Ashford Clinical Commissioning Group

Draft Better Care Fund Plan
NHS Ashford Clinical Commissioning Group

No	Scheme	Description of Scheme	Outcome Measures	High Risks
1	**Integrated Health and Social Care Team** **"Cluster Team"**	We will continue to develop our integrated health and social care team to ensure that they will be available 24 hours a day seven days a week and will be contactable through a single access points. The "Cluster Team" will be focussed on both ends of the patient journey, through supporting patients, carers, social services and clinicians to avoid the need for patients to be admitted to hospitals, however where this is necessary the team will mobilise to ensure timely discharge of the patient. These teams will ensure wider integration with other community and primary care based services, including voluntary sector provided services, as well as hospital specialists working out in the community. The ultimate aim is to enable people to be cared for in their own homes or within their own community. The aim of team is to support people to self-manage and to be independent in their own homes. The model requires specialist input from across the social care, health and voluntary sectors to enable the management of care for more patients in the community for a range of specialisms including the care of the over 75s, this will include undertaking clinics and reviews of patients in or close to their own homes rather than in hospital. This would include actual and remote approaches supported through the use of technology, such as video conferencing with acute specialists.	• Reduced emergency admissions; • Reduced A&E attendances; • Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia; • Improve patient, carers' and relatives' experience; • Improve health and social outcomes; • Reduced length of stay across the health and social care	• Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability. • Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and

		SCHEME REQUIREMENTS: • Aligned to geographical areas the support will be accessible 24 hours a day seven days a week and will coordinate integrated management of patients through a multi-disciplinary approach with patient involvement at every stage of the process including the development and access of anticipatory care planning to ensure patient centred care and shared decision making; • Each Team will include input from the wider community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, and Social Case Managers as part of the multi-disciplinary approach; • The teams will support patients with complex needs to better manage their health to live independent lives in the community, including supporting and educating patients with their disease management by using technology, for as long as possible empowering them to take overall responsibility for managing their own health; • The integrated teams will provide continuity of care for patients who have been referred for support and care in the community, including within care homes. • To ensure continuity for patients with long term needs, the team will provide seamless coordination and delivery of End of Life care; • There will be a single point of access and single assessment to ensure responsive onward referral to either rapid response services or intermediate care services ensuring transfer to most appropriate care setting (including patients own home); • Specialist dementia nursing support, through the Admiral Nurses, will be integrated into the teams as part of an approach to maximising the knowledge of the team through the inclusion of specialists. • Each patient, identified through risk stratification, or as resident of a care home, will have a comprehensive anticipatory care plan to identify their individual needs and to identify possible pressure points so that approaches to the patients care can be identified in advance of the need arising. • We will ensure that patients are supported outside of the hospital	economy; • Improved transfers of care across health and social care; • Reduced long term placements in residential and nursing home beds; • Reduced need for long term supported care packages; • Increase patients returning to previous level of functionality in usual environment • Improving patients ability to self-manage	support integrated outcome measurement and monitoring. • Artificial barriers needs to be broken down (e.g. mental health nurses able to order ECG) • Governance structures within individual organisations may not currently support integrated care • Complex mechanisms for funding of long term care, either social or health, will reduce the impact of early discharge and admission avoidance.

		environment through "Befriending Services" to address and support the needs of vulnerable people. • Improved support for carers during periods of "crisis", including short breaks for carers. • Sharing of practice across professionals will improve the quality of care provided to patients and carers • We will implement a shared IT solution to allow health and social care professionals to access the shared care plan through our IT steering group.. • The aspiration is that, where possible, the team will be co-located. We suspect that this may prove to be the optimum model. • The voluntary sector is seen as having an important role in the delivery of this scheme.		
No	**Scheme**	**Description of Scheme**	**Outcome Measures**	**High Risks**
2	**Integrated Urgent Care Centre**	Extending Scheme 1 is the integration of urgent care services to ensure that patients receive the same standards of care, entering the same pathways, regardless of which point they access the Urgent Care system. It will achieve this by providing rapid access to key health economy services which include: • General Practitioners • Community Support Services • Social Services • Psychiatric Services • Secondary Care Consultants (including Geriatricians) The smooth flow of patients through the health and social care system is fundamental to meeting patients' expectations of urgent care services. It is	• Reduced A&E attendances; • Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia; • Improve patient, carers' and relatives' experience; • Reduced spend on medication;	• Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability; • Detailed modelling required to fully understand impact on acute capacity and

		apparent that a significant proportion of urgent and emergency demand could more appropriately be classified as "primary care related" and undertaken by GPs or practice and community nursing. The model will require a change in how decisions are made with patients at the first point of accessing support. Principally, by front loading expertise, it is possible to significantly reduce the number of patients attending hospital and to improve care and treatment before they go to Hospital and seeing a senior decision maker on arrival. **SCHEME REQUIREMENTS:** Key principles for implementation of the Integrated Urgent Care Centre (IUCC), includes the ability to allow: • a clinician to clinician discussion via a 24/7 'Care Co-ordination' Centre; • enhanced GP out of hours service to replicate what is provided in hours; • enhanced input to review and treat patients within care homes, reducing the need to access acute hospital services; • robust decision making skills through the use of jointly developed 'decision support or assessment' tools; • consistently responsive and reliable service 24/7; • integration of the out of hours service with other care providers; • clear discharge processes from urgent care to planned or primary care, to maintain capacity within the system; and • proactive case management. The IUCC will provide both physical and virtual access 24/7, supporting patients who self-present, are brought in by Ambulance, referred by a GP &/or care professional, as well as responding to patients as a result of a clinical discussion via telephone. The IUCC will require immediate access to clinical support	• Reduced duplications across the health and social care system; • Reduce delays in provision of care • Reduce long term admissions to care homes	requirements of community capacity to inform transition over a defined period of time including investment and dis-investment requirements; • Large scale organisational change to ensure the whole health and social care system has shared vision and values to enable the delivery of required changes; • Governance structures within individual organisations may not currently support integrated care • Integrated performance monitoring of pathways needs to support the level of integration required;

		services such as radiology and pathology to assist with assessment and decision making. It is intended that all providers will gain from a coordinated approach to Urgent Care providing patients with a single contact and intervention with all needs being assessed and met, without the onus being on the patient to know where and who to contact. The service is designed to provide a sustainable approach to Urgent Care across all disciplines and services allowing the IUCC to access and navigate the various components of service delivery. However, the patient will only see and experience those aspects of the service which provide the care, dependant on their needs, thereby ensuring that the service is patient centred, coordinated and efficient.		• IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring.
No	**Scheme**	**Description of Scheme**	**Outcome Measures**	**High Risks**
3	**Mental Health Services**	We recognise that like physical health related long term conditions, mental illness has a huge impact on the quality of life for the patients and their carer. The CCG will work with all partners to deliver improved mental health services for all age ranges to support: • Increased schemes to support health minds and early interventions • Crisis support within all pathway • Integrated models for all pathways to support patients within range of pathway • Systematised self-care/self-management through assistive technologies • Improved care navigation • The development of Dementia Friendly Communities and, • To facilitate access to other support provided by the voluntary sector. **SCHEME REQUIREMENTS:**	• Reduced emergency admissions; • Reduced A&E attendances; • Improve patient satisfaction and well-being; • Increase levels of patient self management of long term conditions;	• Extensive workforce reconfiguration in the community to ensure the workforce has the required skills and training to deliver all elements of the scheme; • Large scale organisational change to ensure the whole health and social care system has shared vision and values to

		• Street triage services, aligned with Kent Police to ensure earlier assessment of a patient in crisis, thus avoiding the need for hospital admission • Develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by General Practice • We will ensure that patients are supported outside of the hospital environment through "Befriending Services" to address and support the needs of vulnerable people. • Improved support for carers during periods of "crisis", including short breaks for carers. • Improvements to 24/7 Psychiatric liaison service provided within urgent care facilities • We will promote the use of integrated personal health budgets for patients with long term conditions and mental health needs to increase patient choice and control to meet their health and social care needs in different ways; • Pathways which are integrated across health and social care • Improved signposting and education will be available to patients through care coordinators and Health Trainers to ensure patients are given information about other opportunities to support them in the community, including the voluntary sector, and community pharmacies; • Develop a Health and Social Care information advice and guidance strategy to enable people to access services without support from the public sector if they choose to. • Introduction of an "all-age" earlier identification and intervention for problematic eating behaviours • Improved discharge pathways for patients with mental health related conditions	• Increase levels of patients with personal health budgets and integrated budgets; • Improve health outcomes by better use of prevention services.	enable the delivery of required changes. This includes ensuring the voluntary sector are aware of the direction of travel; • Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring. • Delay to discharge without flexible, lean and clear process relating to joint funding for care placement (e.g. Section 117)
No	**Scheme**	**Description of Scheme**	**Outcome Measures**	**High Risks**

4	**Support for Care Homes**	This model supports older people with a range of needs including physical disabilities and dementia will align specialists across multiple teams, including secondary care, to ensure patients in care homes have anticipatory care plans in place and those that are admitted to hospital have robust discharge plans in place before they are discharged in order to prevent re-admissions. **SCHEME REQUIREMENTS:** • The CCG and KCC will continue to support care homes through the Joint Geriatrician Project, extending this project further to support care homes out of hours and at the weekend. • Aligned to the integrated teams mentioned in Scheme 1, community based geriatricians will ensure appropriate community based services are in place to support patients as part of their discharge planning, from an acute episode of care. These discharge plans will be in place for every patient and known to all community based teams. The team will also undertake anticipatory care planning with the patients and their carers; • Access to integrated community teams to support ability to care for patients within their own home • Community Matron available to care homes 24/7 • Peer support through the Care Homes forum • Medicines management support • Joined up approach to quality overview and timely interaction where issues are identified • The consultant works in the community providing advice to GP in the treatment and support for patients and along with the wider team provides additional support, advice and guidance to care homes. • Access to specialist services such as Dementia Crisis will be available to support care homes; • Care homes will be given access to additional skills development to support improving quality of care and outcomes for the management of residents	• Reduced A&E attendances; • Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia; • Improve patient, carers' and relatives' experience; • Reduced duplications across the health and social care system; • Reduce unnecessary prescribing; • Improve patient satisfaction through personalised care planning.	• Workforce capacity to deliver the scheme is limited considering the large number of care home beds; • Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring. • Workforce in care homes needs support to increase skills to support more complex patients.

		with long term conditions, compassionate care needs, mental health and wellbeing and management of End of Life care. • Primary care and the integrated team will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the care home • Sharing of practice across professionals will improve the quality of care provided to patients and carers		
No	**Scheme**	**Description of Scheme**	**Outcome Measures**	**High Risks**
5	**Health and Social Housing**	To improve the utilisation and appropriate use of existing housing options and increase the range if housing options available to people and to ensure it's used flexibly and enables more people to live independently in the community with the right level of support. This will also require responsive adaptations to enable people to manage their disability in a safe home environment. **SCHEME REQUIREMENTS:** • An integrated approach to local housing and accommodation provision, supported by a joint Health and Social care Accommodation Strategy, to enable more people to live safely in a home environment and other environments. • Responsive timely adaptations to housing; • Preventative pathways to enable patients and service users to remain in their homes safely; • Improved, rapid, access to specialist equipment to support people to remain in their own home. • Flexible housing schemes locally; • Increased provision of extra care housing locally; • More supported accommodation for those with learning disabilities and mental health needs. • The promotion and development of wheelchair accessible accommodation.	• Reduced A&E attendances; • Reduced hospital admissions and re-admissions; • Improve patient, carers' and relatives' experience; • Reduced duplications across the health and social care system; • Reduce unnecessary prescribing; • Improve patient satisfaction through personalised care	• Policy and legislation for housing and Disabled Facilities Grants need to support the level of integration required.

			planning. • Reduced residential care admissions; • Reduced care packages;	
No	**Scheme**	**Description of Scheme**	**Outcome Measures**	**High Risks**
6	**Falls Prevention and Management**	Development of falls and fracture prevention services for older people to undertake screening and comprehensive assessment aimed at identifying and treating the underlying causes of falls, such as muscle weakness, cardiovascular problems, medication and housing issues. The overall aim of this schemes is to focus on objectives 2 and 3 of the Kent Falls Strategy, and improve the quality of life for Kent residents (particularly over 65yrs of age): • Objective 2 - respond to a first fracture and prevent the second – through fracture liaison services in acute and primary care settings • Objective 3 - early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries **SCHEME REQUIREMENTS:** The strategy recommends following interventions, which if undertaken in a systematic way will prove beneficial at a population level. These include: 1. Screening of adults who are at a higher risk of falls 2. Integrated multi-disciplinary assessment for the secondary prevention of falls and fractures	• Reduction in falls and secondary falls; • Reduction in hip fractures; • Improve patient experience and levels of self management; • Reduced emergency admissions; • Reduced A&E attendances.	• Different skills and training required across multiple professionals and organisations; • Integrated performance monitoring of pathways needs to support the level of integration required as will be challenging to monitor improvements linked to falls prevention; • IT systems need to enable shared care plans between

		3. Use of standardised Multifactorial Falls Assessment and Evaluation tool across Kent 4. Availability of community based postural stability exercise classes 5. Follow on community support for on-going maintenance closer to home **Development of a local specialist falls and fracture prevention service** • This service will work closely with the Cluster Teams, Rapid Response and Intermediate Care and will undertake proactive and responsive screening and multi factorial assessments to identify causes of falls and make arrangements for preventative approaches. **Local integrated falls prevention pathways** • Level of current services across locally will be more integrated to include the increased level of input from geriatrician for integrated management and integration with other professionals e.g., pharmacists, chiropodists, podiatrists, opticians and audiologists; • Develop an Integrated Falls Response Service; • Improve availability and awareness of therapeutic exercise programmes (postural stability classes) via community classes, domiciliary based and within care homes.		organisations and support integrated outcome measurement and monitoring.
No	**Scheme**	**Description of Scheme**	**Outcome Measures**	**High Risks**
7	**"Community Hub"**	The fundamental, underlying, principle which reaches across the CCG Strategic Commissioning Plan is to ensure that care is delivered as close to where patients live as possible. The consequence of this is that patients will be able to access a variety of services in a variety of locations –including their own home, their pharmacy, the optometrist, their GP surgery, community hospitals as well as district hospitals.	• Reduced emergency admissions; • Reduced A&E attendances; • Reduced hospital	• Large scale organisational change to ensure the whole health and social care system has shared vision and values to enable the delivery of

		Ultimately we anticipate that the outcome of this longer term approach will mean larger practices offering more services, including Social Care, and acting as the central hub for a wider variety of services and with improved access for traditional GP services. **SCHEME REQUIREMENTS:** **SCHEME REQUIREMENTS:** • Core set of community based health **and** social care services, with tailored community based services • General Practice as the most frequent point of contact for patients and carers; • Improved GP access - in terms of time waiting for an appointment and telephone access • More services provided locally, within a community setting e.g. at or via the GP surgery • More locally based day services for carers and patients • Improved communication with patients and carers. This could reduce patients' and carers' concerns regarding treatment and disputes regarding decisions about health care provision and support • Improved communication between health care professionals and across health and social care • Better information, whether it is about services that are available (accessibility, timings, contacts) in different formats including easy read • Reduced cost of void space to the CCGs in future • Improved community bed utilisation • Voluntary and social services integrated into community-based contracts • Integrated contracts for defined geographical locations • Increased emphasis on early interventions and health and wellbeing	admissions and re-admissions for patients with chronic long term conditions including Dementia; • Improve patient, carers' and relatives' experience; • Improve health and social outcomes; • Reduced length of stay across the health and social care economy; • Improved transfers of care across health and social care; • Reduced long term placements in residential and nursing home beds; • Reduced need for long term supported care packages;	required changes. This includes ensuring the voluntary sector are aware of the direction of travel; • Different skills and training required across multiple professionals and organisations; • Integrated performance monitoring of pathways needs to support the level of integration required as will be challenging to monitor improvements linked to falls prevention; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring.

			• Increase patients returning to previous level of functionality in usual environment • Improving patients ability to self-manage	