The Kent Better Care Fund

Contents:

Owner: The Kent Health and Wellbeing Board

Date: 26 March 2014

Version No: 2

The Kent Better Care Fund

1. Introduction

Health and social care integration in Kent is about improving outcomes for our 1.5million population by transforming services within the community so they support independent living, empower people and place 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. 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.

By 2015 you will see integrated health and social care teams working 7 days, 24/7 in your local community, wrapped around your GP as the coordinator of your care, bridging the gap between your GP, social care, community health services and your hospital. You will have access to a shared care plan so you and everyone around you know about your care and support.

By 2016 you will be able to access services through a local referral unit, with crisis teams and rapid response and the creation of 'hospitals without walls'. There will be one team, one estate working towards one budget, all with the continued focus on enablement, admission avoidance and crisis intervention.

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.

"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 and crosses the boundaries between primary, community, hospital and social care with services working together, along with voluntary organisations and other independent sector organisations. There will be improved outcomes for Kent's 1.5 million population and includes the Kent £ across the entire health and social care economy.

What does this mean for the people of Kent?

We will use the Better Care Fund to:

- Deliver the 'right care, in the right place at the right time by the right person' to the individual and their carers that need it. Reducing the pressure on the acute hospitals by ensuring the right services are available and accessible for people when they are required.
- 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".
- Enable people to take more responsibility for their own health and wellbeing.
- Get the best possible outcomes within the resources we have available.

The Kent Vision – the citizen at the centre with services wrapped around what's important to them.

The Kent Better Care Fund

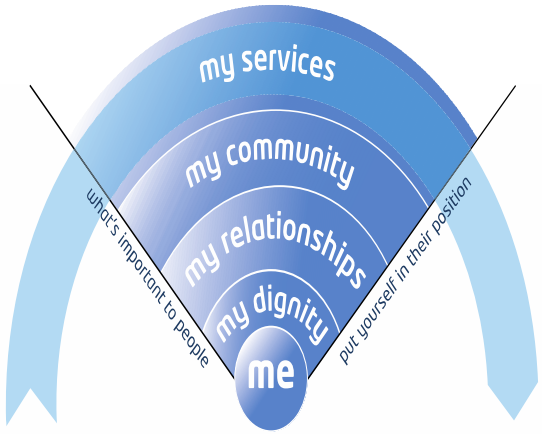
The Kent Better Care Fund

Our Vision of Transformation

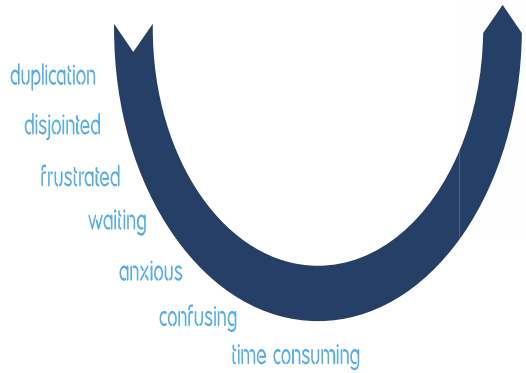
Wellbeing priorities that tend to be held by organisations, practitioners and professionals:

target, save, managing, treatment, helping, risk, effective, process, safety

Shared wellbeing priorities



But is this leading to the best outcomes and experiences for patients, services users and their families or carers?



So what if... the health and social care system shared the same priorities as the people it's designed for?

Seeing things this way puts the citizen at the centre of the system...

"treating me as a whole person not just my condition"

...and will help us all to create...

...an integrated health and social care system able to assist people to live as independent a life as their needs and circumstances allow.

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.

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.

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. This will be achieved through Kent's Pioneer programme, the successful implementation of the Better Care Fund and supported by the updated Health and Wellbeing Strategy.

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. 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.

Our Model of Integrated Services

The diagram below outlines the detail Kent will achieve through the Better Care Fund, the tables then capture our plans on a thematic Kent wide level, full detail of local implementation is provided in the appendices. As a whole system Kent is committed to delivering the following:

By 2015 there will be integrated health and social care teams working 7 days, 24/7 in your local community, wrapped around your GP as the coordinator of your care. This will include a focus on dementia and mental health support for patients and carers. Changes in workforce will mean there will be a core team of the GP, generic community nurse teams, named social care professionals, primary care mental health and dementia workers, adult health visitors, health trainers & public health workers. During 2014 we will develop shared information systems with integrated care plan sharing.

During 2015/16 there will be further integration across mental health, community, social care with acute care, palliative care specialist with the voluntary sector/third party providers extending in as required to meet patient needs.

By 2016 you will see acute inpatient services to those who need acute care and the creation of 'hospitals without walls'. There will be a clear interface with out of hours services, local referral units, crisis teams and rapid response with fast community responses within 4 hours to mirror the targets and pressures in the acute trusts.

By 2016 we will have reduced the need for hospital acute admissions by 15% - through having one team, one estate working towards one budget with a focus on enablement, admission avoidance and crisis intervention.

The Kent Better Care Fund

Our Model of Integrated Services

Integrated days a week working.

Non Acute Bed Provision: 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; access to one shared care plan for patient & professionals.

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

"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 Access: Integrated Locality Referral Unit; 7 days a week direct access and 24/7 crisis response; Access to shared care plan on an integrated platform.

Integrated Equipment, DFGs, capital adaptations & assistive technologies at the front end of all services, video conferencing with clinicians and 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/learning disability.

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

NHS

Kent County Council kent.gov.uk

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.

NHS

Kent County Council kent.gov.uk

The Kent Better Care Fund
First Draft Submission

2014/15 Schemes	Summary Description	Investment £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.	**16527**
Ease of Access to Services / Access to health and social care information.	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. 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.	**1611**
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, working in partnership with Public Health.	**3228**
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 joint accommodation strategy to support the needs of Kent.	**531**
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. In partnership with funding from Public Health.	**166**
CCG area schemes to increase pace and scale of transformation.	Including developing enhanced rapid response, integrated discharge referral service, integrated urgent care/LTC model, Neighbourhood Care Teams, shared information systems with integrated care plan sharing.	**5136**
	Total	**£27m**

NHS

Kent County Council kent.gov.uk

The Kent Better Care Fund
First Draft Submission

2015/16 Schemes	Summary Description	Investment £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.	Total across all CCG areas on schemes: **77132**
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.	
Develop models that support pro-active 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 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.	**27200**

NHS

Kent County Council kent.gov.uk

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.	**7208**
ASC Capital Grants	Home support fund and equipment.	**3432**
Implementation of the Care Bill	Carers assessments and support services; Safeguarding Adults Boards; and national eligibility.	**3541**
Carers support	Continue to develop carer specific support – including carers breaks.	**3443**
	Total	**£122m**

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:

- Every child has the best start in life.
- 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.

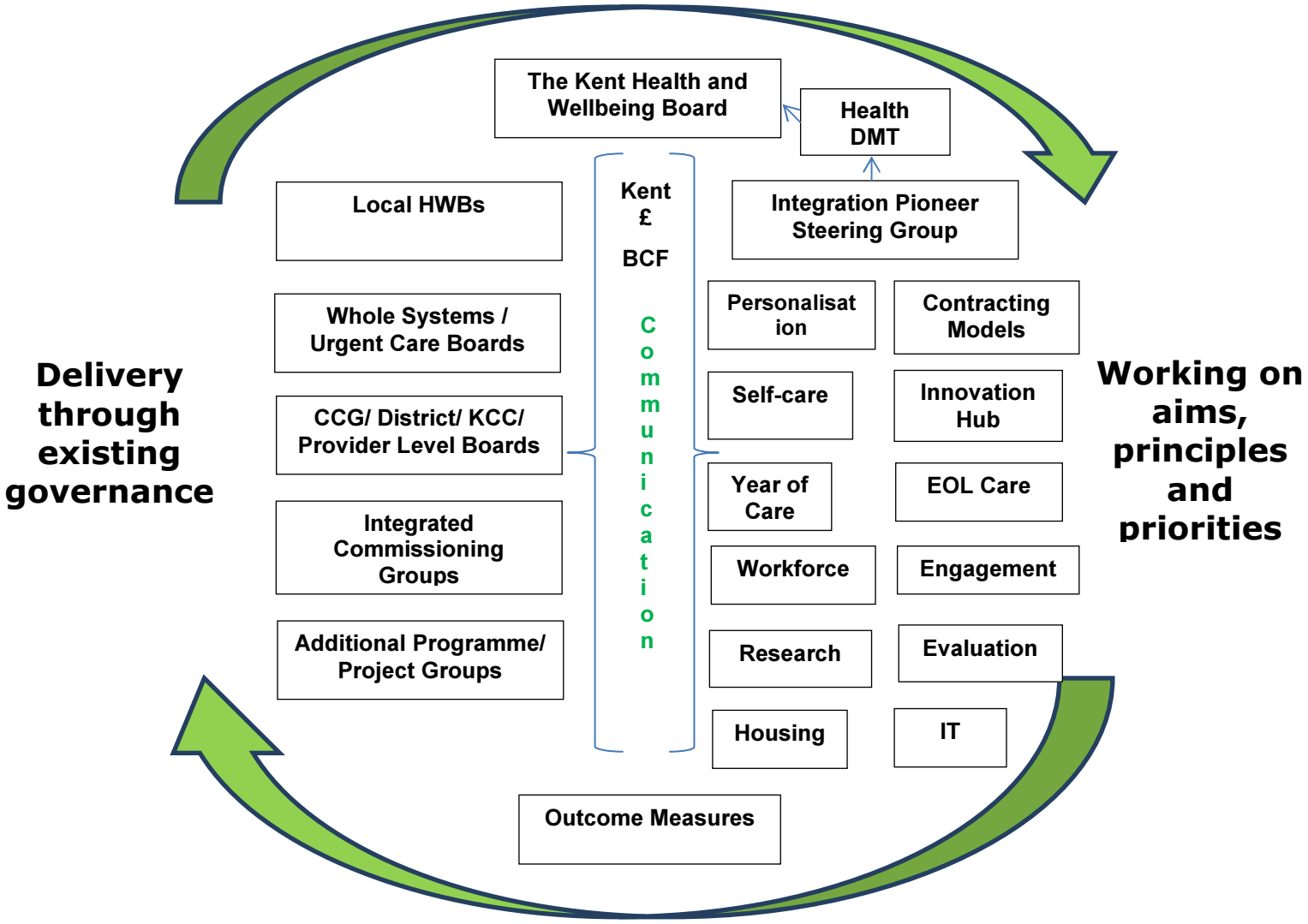
Metric	Definition
Permanent admissions to residential and care homes	Reduction in admissions based on rate of council-supported permanent admissions to residential and nursing care.
Effectiveness of reablement – those 65+ still at home 91 days after discharge.	Range to be between 82-88% and not show a reduction over 2 years.
Delayed transfers of care	Reduction in DTOC using total number of delayed transfers of care for each month.
Avoidable emergency admissions	Up to a 15% reduction in admissions.
Patient / service user experience	Kent will use the national metric implemented in 2015/16.
Local Metrics: Social Care Quality of Life Injuries due to falls in people aged 65 and over	Further local metrics may be used at CCG level; however as part of the Kent HWB dashboard improvements will be required in quality of life and reduction in injuries due to falls.

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.

The risks and mitigations associated with the Better Care Fund are outlined in Appendix A. Any additional local governance for delivery of area plans is also 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.

NHS

Kent County Council kent.gov.uk