West Kent Better Care Fund

Appendix F West Kent BCF Plan

Owner: The West Kent Health and Wellbeing Board

Date: 11 March 2014

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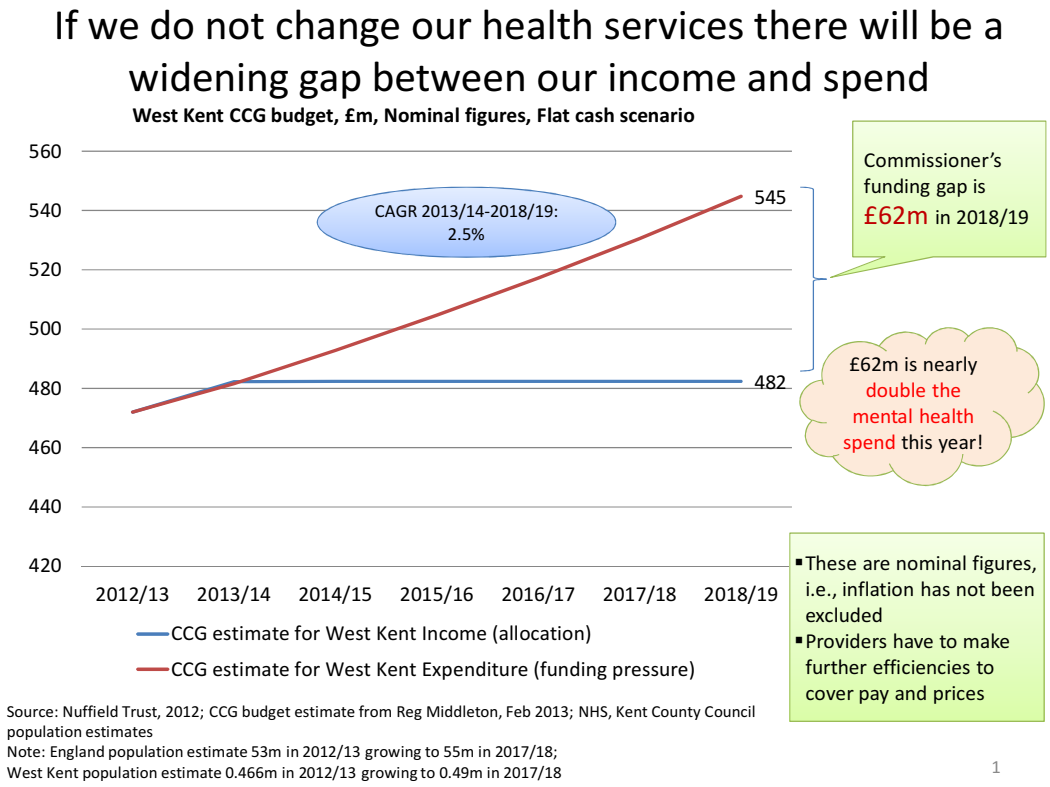
1. Introduction

West Kent's health and care services need to change as there is a widening gap between what people in West Kent need and what can currently be afforded within the funding available. Based on current trends, and specifically linked to the ageing population, the demand for healthcare will increase by 20 per cent over the next five years with no increase in funding.

NHS West Kent Clinical Commissioning Group (CCG) budget for 2014/15 will be £489 million to spend on healthcare in the area. If we continue to deliver services in the way we do now and meet demands for care, by 2018-19, it is estimated we will have a funding gap of approximately £60 million



In 2013/14 although the local system has met the vast majority of constitutional pledges to its population, it has struggled to maintain performance in a number of key areas, specifically those around waiting time in A&E, delayed discharges from hospital, and the 18 week Referral To Treatment (RTT) target.

In addition, there are a number of challenges facing the health system in West Kent:

- Increasing needs of ageing population
- Lack of integrated information systems
- Inability to move patients onto rehabilitation pathways, especially neuro-rehabilitation and slower stream
- At times of pressure there is over-reliance on key individual members of staff
- Insufficient level of capacity outside of acute hospitals meaning sometimes patients stay in acute beds longer than is necessary, creating bottlenecks and pressures elsewhere in the system i.e. A&E and acute medical wards
- Insufficient number of Elderly Mental Infirm (EMI) placement beds in West Kent
- Delivering on 18 week referral to treatment time constitutional commitment
- Delivering timely reporting of diagnostic investigations, although the tests are achieved within the target time
- Higher than desired number of patients admitted to acute hospitals for end of life care
- Gaps in expected levels of detected disease leading to health inequalities
- Opportunity for patients with long term conditions to be more involved in their own condition management and for them to receive more of their necessary care in a planned way outside of hospitals
- Timely provision of equipment to keep patients at home
- Delivery of the desired ambulance response times
- Recruitment to specific specialist roles
- Achieving timely access to Children and Adolescent Mental Health (CAMHS) and Improving Access to Psychological Therapies (IAPT) services

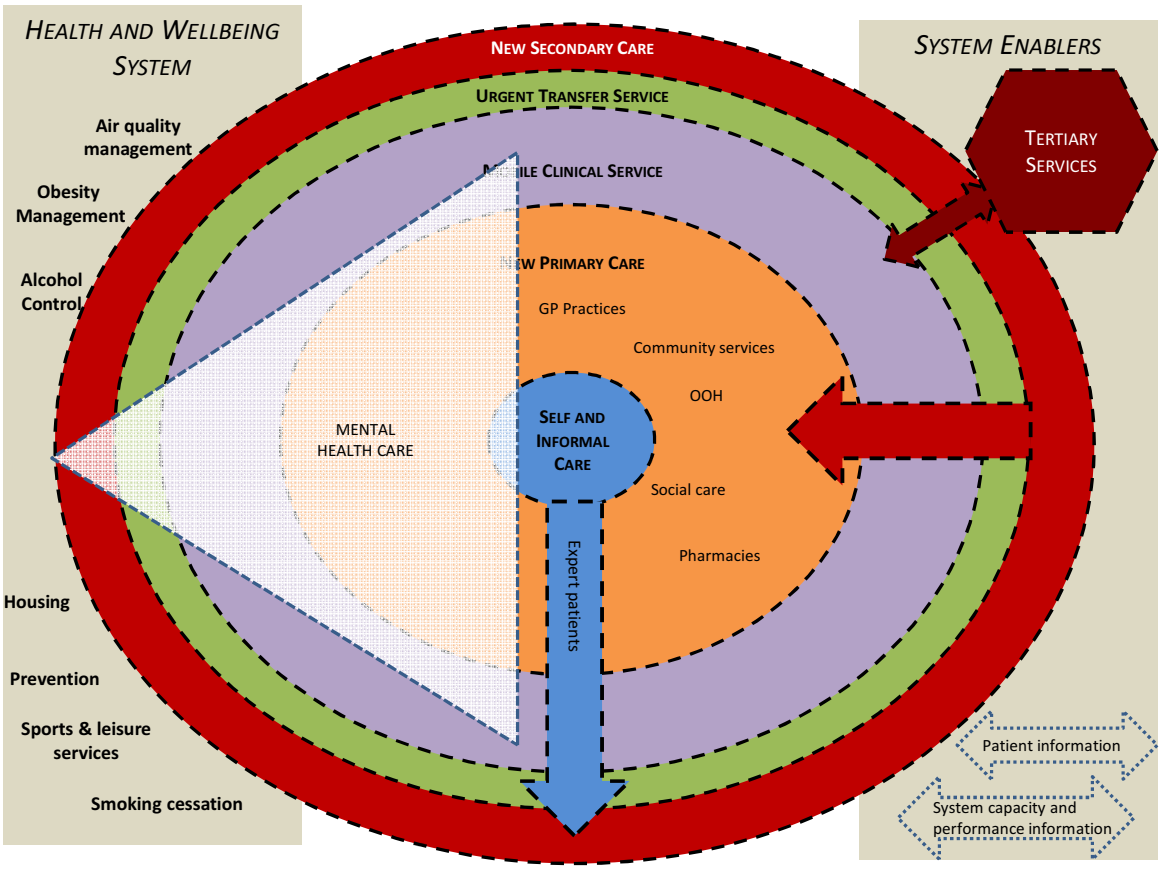
Given the resource outlook for both the public sector and the NHS in the coming decade, the cost of additional demand facing the NHS will need to be mitigated to be financially sustainable, and the effective use of the Better Care Fund is one key way in which the health system will secure best value through the transformation of services in West Kent.

Mapping the Future is a programme of work which has been started in West Kent to describe what the system needs and what a modernised health and care service for the 463,730 people who live in West Kent will look like. The programme has produced an initial future picture of the modern, efficient health and care services that we will need to provide in order to meet the changing needs of people in West Kent over the next 5 years. This programme is delivering the NHS Call to Action within West Kent.

To help develop the Mapping the Future programme four workshops have been held involving patient representatives, clinicians, health and care professionals and managers.

2. West Kent's Vision

Mapping the Future sets out a whole system approach for West Kent where all health and well-being system partners use their individual and collective efforts to tackle the root causes of health and well-being problems where people are encouraged and supported to take greater responsibility for their health and healthy choices (the Blueprint). This blueprint places self and informal care at the centre, enhancing the capacity of communities and individuals to support themselves and each other. People are fully informed and take part in planning their care helping are supported to stay at home and independent longer.



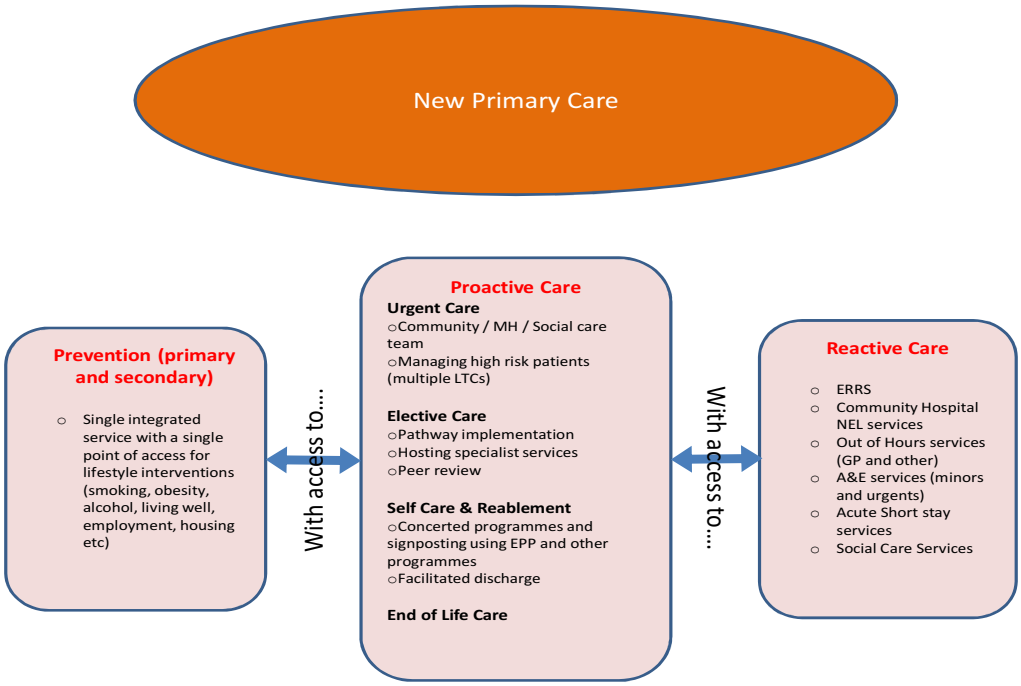
It introduces a new model of Primary Care focusing on three distinct but interlinked areas of care (prevention, proactive and reactive) creating larger scale GP led multi-disciplinary teams which are wrapped around a suitably sized group of practices.

It supports the provision of more capable and cost effective out of hospital proactive care and brings together elements of urgent care, elective care, self-care, reablement services and end of life care.

The teams will include clinically-led professionals that take a care management and coordination role for patients who are elderly and those with the most complex needs. They will operate within a framework of clear clinical pathways spanning the health

and care system and will have access to consultant opinion to enable them to support patients, most often without the need to send them to hospital.

The focus will always be to support citizens to manage and coordinate their own care whenever possible.



Community based support and prevention will be available to residents of West Kent. A core offer will be developed and commissioned which will ensure a comprehensive range of universal support services are available to people. Some will be targeted services for particular populations e.g. smoking cessation, weight management, and employment support. Other support services commissioned via voluntary sector organisations will help reduce demand on more specialist health and social care services through preventative activities. Some will be linked to care pathways, for example, falls prevention classes, while others will offer universal access e.g. carer support, or dementia support.

NHS 111 will continue to provide advice online and by phone to patients and carers supported by GPs. This will be complemented by an integrated Information, Advice and Guidance service which will enable residents to access information and will enable those working within health, social care and housing services to signpost people to other support available within local communities.

Self and informal care will be an important part of the new system, with more people and their families being supported to manage their own care and long term conditions through the use of smart technology. Integrated telecare / telehealth solutions will be backed up, where necessary, by trained staff working in an integrated telecare / telehealth monitoring centre, who will be pro-actively monitoring changes in activity and health condition, alerting integrated community teams where further intervention to prevent increases in care needs.

Mobile clinical services (MCS) will provide direct care to people at the point it is needed by taking care to the patient wherever possible and clinically appropriate to do

so. The MCS will work as a complementary workforce to the new Primary Care System using similar pathways, protocols and medical records.

MCS will be supported to help people remain at home, through the development of a new integrated (health and social care) intermediate care/ reablement service with a workforce trained to deliver comprehensive care that supports independence, recovery, maintenance of existing situation or for some people, quality end of life care. The breadth of these services will be enhanced to include best practice use of assistive technologies to complement hands on care.

Community based integrated care teams will be established to provide targeted, proactive co-ordinated care and support to those people identified as being of highest risk of hospital attendance or increasing use of care services.

New Secondary Care will seek to manage urgent and planned care as separate entities for optimum efficiency with some highly specialised services concentrated in larger centres. Hospital based urgent care will work as part of the total system connected with primary and community services and mobile clinical services. Together they will optimise patient flows to deliver the most cost effective service with coordinated care around people with complex needs. It is anticipated that this will allow secondary care services to be provided with a more community base model that reduces dependency on beds and buildings.

To enable mapping the future to be delivered we will look to develop our approach to risk management to ensure that financial and contractual levers are aligned and promote access to shared information management systems.

3. West Kent's Aims and Objectives

West Kent CCG and Kent County Council are committed to commissioning care for people to ensure these commitments are honoured. Mapping the Future has identified that in the West Kent health system a significant reduction is required over the next 5 years in the level of activity which is currently delivered as non-elective care in hospitals. This is required

- to ensure that the urgent care elements of the local health system can function safely and efficiently,
- to ensure that those patients requiring planned care do not experience unexpected delays due to emergency pressures
- to enable the system to operate at optimum capacity which allows it to cope with peaks in demand when necessary
- to allow as much of a patient's diagnosis and care delivery to take place in a planned and therefore well managed way
- to allow people with health and social care needs to be in greater control of their health and social care support and are enabled to keep themselves well through access to self-care services
- to allow a reduction in the level of funding spent on care provided in hospitals and residential care and use this more effectively to provide care in a planned way and outside of the hospital or care home setting
- to meet the challenges presented as a result of demographic demand pressures

The outcomes we are aiming for are

- Consistent, high quality health and social care services that are interconnected and available round the clock
- A system that offers the most effective and efficient care so that people get the right care in the right place by professionals with right skills the first time
- Proactive care which aims to prevent people from developing illnesses and limiting the severity of their conditions
- Individuals and carers are active partners in their care, receiving personalised and coordinated services and support
- Care is organised in a way that enables people to be as independent as possible and to only visit hospital when it is absolutely essential
- Health and care services that are efficient in the way they use resources

We will use the BCF to

- buy more provision of reablement and 7 day access to services to keep people independent in their own homes
- Invest in falls prevention services to prevent falls and fractures in the first place (a major cause of health and social care spend)
- rapidly develop integrated care through bringing together inreach/outreach services, community hospital provision, and GP out of Hours as part of a network of integrated multi-disciplinary teams. All of this will be delivered with strong medical/clinical leadership and joint assessment processes.
- minimise use of physical resources i.e. hospital buildings and maximise use of human resources i.e. skilled workforce with a multi-disciplinary health and social care approach
- support the principle of unequal investment to close the health inequality gap by addressing specific needs in specific areas to improve health outcomes

Interventions provided from the Better Care Fund need to achieve

- Reduced admissions to residential care (national measure)
- Avoidable emergency admissions (national measures)
- Reduced admission to care homes (national measure)
- Effectiveness of reablement (national measure)
- Delayed transfers of care (national measure)
- Injuries due to falls in people aged 65 and over (local measure)
- Social Care related quality of life (local measure)
- Health related quality of life for people with long term conditions (local measure)
- Reduced occupied number of bed days (draft local measure)

Delivery of these initiatives will require support to:

- Improve information sharing
- use of year of care tariffs where appropriate
- Use of Risk stratification and case finding tools.

Our success will be dependent on ensuring the achievement of the productivity benefits that are promised by integration.

4. Financial Implications

2015/16 Scheme Proposed	Description	Investment Baseline BCF (£000)
Reactive Care (including GP OOH, Community Hospitals, Rapid Response services, etc.)	• Combine current in reach and outreach teams to integrate the approach to assessment and eliminate delays • Commission and secure wider use of enhanced rapid response services after pilot evaluation (from 2014) • Continue to develop carer specific support – including carers breaks	11,747*
Proactive Care	• Support the principle of unequal investment to close the health inequality gap by addressing specific needs in specific areas to improve health outcomes • Minimise use of physical resources ie hospital buildings and maximise use of human resources ie skilled workforce with a multi-disciplinary health and social care approach	0
Effective reablement	• buy more provision of reablement and care packages to keep people independent in their own homes	2,111*
Reducing admissions to residential care	• Ensuring people have anticipatory care plans in place. • Enable consultant access via technology – video conferencing, improved access to integrated health and social care team	1,379*
Better data sharing between health & social care	• promotion of the NHS number as the prime identifier; better exchange of health information; use of the health and social care information centre; patients accessing own health records; GPs linked to hospital data	0
Protection for social services	• Includes monies for Care Bill Implementation e.g. Carers assessments and support services; safeguarding adults boards and national eligibility	3,001*
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	0
Section 256 Social Care to Benefit Health	• Ensure existing services commissioned under s256 agreements are aligned to the objectives of the transforming integrated working and continue to protect social care	* indicates value includes an element of s256
ASC Capital Grants	• Home support fund and equipment	Unable to break out WK figure
Facilitating discharge /delayed transfers of care and 7 day working including: Enhanced Rapid Response Integrated Discharge Referral Service Integrated urgent care/LTC model	• commission and secure wider use of enhanced rapid response service • Integrate LTC 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 implications and access to specialist input such as community geriatricians • Ensure provision of mental health and dementia is within all services	8,156*
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	2,050i
Total		28,444

i figures is calculated from district level figure provided for Maidstone, Tonbridge and Malling, Sevenoaks and Tunbridge Wells, Sevenoaks figure includes Swanley which is in the Dartford and Gravesham Clinical Commissioning Group area

Mapping the Future sets out ambitious targets for reducing urgent care costs by £25m by 2018-19. Our plans for the forthcoming operating plan period up until the end of 2015-16 are to secure cost reductions totalling £10m.

In order to drive out this level of cost reduction, there will need to be significant reduction in the level of emergency admissions and A&E attenders in the acute care setting. By the end of 2015-16 the target level of avoided urgent care admissions could represent up to 18% of the level of today's emergency admissions, with a target end point of 33% by 2018-19.

Similar reductions in interventions will be targeted in A&E attendances, and ambulance conveyances.

In the event that these admissions are not avoided, the CCG will continue to incur costs above planned levels, putting at risk the longer term sustainability of the local health system. Contingency plans will need to be put in place to underpin the risk of this scenario.

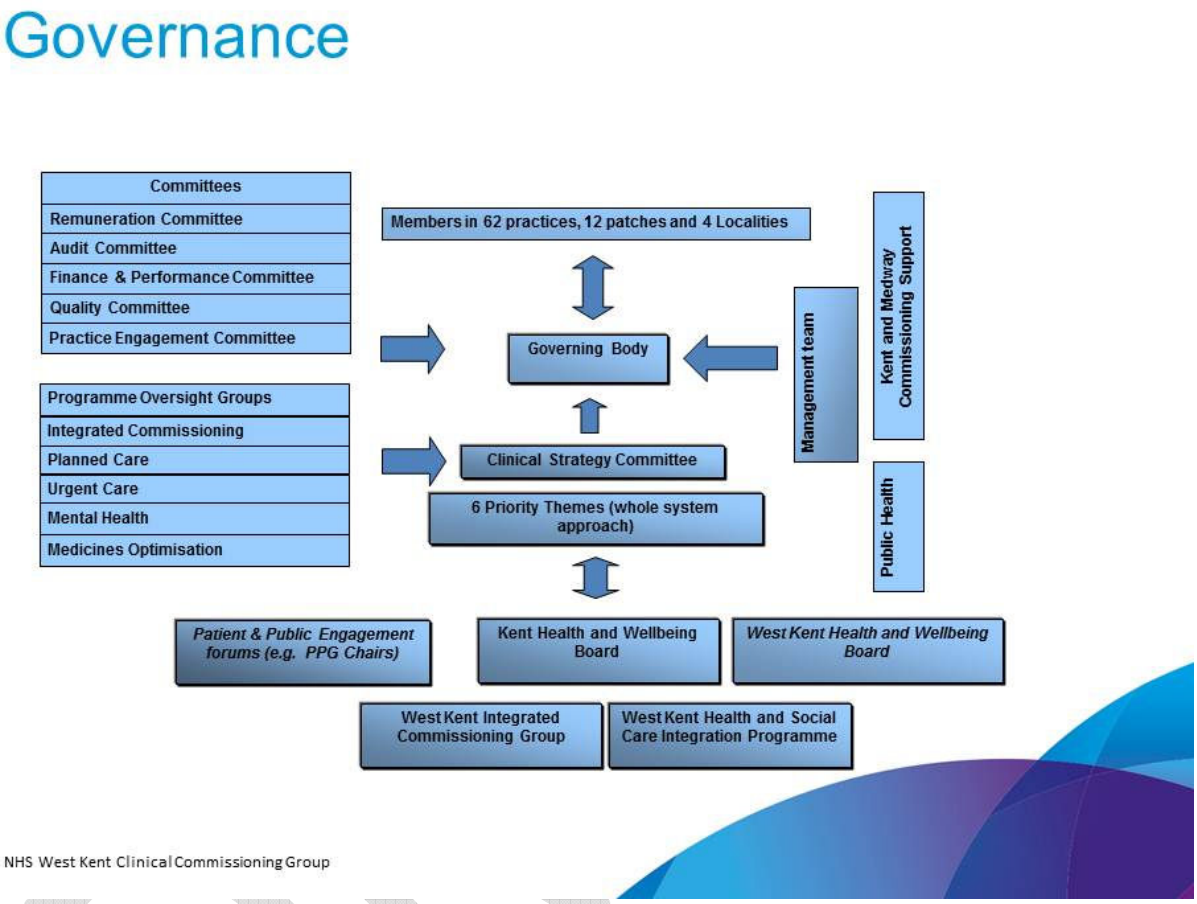
Metrics

The West Kent Better Care Fund Plan will contribute to the outcomes identified in the Kent Integrated Care and Support Pioneer Bid and support delivery of the 5 outcomes identified within the Kent Health and Wellbeing Strategy.

The Better Care Fund Plan will also contribute towards the West Kent Clinical Commissioning Group' Strategic commissioning Plan.

Metric	Current Baseline (April 2012 – March 2013)	Target
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	845	Tba a reduction in admissions based on rate of council-supported permanent admissions to residential and nursing care
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	0.84	0.84 Range to be between 82-88% and not show a reduction over 2 years.
Delayed transfers of care from hospital per 100,000 population (average per month)	5.10	Tba Reduction in DTOC using total number of delayed transfers of care for each month.
Avoidable emergency admissions (composite measure) (	618*	525.3 (15% reduction in admissions)
Patient / service user experience - West Kent will be using the national metric (under development)	Tba	
Injuries due to falls in people aged 65 and over	Tba	
Social Care related quality of life (from ASCOF 1A, linked to NHSOF 2)	Tba	
*timeframe covers July 2012 to June 2013		

5. Governance and management of Better Care Fund



West Kent Better Care Fund

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