.

Our vision is to be providing person centred care with easy to access, 24/7 accessible services wrapped around them that crosses the boundaries between primary, community, hospital and social care with services working together, along with voluntary organisations and other independent sector organisations. The GP neighbourhood practice will be at the heart, directing the suite of community health and social care services – providing a neighbourhood team around the patient and a neighbourhood team around the GP to forge common goals for improving the health, wellbeing and experiences of local people and communities.

The Kent Vision



The Kent Better Care Fund
First Draft Submission

We will use the Better Care Fund to:

- Take the transitional steps that achieve transformation of health and social care – delivering the 'right care, in the right place at the right time by the right person' to the individual and their carers that need it.
- Support people to stay well in their own homes and communities, wherever possible – avoiding both avoidable and where appropriate some currently unavoidable admissions by developing "hospitals without walls".
- Support people to take more responsibility for their own health and wellbeing.
- Reduce the pressure on the acute hospitals by ensuring the right services are available and accessible for people when they are required.
- Get the best possible outcomes within the resources we have available.

Bring care closer to home – health and social care in Kent by 2018

Amanda knows that she can receive 24/7 access to community health services and preventative services through her GP or by contacting the local single point of access.

She knows that if the worst should happen and an ambulance is called they will have immediate access to her care plan through her online record. A record of what she wants to happen has been discussed with her by her care co-ordinator, so Amanda has confidence that she is in charge of her support team.

Amanda's family know they can receive an update on her condition when they need it as they've been given access to her care plan. They also have access to some really great You Tube videos which help them to understand supporting someone with diabetes.

All services that Amanda comes in to contact with are focused on treating her – a person and not just her condition – she feels confident in the quality of services she's receiving.

The Kent Better Care Fund
First Draft Submission

What we want to achieve in 5 years (as outlined in Kent's Integrated Care and Support Pioneer Programme):

Integrated Commissioning:

- Together we will review current models of integrated care, and re-design and commission new systems-wide models of care that ensures the financial sustainability of health and social care services in Kent. These services will give people every opportunity to receive personalised care at, or closer to home to avoid hospital and care home admissions.
- We will use an integrated commissioning approach to buy integrated health and social care services where this makes sense.
- The Health and Wellbeing Board will be an established systems leader, supported by clinical co-design and strong links to innovation, evaluation and research networks. Integrated Commissioning will be achieving the shift from spend and activity in acute and residential care to community services, underpinned by JSNA, Year of Care financial model and risk stratification. We will have a locally agreed tariff system across health and social care commissioning based on the year of care funding model, allocating risk adjusted budgets, co-managed and owned by the integrated teams and patients.
- We will see integrated budget arrangements through section 75s as the norm alongside Integrated Personal Budgets.
- New procurement models will be in place, such as alliance, lead provider, key strategic partner and industry contracts, delivering outcome based commissioned services.
- Public Health will lead on an integrated intelligence initiative, linking data sets from various NHS & non NHS public sector organisations across health and social care which will underpin the basis for integrated commissioning.

Integrated Provision:

- A proactive model of 24/7 community based care, with fully integrated multi-disciplinary teams across acute and community services with primary care playing a key co-ordination role. The community / primary / secondary care interfaces will become integrated.
- We will have a workforce fit for purpose to deliver integrated health and social care services. To have this, we need to start planning now and deliver training right across health, social care and voluntary sectors.
- An IT integration platform will enable clinicians and others involved in someone's care, including the person themselves, to view and input information so that care records are joined up and seamless. We will have overcome information governance issues. Patient held records and shared care plans will be commonplace.
- We will systematise self-care/self-management through assistive technologies, care navigation, the development of Dementia Friendly Communities and other support provided by the voluntary sector.
- New kinds of services that bridge current silos of working where health and social care staff can "follow" the citizen, providing the right care in the right place.

3. Our Plan

Kent has an established record of joint commissioning through learning disabilities, mental health and older peoples services. Our plan involves building on existing joint working whilst recognising that we need to increase the scale and pace of what we want to achieve and do some things differently.

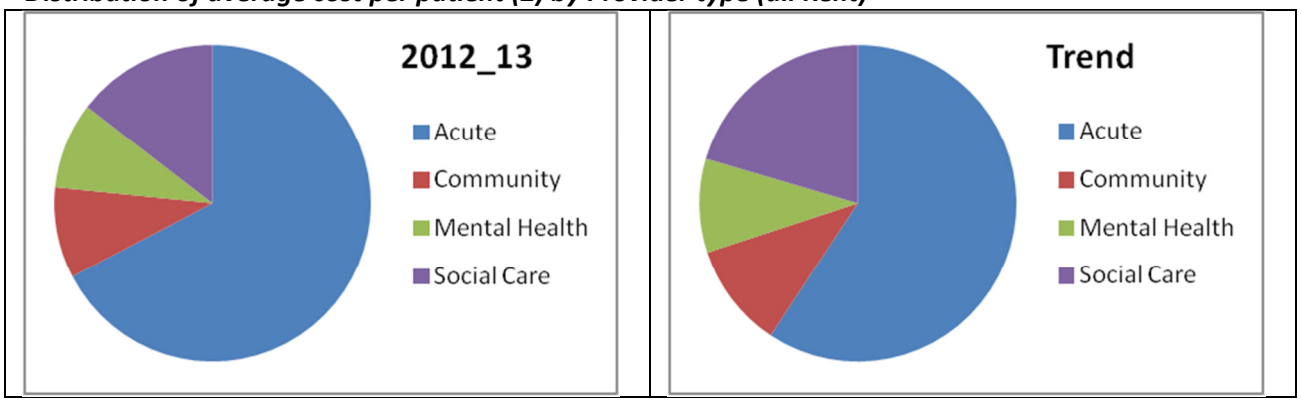
The value of the Better Care Fund across Kent is £27m in 2014/15 and £101m in 2015/16, however Kent as a Pioneer wants to go further than this and by 2018 be considering the Kent £ across the entire health and social care economy.

Year of Care

Kent is an early implementer of the Year of Care tariff which will help establish improved funding streams going forward. Public Health will work with key organisations to develop an information system that monitors and evaluates the YOC programme, through its shadow testing phase in 14/15 and its anticipated implementation from 15/16 alongside national rollout. The same system will also be used to help evaluate integrated care models across different CCGs and understand their impact on the whole system.

YOC is currently forecasting the need for a shift in trend of spend across the health and social care system to deliver whole system transformation:

Distribution of average cost per patient (£) by Provider type (all Kent)



System Change

It is recognised that the basis of the funding for the Better Care Fund is money that is already committed to health and social care services of many different types. We will work together to ensure we are reviewing the current commitments to ensure they are achieving what we was agreed in the original business case. Some services will need to change to support the aims and vision we want to achieve, others will need stability.

The schemes we have identified in our plan are about applying targeted investment to transform the system and improve outcomes for citizens and the entire care economy. Detailed investment and benefit management plans will be designed throughout 2014/15 in line with CCG and Social Care commissioning plans. The tables below captures our current plans on a thematic Kent wide level, full detail of local implementation is provided in the appendices.

The Kent Better Care Fund

Our Model of Integrated Services

Integrated Discharge Teams: Acute Hospital sites; 7 days a week working

Non Acute Bed Provision: Step down & step up; Consultant and GP support; Integrated Care Centres; Extra Care; Rehab Units; Community Hospital beds; Private Residential and Nursing bed provision

Integrated Enhanced Rapid Response: Rapid Response; active reablement; "Going Home Teams"

Crisis Response Services: Access to Shared Anticipatory Care Plans by the Ambulance service, Enhanced Rapid Response, Enablement Services and Voluntary Sector based crisis response services

Integrated Long Term Conditions/ Neighbourhood teams: 24/7 access to multi-disciplinary teams coordinated by the GP, inc mental health/dementia; Risk Stratifying patients; Anticipatory Shared Care Planning; Access to one Care Plan for patient/service user & professionals

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

Integrated Care Home Support: Integrated teams including Consultant and GP support; Use of technology to Care Homes / Extra Care Housing providers to prevent unnecessary admissions to hospital

Integrated Access: Integrated Locality Referral Unit; 7 days a week direct access and 24/7 crisis response; Access to 1 Care Plan based on integrated platform

Integrated Equipment, DFGs, Capital adaptations & Assistive Technologies at the front end of all the services video conferencing with clinicians, teletechnology, equipment development of new pathways

Improved data sharing Promotion of NHS number, better exchange of health information, use of the health and social care information centre, patients accessing own health records, GPs linked to hospital data

Operating model: Integrated skill mix, assessors accessing integrated care direct: i.e. nurses accessing social care and case managers nursing care, skills for mental health/dementia

Integrated Therapy Services: in the acute community, social care and housing settings

The Kent Better Care Fund
First Draft Submission

The Better Care Fund in action:

The GP practice has a nurse, case manager and dementia nurse working as part of the Neighbourhood Practice team. They also have access to an Enhanced Rapid Response Service. The multi-disciplinary team has agreed with the Clinical Commissioning Group, Social Care and the Acute Trust that they will work to a 4 hour target in responding to acute needs of their patients.

The Ambulance Trust knows that if a 111 call comes in then the community team will respond in 4 hours. The Enhanced Rapid Response Team will come out and will have 24/7 access to health and social care practitioners and a social care private and voluntary sector Crisis Response team who can provide a 72 hour sitting service if needed. The Acute Trust has a Consultant on standby for video consultation and the Out of Hours GP service is able to be involved in a video-conference or come out to the person's home or residential / nursing home for a consultation if needed.

If the ambulance was called out via a 999 call and needs to transport the person to A&E then the A&E triage team is able to call on the Rapid Response Service and take the person back home after an initial assessment. After the Enhanced Rapid Response service has finished , the Intermediate Care or Enablement service will take over for up to 6 weeks reablement and will fully utilise tele-technology in order to make the person as independent as possible.

The professionals, the patient and their carer will be able to communicate through a shared communication system with, at its heart, a shared care or advanced care plan.

The Kent Better Care Fund
First Draft Submission

2014/15 Schemes	Description	Investment	
		Min £000	Max £000
Enabling people to return to/or remain in the community	Working together to improve pathways and ensure "own bed is best". Ensuring people are provided active reablement and enabled to return home from hospital through enhanced rapid response.	16153	17000
Ease of Access to Services	Continue to improve and enable ease of access to services through extended working hours across 7 days. Providing multi-disciplinary community teams – including GPs and mental health wrapped around the citizen.	1610	2000
Enabling Prevention and Self Care	Expanded and co-ordinated community capacity to meet the citizen's priorities without necessarily having to utilise NHS and social care services and resources.	3228	3603
Expand integrated commissioning of schemes that produce joint outcomes.	Initiatives such as Health and Social Care Co-ordinators improve outcomes across health and social care and help avoid admissions to hospital and residential care. Jointly commissioned services with private providers and the voluntary sector. Development of a join accommodation strategy to support the needs of Kent.	531	970
Falls prevention exercise classes	Falls are the principal cause of hospitalisation in the elderly. Implementing a programme of exercise classes has been proven to significantly reduce the risk of falling through improvement of postural stability, muscle strength, balance and confidence. Postural stability classes can support the delivery of fitness, confidence and social interaction.	649	649
Falls Car Service	An appropriately equipped and staffed vehicle that can respond to emergency falls requests and install measures designed to enable someone to remain in their own home.	759	759
Access to health and social care information	Citizens and health and social care professionals to have access real time to agreed health and social care information with NHS number as prime identifier, through an integrated platform and shared care plan.	759	1334
Supporting implementation of Integration	Support the coordination of delivery of integration through the HASCIP / Pioneer Programme Team.	310	685
	Total		**£27m**

The Kent Better Care Fund
First Draft Submission

Note: **further detailed analysis on the amounts of finance allocated to schemes is taking place within local areas; this includes a commitment to providing additional funding to the baseline BCF.**

2015/16 Schemes	Description	Finance		
		Baseline BCF £000	New Investment £000	Total £000
Integrated working through local models that deliver 7 day access including: Enhanced Rapid Response Integrated Discharge Referral Service Integrated urgent care/LTC model. Neighbourhood Care Teams	Improved services wrapped around the citizen, accessible 24/7 through the commissioning and delivery of: Wider use of enhanced rapid response services. Integrated Long Term Condition Teams, with GPs coordinating care and involving mental health and dementia services. Integrated contacts and referrals, where possible through a single point of access. Workforce development and access to specialist input such as community geriatricians. Provision for mental health and dementia within all services.			
Enhanced support to residential and nursing homes	Ensure people have anticipatory care plans in place. Enable consultant access via technology – video-conferencing, improved access to integrated health and social care team. Community Geriatrician projects – to support care homes out of hours and at weekends.			
Integrated personal health and social care budgets	Extend the use of personal health budgets, social care budgets and implementation of integrated budgets, including the use of the Kent Card.			
Pro-active care	Support the principle of unequal investment to close			

2015/16 Schemes	Description	Finance		
	the health inequality gap by addressing specific needs in specific areas to improve health outcomes. Minimise the use of physical resources i.e. hospital buildings and maximise the use of human resources i.e. a skilled workforce with a multi-disciplinary health and social care approach.			
Self-Care/Self-Management	Co-produce with patients, service users, public and voluntary and community sector improvements in self-care. Including care navigators, advanced assistive technology, patient held records and the development of Dementia Friendly Communities.			
Section 256 Social Care to Benefit Health	Ensure existing services commissioned under 256 agreements are aligned to the objectives of transforming integrated working and continue to protect social care.	27000		
Disabled Facilities Grant	Equipment and adaptations are a key enabler to maintaining independence we will work with Districts to consider future actions required in delivering DFG.	7,208		
ASC Capital Grants	Home support fund and equipment.	3,432		
Implementation of the Care Bill	Carers assessments and support services; Safeguarding Adults Boards; and national eligibility.			
Carers support	Continue to develop carer specific support – including carers breaks.			
	Total	**£101m**		

4. Measuring Success

Kent will continue to measure success against the outcomes identified as being an Integrated Care and Support Pioneer, including using the I Statements to measure improved outcomes for people.

The Kent plan will also contribute to meeting the 5 outcomes identified within the Kent Health and Wellbeing Strategy:

- Effective prevention of ill health by people taking greater responsibility for their health and wellbeing.
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.
- People with mental ill health issues are supported to live well.
- People with dementia are assessed and treated earlier.

As part of the Better Care Fund Plan we will also measure against the national metrics and Kent's agreed local metrics. Local area plans may have additional metrics as required.

Year of Care is providing additional metric information to inform final submission.

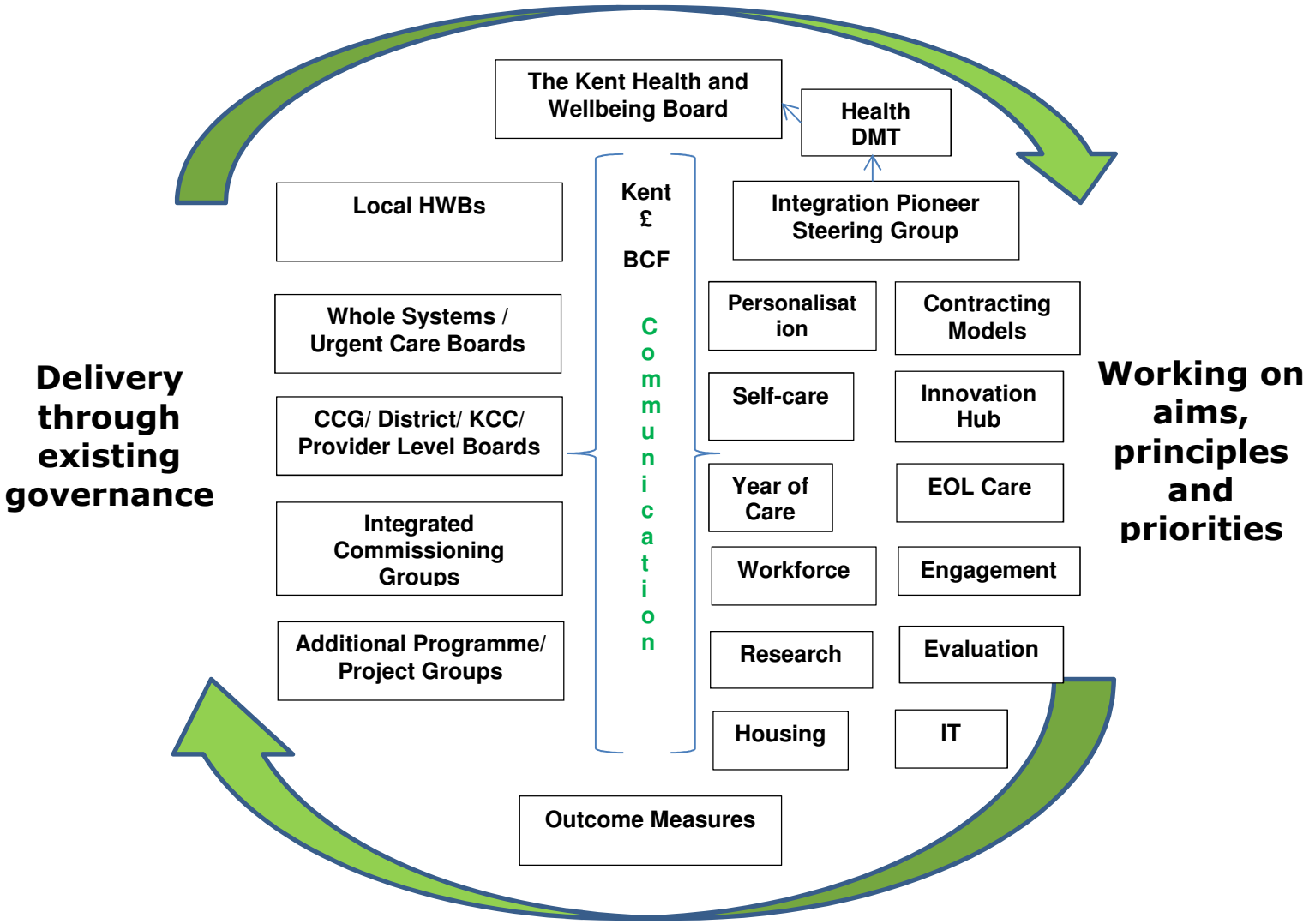
Metric	Current Sept 2013	Baseline Sept 2014	Progress April 2015	Target Sept 2015
Permanent admissions to residential and care homes				
Effectiveness of reablement – those 65+ still at home 91 days after discharge.				
Delayed transfers of care				
Avoidable emergency admissions				
Patient / service user experience	Kent will use the national metric provided			
Local metric to be confirmed based on area plans				

5. Governance and management of the Better Care Fund

Kent's governance for delivering as an Integrated Care and Support Pioneer is set out below, the responsibility and management of the Better Care Fund will sit within this. Existing governance structures will ensure delivery and the Integration Pioneer Steering Group provide advice and guidance.

Any additional local governance for delivery of area plans is outlined in appendices.

Kent is committed to engaging and involving with the public and wider stakeholders and as a Pioneer will use ICASE (www.icase.org.uk) as a mechanism to provide updates on our progress within integration and the implementation of the Better Care fund.



The Kent Better Care Fund
First Draft Submission

The Better Care Fund in action:

"The professionals involved with my care talk to each other. We all work as a team."

Sarah (care manager and trained nurse) is making a home visit today to re-assess Dorothy after she experienced a fall. Sarah is updating Dorothy's electronic anticipatory care plan with both Dorothy and her son. Sarah is able to carry out both routine health and social checks on Dorothy and update her plan accordingly.

Sarah has noticed Dorothy had previously been in attendance at the falls clinic and makes contact directly to update on the recent fall an appointment is made to attend the clinic for a routine check-up. Sarah noticed Dorothy's blood pressure was a little high: From reading Dorothy's patient held record she can see Dorothy was supported by the NCT after a discharge from hospital, Sarah makes contact with the named nurse and informs of current health check, again a routine appointment is made for one of the community nurses to visit and check Dorothy's blood pressure over the next few days.