Health and Wellbeing Board Expenditure Plan

APPPENDIX 2

Kent

Please complete white cells (for as many rows as required):

	Expenditure						
Scheme Name	**Area of Spend**	**Please specify if Other**	**Commissioner**	**Provider**	**Source of Funding**	**2014/15 (£000)**	**2015/16 (£000)**
Social Care Capital Grant	Social Care		Local Authority	Local Authority	Local Authority Social Services		3,432
Disabled facilities Grant (DFG)	Other	District Council	Local Authority	Local Authority	Local Authority Social Services		7,208
Care Act	Social Care		Local Authority	Local Authority	CCG Minimum Contribution		3,552
Carers Break	Other	Joint	Joint		CCG Minimum Contribution		3,443
Protection of social care	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	28,254	28,254
Schemes-Ashford CCG	Other	Detail within local schemes	CCG		CCG Minimum Contribution		4,273
Schemes- Canterbury & Coastal CCG	Other	Detail within local schemes	CCG		CCG Minimum Contribution		7,914
Schemes-Dartford, Gravesham and Swanley CCG	Other	Detail within local schemes	CCG		CCG Minimum Contribution		8,968
Schemes-South Kent Coast CCG	Other	Detail within local schemes	CCG		CCG Minimum Contribution		8,437
Schemes-Swale CCG	Other	Detail within local schemes	CCG		CCG Minimum Contribution		3,977
Schemes- Thanet CCG	Other	Detail within local schemes	CCG		CCG Minimum Contribution		6,416
Schemes- West Kent CCG	Other	Detail within local schemes	CCG		CCG Minimum Contribution		15,530
Total						**28,254**	**101,404**

Ashford and Canterbury Clinical Commissioning Groups

Scheme ref no.

Scheme name

Community Networks

What is the strategic objective of this scheme?

The fundamental, underlying, principle which reaches across our strategic direction is that the CCG are keen to ensure that care is be 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 number of locations –including their own home, their pharmacy, the optometrist, their GP surgery, community hospitals as well as district hospitals.

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.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

"Community Networks" is the title given to a number of projects leading towards an overall strategic aim.
The component projects, forming part of the Better Care Fund initiative are detailed individually below

The delivery chain

Kent Adult Social Care
The CCG
Provider Organisations including Voluntary Sector

The evidence base

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

The schemes will ensure that residents received both health and social care using pathways that address all of the issues. Through a coordinated approach this will support the dependence upon health services

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

Feedback loop

What are the key success factors for implementation of this scheme?

- 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 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

Ashford and Canterbury Clinical Commissioning Groups

Scheme ref no.

Scheme name

Integrated Urgent Care Centre (IUCC)

What is the strategic objective of this scheme?

This initiative will improve the effectiveness of multi-disciplinary agencies for the following benefits:

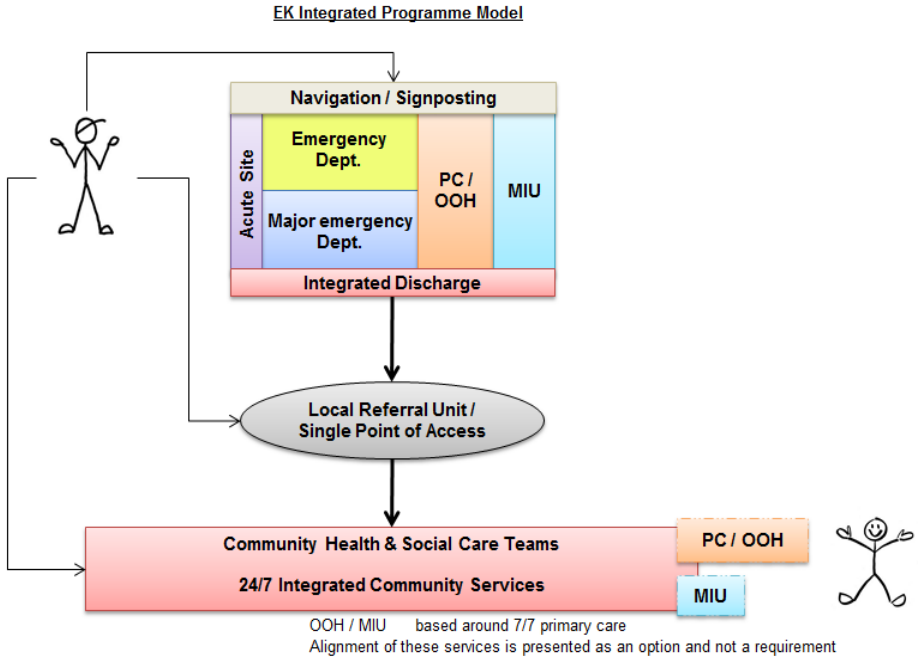
- Enhanced Patient Experience
- Reduced Admissions
- Improved flow of discharges over 7 days a week
- Reduced Acute Hospital Length of Stay

Overview of the scheme

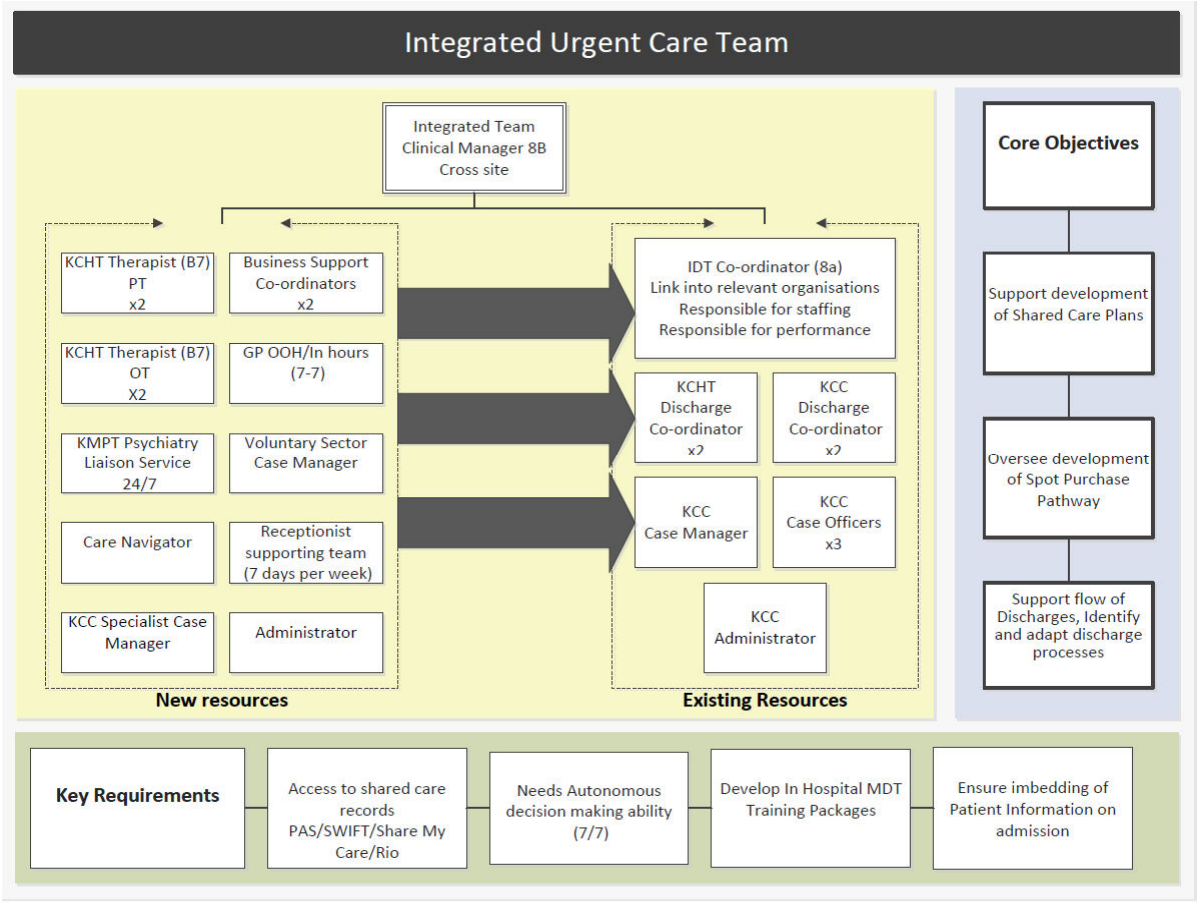
Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The IUCC is an initiative which will bring together providers across health and social care settings under one management structure. It aims to reduce administrative burdens and to enhance productivity by creating a team of senior decision makers working towards shared objectives with shared governance arrangements.
The team will be responsible for working both within the Acute aspects of Hospitals (A&E, Clinical Decision Unit and Surgical Assessment Unit) and also the speciality inpatient wards, covering a 7 day per week service provision.
The model is described below



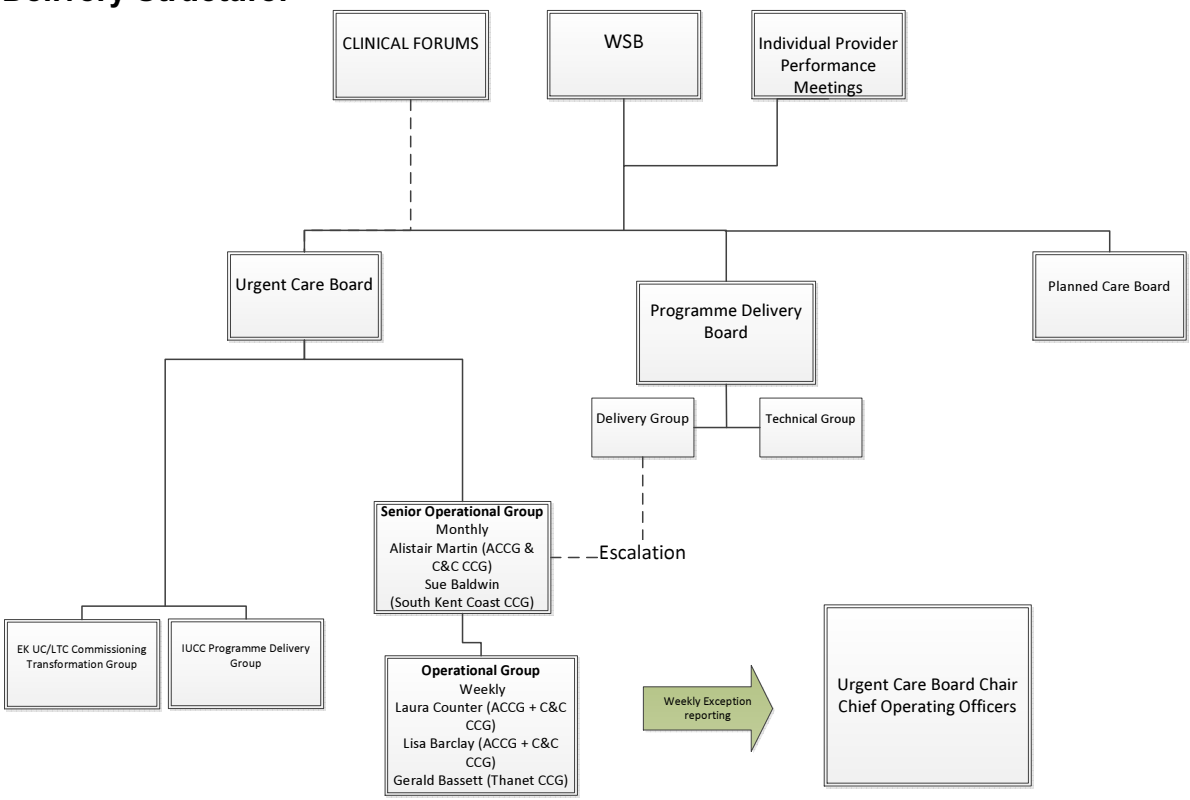
The Team Structure is outlined below:



The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners
Ashford CCG
Canterbury and Coastal CCG
South Kent Coast CCG
Thanet CCG
Providers
Kent County Council
East Kent Hospitals University Foundation Trust
Kent Community Healthcare Trust
Kent & Medway Partnership Trust
South East Coast Ambulance Service
Intermediate Care 24 Ltd
Invicta Health
Delivery Structure:



The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Transforming Urgent and Emergency Care services in England (Sir Bruce Keogh, 2013)
Urgent and Unplanned Care: Operational Resilience and Capacity Planning for 2014/15 (NHS England, 2014)
Costing 7 day Services: The Financial Implications of seven day services for acute and urgent services and supporting diagnostics (Healthcare Financial Management Association (HFMA), 2013)
The Diseconomies of Queue Pooling: An Empirical Investigation of Emergency Department Length of Stay (Harvard Business School, 2014)
East Kent Integrated Urgent Care Centre Strategy (East Kent Hospitals University Foundation Trust, 2013)

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Key deliverables:

- Reduction in Admissions: - 3 patients per day per site
- Reduction in Reportable Delayed Transfers of Care (DTOC): - 30% reduction on last year
- Reduction in 0-7 day unplanned re-attendance rate (3% reduction)
- Reduction in <28 day LOS by 0.5 days
- Increase in early morning discharges (plan 10 by 10:00 to ensure throughput to new Medical Assessment area)
- Discharge Rate at Weekends (20% improvement)

Enabling KPI

- GP in A&E Productivity/Utilisation to increase from 1.2 Pts per hour to 4 Pts per hour

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Key performance indicators will feed into a live urgent care dashboard from October 2014

What are the key success factors for implementation of this scheme?

- 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;
- Reduced duplications across the health and social care system;
- Reduce delays in provision of care
- Reduce long term admissions to care homes
- Reduction in A&E waiting times
- Reduction in Ambulance Conveyances to Hospital
- Improvement of Emergency Access Standard
- Reduction in Acute Hospital Length of Stay
- Reduction in 0-7 day Acute Hospital re-attendances

Ashford and Canterbury Clinical Commissioning Groups

Scheme ref no.

Scheme name

Support for Care Homes

What is the strategic objective of this scheme?

To support the reduction in A&E attendances and unplanned admissions for care home residents (nursing and residential).

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?

- Which patient cohorts are being targeted?

The services provide specialist assessment, advice and treatment to older people in care homes (nursing and residential). The models differ slightly in each locality, an overview of each is provided below;

Ashford:

Funding supports the employment of a Community Matron, available 8am-8pm 7 days a week and 8pm-8am 7 days a week via an on call bleep for advice only, and a Community Geriatrician available in office hours (9am-5pm Monday to Friday). The Geriatrician job plan includes the provision of a Community Geriatric Assessment clinic.

New care home admissions, residents who have been discharged from hospital, and those with perceived high risk of unplanned emergency attendance will be identified and referred to the Community Matron Team to arrange a visit, commence assessment and future planning. The Community Geriatrician and Matron Team work together to ensure individuals are assessed in their care home or own home, with a view to assessing their health and care needs and where appropriate initiate anticipatory care plans with clients and relatives. By working with care home staff, it is anticipated that this will continue to improve confidence in managing frail older people in the community.

Fixed, daily sessions of Consultant Geriatrician time will be provided for domiciliary assessments of care home residents

Weekly outpatient clinics will be provided enabling the removal of secondary care outpatient activity into the community. The clinics will be accessible by care home residents and GP referred complex elderly patients living within their own homes providing care closer to home.

Canterbury:

Community Geriatrician is funded to provide joint visits to care homes (nursing and residential) with Community Matrons, GP, Clinical Nurse Specialist for Care Homes and Medicines Management. Medical Management Plans are put in place for patients referred to the service.

There is also a 7 day a week Community Matron on call service. The Community Matrons proactively call the top ten care homes, as identified by the Care Home Dashboard, between 5-7pm to ask if there are any issues the care home needs support with.

Investment has recently been provided to allow the Neighbourhood Care Team to provide locality focused advice and treatment for the care home community 7 days a week, with a pro-active on call service being available for care homes 8pm-8am, Monday to Sunday

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

- Rachel Grout/Lisa Barclay - Commissioning Project Manager Ashford/Canterbury and Coastal CCG
- Sue Luff - Head of Commissioning Ashford CCG
- Dr Caroline Ruaux – GP and Clinical Lead Ashford CCG
- Dr Geoff Jones – GP and Clinical Lead Canterbury and Coastal CCG
- Kirstie Willerton - Commissioning Officer, Accommodation Solutions, KCC
- Francesca Sexton - Commissioning Officer, Accommodation Solutions, KCC
- Paula Parker – Commissioning Manager, Community Support, Strategic Commissioning, KCC

Providers:

- GPs
- East Kent Hospitals University Foundation Trust (EKHUFT)
- Kent Community Health NHS Trust (KCHT)

- South East Coast Ambulance Service (SECAmb)
- Local Care Homes

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Frail older people with multiple comorbidities are at risk of health and functional decline. They have high health and social care requirements that require detailed assessments. Such individuals are at risk of unplanned admission and readmission to hospital. Projections from office for national statistics show a rise in all age groups over the next 5 years with the largest percentage rises occurring in the 65+ age group (16%) resulting in additional pressure on local urgent services.

Analysis of activity data in relation to care homes in 2012 demonstrated that over 40% of patients who were transferred to Accident and Emergency for urgent review were discharged back to the care setting for continuation of their current care package. In addition the majority of transfers occurred out of hours.
The initial investigation highlighted that care homes felt that they had no alternative option due to lack of anticipatory care planning, lack of advice out of hours and whilst GPs were assigned to undertake medical services within the care home they do not necessarily have the depth of knowledge in relation to care of the elderly patients. The community matron did have responsibility for the care homes but did not work beyond 5pm.
There was also evidence that the readmission rate for care home patients was above 20% due to lack of robust care plans.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total expenditure:

Canterbury and Coastal CCG - £135,000
Ashford CCG - £160,000 (Community Geriatrician and Community Matron)

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

To improve care for patients in care homes (both nursing and residential)

- Reduction in avoidable A/E attendances in care home residents.
- Reduced admissions for care home residents
- Support and education for care homes in the management of frail older people.
- Improved communication streams between secondary, community and primary care.
- Improved satisfaction and quality of care for care home residents and complex elderly patients living in their own homes
- Support to GPs in managing complex elderly patients

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

A&E and admission data will be reviewed on a monthly basis to identify admission avoidance against pre agreed criteria.
The project reports into the joint CCG and KCC Health and Social Care Operational Group for Care Providers (Adults), this feeds into the Integrated Commissioning Group, a

sub-group of the Health and Wellbeing Board.

What are the key success factors for implementation of this scheme?

- 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.

Ashford and Canterbury Clinical Commissioning Groups

Scheme ref no.

Scheme name

Falls Prevention and Management

What is the strategic objective of this scheme?

The Kent Health and Wellbeing Board have agreed a framework which promotes an integrated multi-agency, multidisciplinary service for the secondary prevention of falls and fractures and is based on a recommendation made by the Department of Health (DH 2009) for developing an Integrated Falls Service. The overall aim of the proposed 'framework' is to focus on objectives 2 and 3, and improve the quality of life for local 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

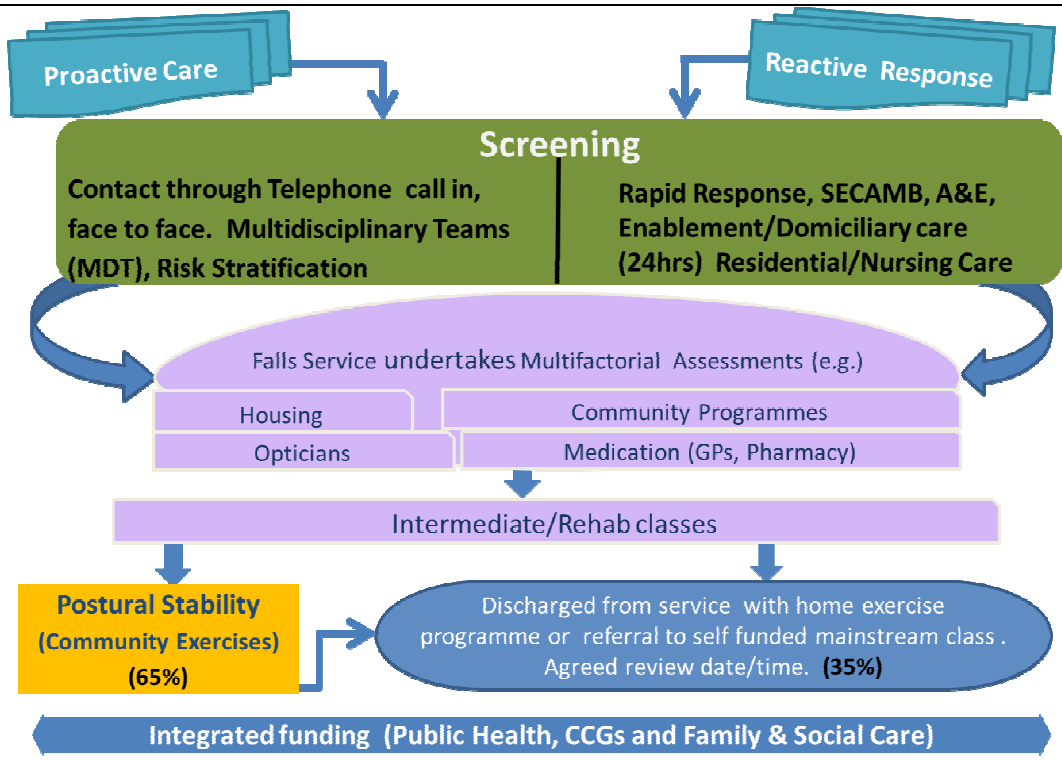
Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The intention is to work with partners to develop an integrated multi-agency, multi-disciplinary falls service across Ashford and Canterbury. This will focus predominantly on those aged over 65 years.

The Kent Health and Wellbeing Board have agreed a framework which promotes an integrated multi-agency, multidisciplinary service for the secondary prevention of falls and fractures and is based on a recommendation made by the Department of Health (DH 2009) for developing an Integrated Falls Service.



The 'framework' covers the entire spectrum across a range of stakeholders including acute trusts, community health trusts, CCGs, adult social services, district authorities and voluntary organisations.
Considering the guidance from NICE and the National Service Framework, the framework 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
3. Use of standardised Multifactorial Falls Assessment and Evaluation tool
4. Availability of community based postural stability exercise classes
5. Follow on community support for on-going maintenance closer to home
These interventions should be available as a "core offer" for the population if we are to see a reduction in the number of falls related hospital admissions and reductions in numbers of older people living in residential care as a result of falls.
A scoping exercise has been undertaken to review the existing pathways (re-active and pro-active) and services identifying what works well, what requires further development and gaps in existing provision. The outputs of this will be reviewed by the falls task and finish group to support the move to an integrated service.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

- Rachel Grout – Commissioning Project Manager Ashford CCG
- Laura Counter – Commissioning Manager Canterbury and Coastal CCG
- Dr Neil Pilai, GP and Ashford CCG Clinical Lead
- Paula Parker – Commissioning Manager, Community Support, Strategic Commissioning, KCC
- Dave Harris – Commissioning Officer, Community Support, Strategic Commissioning KCC
- Martin Field - Commissioning Officer, Community Support, Strategic Commissioning KCC
- Karen Shaw – Public Health Programme Manager, Public Health, KCC

Providers:

- GPs
- East Kent Hospitals University Foundation Trust (EKHUFT)
- Kent Community Health NHS Trust (KCHT)
- South East Coast Ambluance Service (SECAmb)
- Integrated Care 24 (IC24)

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Both health and social care organisations are facing unprecedented challenges. Evidence has shown that a lot of falls, especially amongst the older population can be prevented provided at risk individuals are identified from the first fall, with infrastructure in place to prevent a second fall.

The current system is uncoordinated and requires integration across stakeholders. The financial constraints which exist across all organisations require an urgent need to use existing resources more effectively.

A scoping exercise identified the following issues and gaps in existing provision:

- Lack of falls prevention pathway
- Lack of Fracture Liaison Service
- Improved integration needed with South East Coast Ambulance Service (SECAmb)
- Improved integration and working needed with Kent Fire and Rescue Service
- Lack of pathway with Housing linking into falls service
- No concrete links to Pharmacies and GPs especially around medication reviews
- No links with Opticians for eyesight reviews
- Low GP referrals into falls services
- Training

Both NICE and National Service Framework (NSF) for older people recommend the prompt delivery of multifactorial assessment and interventions to be delivered by a specialist falls and fracture prevention service working closely with primary care and social care professionals.

Nationally the NHS Confederation (2012) suggests that a falls prevention strategy could reduce the number of falls by up to 30% and that effective falls prevention schemes can be implemented at little cost with the involvement of professionals working in health, social care and in the community. The report further suggests that prevention by one partner can create efficiencies for others and that when addressing falls and fractures, health and social care organisations should be encouraged to align their own budgets to support joined-up working in this area.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The overall aim is to improve the quality of life for residents (particularly over the age of 65 years) and to lessen the burden of ill health related to falls.

The outcomes of this service will be to;

- Minimise duplication of existing services, to maximise the use of existing resources
- Ensure service delivery is in line with National Guidance and is evidence based
- Ensure equity of provision
- Improve access to services

- Reduce hospital admissions related to falls by preventing the patient from having a second fall
- To reduce the number of health and social care activity related to falls and fracture in older people
- Improve patient experience of services
- Improve outcomes for patients

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Outcome measures will be identified in conjunction with the development of the pathway and supporting business case.
The project reports into, and is monitored by, the Integrated Commissioning Group a sub-group of the Health and Wellbeing Board

What are the key success factors for implementation of this scheme?

- Reduction in hospital admissions related to falls by preventing the patient from having a second fall
- Reduction in the number of health and social care activity related to falls and fracture in older people
- Improved patient experience of services
- Improved outcomes for patients
- Reduction in hip fractures;
- Improve patient experience and levels of self management;
- Reduced A&E attendances.

Ashford and Canterbury Clinical Commissioning Groups

Scheme ref no.

Scheme name

Mental Health

What is the strategic objective of this scheme?

Through provision of integrated services patients will be able to access coordinated mental health service provision ensuing that the pathway is designed to have maximum input from prevention to treatment.

Overview of the scheme

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:

- 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 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
- 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 community;
- 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

The delivery chain

Sue Scammel Mental Health Commissioner KCC
Jacqui Davies Mental Health Commissioner Kent & Medway Commissioning Support Unit
Ian Reason Commissioning Project Manager Ashford CCG
Kent Police
Kent and Medway Partnership NHS Trust
East Kent Hospitals University Foundation Trust

The evidence base

Closing the Gap DOH 2014
Kings Fund Making the Case for Family Networks 2014
Kings Fund Lesson from Mental Health 2014
Kent Health and Wellbeing Strategy

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

The delivery of mental health pathways will incorporate integrated service delivery to manage the full range of the patient’s pathway from prevention to medical intervention. This will support patients with their needs across their support network and social needs

Feedback loop

The projects will report into the Integrated Commissioning Group which is a sub group of the Health and Wellbeing Board

What are the key success factors for implementation of this scheme?

- Reduced emergency admissions;
- Reduced A&E attendances;
- Improve patient satisfaction and well-being;
- Increase levels of patient self management of long term conditions;
- Increase levels of patients with personal health budgets and integrated budgets;
- Improve health outcomes by better use of prevention services.
- Increase in number of patients returning to their normal daily activities

Ashford and Canterbury Clinical Commissioning Groups

Scheme ref no.

Scheme name

Health and Social Care Housing

What is the strategic objective of this scheme?

To ensure that development of Health and Social Care Housing schemes are developed in partnership across the health and social care economy. This will facilitate the ability to maximise the benefits of the facility through access to focused health provision

Overview of the scheme

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.

There are several housing projects in various stages of development. The largest of these are focused on elderly and homeless patients.

It is proposed that the facility for elderly patients will support the ability to provide site based health delivery to include the primary care, consultant geriatrician and the wider integrated team.

The homeless facility will be supported by the integrated team and will include primary care, social services, mental health and voluntary agencies. The team will ensure that all residents are fully assessed and where required implement a plan to manage the complex care needs of this patient group

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;
- Flexible housing schemes locally;
- Increased provision of extra care housing locally;
- More supported accommodation for those with learning disabilities and mental health needs

The delivery chain

Paula Parker Commissioner KCC
Sue Luff Clinical Commissioning Group
Ashford Borough Council
Canterbury City Council

The evidence base
District Council Housing Strategy documents the importance of ensuring that new developments incorporate services to meet the needs of the residents. Kent Health and Wellbeing Strategy
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme
The schemes will ensure that residents received both health and social care using pathways that address all of the issues. Through a coordinated approach this will support the dependence upon health services
Feedback loop
The projects will report into the Integrated Commissioning Group which is a sub group of the Health and Wellbeing Board
What are the key success factors for implementation of this scheme?
Delivery of services at point of facility opening. • 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 planning. • Reduced residential care admissions; • Reduced care packages

Ashford and Canterbury Clinical Commissioning Groups
Scheme ref no.
Scheme name
Integrated Health and Social Care Teams
What is the strategic objective of this scheme?
To implement new ways of working which will ensure that the service delivery is a joint service across health and social care thereby facilitating the ability to shift care from secondary to community.
Overview of the scheme
Through reducing the current division across health and social care this will support the ability to implement services which are delivered by one team sharing their skills and competencies to reduce duplication and unnecessary interventions from multiple agencies. The impact of this is that patients will be supported within their own care environment as the norm • 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, the Health and Social Care Co-Ordinator, 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 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.
- 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.

The delivery chain

Paula Parker Commissioner KCC
Sue Luff/ Lisa Barclay Commissioner Clinical Commissioning

The evidence base

Kent Health and Wellbeing Strategy
A New Settlement for Health and Social Care, Kings Fund 2014
Community Services – How they can transform care, Kings Fund 2014

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Delivery of pathways meeting both health and social care needs through an integrated team. Patients will be supported to manage their own needs and where intervention is required this will be delivered through community based services as an alternative to

secondary care
Feedback loop
The projects will report into the Integrated Commissioning Group which is a sub group of the Health and Wellbeing Board.
What are the key success factors for implementation of this scheme?
• 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 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

North Kent Clinical Commissioning Groups

Scheme ref no.

1

Scheme name

Integrated Primary Care Teams – iPCT's

What is the strategic objective of this scheme?

The Joint Strategic Needs Assessment (review at January 2014), and local modelling confirms a number of key issues across North Kent which the development of Integrated Primary Care Teams (IPCT's) are expected to improve:

- There is a significant increase in the older population – by 2020 there will be a 34% increase in people over 85 years in DGS and 22% increase in Swale (with an overall increase in the population by 8% and 4% respectively).
- There is emerging significance of the importance of patients who have multiple morbidities which impact more and more on our health and social care services. The latest risk stratification analyses indicate that the highest intensive users (approximately 5% of the population) of hospital services are mostly elderly patients with complex needs and multiple morbidities. These patients represent almost 60% of the total unscheduled hospital admission spend for the CCG's.
- While the current Kent Health and Wellbeing Strategy is under review, it outlines the following expected outcomes which underpin the rationale for IPCT's:
- Effective prevention of ill health by people taking greater responsibility for their health and well-being – these plans aim to support people to take responsibility by providing appropriate information, advice and signposting.
- 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.

These two significant strategy documents underpin the two and five year strategies for the CCG's.

The challenge for health and social care nationally is predominantly 2-fold:

- Resources, both financial and human are finite and require further efficiency gains
- The number and complexity of morbidities within, particularly, the elderly population are increasing year on year. This is however, true for all age groups with long term conditions.

The response to this cannot be to keep doing more of the same and the need to completely revise the way health and care services are offered has been accepted for a number of years. The need has become more acute and real action is required now to facilitate that change.

The challenge across the North Kent health and care economy has been set to reduce non-elective admissions by 10% at Darent Valley Hospital in 2014/15 with a further 5% reduction in 2015/16. Similar aspirations are expected at Medway Hospital. Plans are in place to achieve this target using the Better Care Fund programme to support the change. A number of projects have been established under the BCF banner to achieve the aims associated with it of which integrating primary health care teams is one.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The vision for community based care delivered by integrated primary care teams is that it should be centred round the patient with the GP as the named accountable person. The teams themselves should be grouped around this construct and developed to work in an integrated, multi-disciplinary model. In order to facilitate this, there needs to be a new framework in place for the team, which has the relevant staff 'allocated' to practice populations.

To that end the iPCT's are being developed around a combined practice population or neighbourhood of c20-40,000. This figure enables the team to remain small enough to promote good relationships but to provide the resilience and flexibility needed to operate effectively when dealing with annual leave, sickness and training absences.
Success of the teams will be reliant on the following:

- Effective communication and relationships between all team members
- Core membership commensurate with the demographic and local needs
- Skills and competence of the team members
- Effective coordination and care planning
- Effective and robust operation within pathways for secondary and tertiary healthcare and also out of hours services

Whilst there is no absolute requirement for primary care itself to re-structure or to adopt different organisational structures to support the iPCT's, there are a number of options which may want to be considered by some practices. Work undertaken by the Kings Fund specifically suggests that this may support the development of primary care more generally and improve the quality of care provided. These are detailed in the draft Primary Care Strategy, which is currently in development for DGS CCG and one for Swale CCG. However, for the purposes of developing and testing out the right configuration of the iPCT's, the current plans are proposed around the current practice configuration.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

As the iPCTs will be multi-disciplinary teams the members of the teams will be commissioned by a number of commissioners and from various provider organisations. Essentially it will be delivered as follows and under existing contractual arrangements:
DGS & Swale CCG's will commission:

- District Nurses and Matrons from Kent Community Health NHS Trust
- Community MH Nurses from Kent & Medway Partnership NHS Trust
- Palliative Care Nurses from Ellenor Lions Hospice (DGS only at this stage)
- Outreach acute, specialist services from Dartford & Gravesham NHS Trust and Medway Maritime NHS Foundation Trust
- Paramedic Practitioners from South East Coast Ambulance NHS Foundation Trust

NHS England will commission:

- Primary Care services

Kent County Council will commission:

- Care services
- Voluntary and carer services

DGS & Swale CCG's have jointly secured external consultancy support to lead the project with accountability to the CCG Accountable Officer for delivery. The Programme Manager works within the programme governance and is responsible for presenting

regular reports on delivery of the project plan and the agreed KPI's. The project itself is managed through the iPCT Working Group which reports into the Integrated Operational Commissioning Group and has representatives from all member organisations.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The concept of iPCT's is not new and has been implemented and further developed quite widely nationally and internationally. As such there is a wealth of evidence which supports such an approach and has demonstrated a positive impact in terms of avoided admissions, reduced length of stay and improved patient experience. The models from which local plans have been drawn include those in Torbay, Devon and Canterbury in New Zealand.

References to their work can be located at:

1. March 2011. The Kings Fund. 'Integrating health & social care in Torbay: Improving care for Mrs Smith'
2. September 2013. The Kings Fund. 'The quest for integrated health a social care. A case study in Canterbury, New Zealand'

In addition close watch is being kept on Pioneer projects nationally, in particular the work in inner North West London. As more evaluation becomes available any learning will be applied to the Nth Kent approach.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The impact of this scheme will be measured accordingly to the project KPI's which are listed below Dashboards tracking the local metrics are being developed and will be monitored by the Executive Programme Boards for DGS and Swale:

Category	Group	Sub-group
Pt experience	Improvement in patient reported outcomes	People report system is not as complicated
		People report no delays in referral or assessment
		People report being treated with respect
		People report being involved in the development of their care plan
		People know name of their Care Coordinator
		People know how to access care and advice from team members
		People feel supported in the management of their condition
	Reduced admissions	

	related to their LTC	
Team Operation	Team establishment	Team configuration & establishment agreed
	Referrals made via the SPA	Actual number of referrals
		Reduced time from referral to first assessment visit
	MDT meetings	Dates and times agreed and set
		Evidence of meetings taking place
		Attendance for all members
		Care Coordinator reports access to specialist advice
		Practice based telephone advice line in place & operational – others
	Staff satisfaction	report improved communication within the team
		report improved morale amongst team
		report enhanced ability to provide a good quality service
Clinical Quality	Integrated Care Plans	in place for all patients on the caseload
		shareable and shared across all members of the team
	Risk stratification tool	applied monthly and reports shared with the team
		at risk patients discussed at MDT's

Using a risk stratification approach the 'at risk' patients will be identified enabling proactive management of individuals by all members of the iPCT as appropriate to the care required. This proactive involvement by the team will reduce the number of crises experienced by patients and a resultant early deterioration in their general health and wellbeing.

The contribution of these metrics to the overall BCF Programme for North Kent will be in terms of the contribution to avoiding hospital attendances from which might result an admission and the provision of a community based support infrastructure will enable a speedier discharge. These in turn will enable people to stay supported in their own homes for longer and thus reduce the number of admissions into long term care.

What are the key success factors for implementation of this scheme?

The local and care environment will need to ensure the following for this scheme to succeed:

- strong governance arrangements are in place to ensure senior level commitment and support
- a full and transparent approach to joint working, sharing resources and enabling delegated assessment and decision making powers within teams
- a pooled budget in support of the above
- a joint commitment to developing and retaining good staff to ensure sustainable services in a notoriously 'hard to recruit to' area.

Evidence elsewhere has been that a significant local imperative has been the key to innovative and true joint working. In Torbay it was a severely financially challenged local authority, in Canterbury NZ, it was an earthquake, In North Kent a similar outcome

needs to be achieved based on learning from best practice elsewhere, whatever the catalyst.

North Kent Clinical Commissioning Groups
Scheme ref no.
2
Scheme name
Integrated Dementia Care
What is the strategic objective of this scheme?
To establish an effective integrated care pathway for people with dementia. The ageing population in North Kent will continue to place significant financial challenges on the care system with an increase in the number of people with long term conditions, the concomitant increase in dementia and a subsequent increase in carers and the people they care for experiencing crisis situations. People with dementia and their carers need a range of services, some of which will be dementia- specific and others which will be more mainstream in nature. These services need to respond well to people affected by dementia and in the main meet their needs within the home environment where possible, If people do need a hospital admission effective joint care planning is essential and better cross-organisational and inter-organisational working to improve discharge planning is essential. The development and implementation of an integrated care pathway for people with dementia will see their needs assessed through a framework of care management and coordination that ensures delivery of health and social care services by means of a combined shared care plan. The integrated care pathway is being jointly developed by health, social care and voluntary organisations within North Kent to provide guidance about effective services and interventions that deliver outcomes for people living with dementia and their carers from early diagnosis and throughout the course of the condition. Transformation of dementia care within North Kent to a multi-disciplinary, multi-agency planned approach to the delivery of care and support for people with dementia and their carers will provide improved access to resources and services throughout the course of the disease. Effective joint care planning and crisis management will reduce the use of more intensive, higher cost services and incur a delay in the need for more intensive services in the later stages.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
At the present time there are various aspects regarding service provision for people with dementia that requires changing to ensure continuity of patient care and an effective pathway for patients from earlier diagnosis, integrated service provision within the community, effective crisis management through to end of life care. The dementia programme focuses on three elements of the pathway which will have the highest impact in reducing admissions to acute hospitals, all of which are designed to improve the experience of people with dementia as we progress to establishing a fully integrated care pathway.

Effective co-ordinated care will be introduced by establishing mental health nurses within Integrated Primary Care teams based around practice populations of 30,000 people.

Mental health expertise will become an integral function within Integrated Primary Care teams to provide post diagnostic support and effective case management for people with dementia in the community. The ambition is to treat dementia under the long term condition model of care where a person's needs are treated holistically factoring in physical and mental health needs together where services are responsive to individual need and carers are supported through the journey with dementia. The Integrated teams will support the management of the higher risk stratified population and caseloads for dementia currently in Cluster 18 and 19.

A crisis service for people with dementia and their carers will be jointly commissioned by Kent County Council and North Kent CCGs and procured through the voluntary sector. The service will provide a short term rapid response to a physical and/or mental health crisis through intensive support and home treatment more often than not due to an escalation in difficult behaviour that results in carer breakdown and risks unplanned admissions to hospital or care homes.

This will be achieved by shifting current resources to improve care coordination, improve access to services, and provide greater support to carers by reducing inefficiencies and duplication without significant infusion of financial resources and subsequently reduce the use of more intensive, higher cost services.

An acute hospital bridging service provided by a specialist dementia voluntary sector organisation has been established to work within the Integrated Discharge Team. This will optimise effective client transfer to avoid admissions where it is safe to do so and to facilitate timelier discharge operating a 'pull' system via a single point of case management. The service will support people with dementia or other cognitive impairments by the provision of short term care support services to re-establish the patient in the community, including support to family carers, to allow time for decision making by health and social care for their future long term care needs if required.

All three initiatives are underpinned by integrated working between health, social care and the voluntary sector and the development of the shared care plan.

Commissioners and Providers are working together to develop local policies and protocols embedded within the shared care plan which cross professional boundaries to focus on meeting the needs of people with dementia within the community.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This service will be part of the wider multi-disciplinary iPCT's and the members of the teams will be commissioned by a number of commissioners and from various provider organisations.

Essentially it will be delivered as follows and under existing contractual arrangements:
DGS & Swale CCG's will commission:

- Community MH Nurses from Kent & Medway Partnership NHS Trust

NHS England will commission:

- Primary Care services

Kent County Council will commission:
- Care services
- Voluntary and carer services

DGS & Swale CCG's have jointly secured external consultancy support to lead the project with accountability to the CCG Accountable Officer for delivery. The Programme Manager works within the programme governance and is responsible for presenting regular reports on delivery of the project plan and the agreed KPI's. The project itself is managed through the integrated Dementia Working Group which reports into the Integrated Operational Commissioning Group and has representatives from all member organisations.

DGS CCG has commissioned the Alzheimer's and Dementia Support Service to work with the Integrated Discharge Team based within Darent Valley Hospital. The Integrated Discharge Team is collaboration between DGS CCG, Darent Valley Hospital and Kent Community Healthcare.

A change in approach to crisis management will be required and joint working is already taking place between the CCG and Kent County Council. Kent County Council short breaks for carer's contract started on November 2013 continuing through to 31st March 2016 (18 months plus an additional year extension). The service builds on the objective of the current crisis service and moves to a more holistic and proactive approach to preventing crisis' arising focusing on the capacity and capability of carer to continue their caring role, alongside building greater links with existing services. The CCG can access the contract through expanding the scope of the existing Section 256, allowing CCG transfer of a corresponding allocation to KCC buying into the service outlined in the service specification.

The development of the Integrated Care Pathway for dementia is a collaborative planning process working in partnership with:
- DGS/Swale CCG
- GP Dementia Clinical Leads
- Darent Valley NHS Trust
- Kent and Medway Partnership Trust
- Kent Community Healthcare Trust
- Kent County Council
- Crossroads Care
- Alzheimer's and Dementia Support Services

Dementia Leads from all listed organisations participate and take forward specific tasks within their respective organisations**.**

The evidence base

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There are numerous examples of evidence for the improvement and development of consistent high quality care for dementia that has influenced the service transformation within North Kent most notably:

National Strategies
- Department of Health (2009), Living Well with Dementia: A National Dementia Strategy

- Dementia: A NICE–SCIE Guideline on supporting people with dementia and their carers in health and social care, National Clinical Practice Guideline
- National Audit Office (2007), Improving services and support for people with dementia. London: TSO.
- Alzheimer's Society (2008), Out of the Shadows. London: Department of Health.
- Department of Health/Care Services Improvement Partnership (2005), Everybody's Business – integrated mental health services for older adults.
- The National Dementia Declaration (Alzheimer's Society, 2010)

There are a number of areas within the UK that have implemented the same approach to dementia care and the evidence has been recognised nationally as good practice and improving overall outcomes for people with dementia and their carers. Although service provision cannot always be replicated exactly the main driver of integrated care for dementia has provided the catalyst to base our joint plans around the needs of the person with dementia.

The models that have proved beneficial in improving care for people with dementia and influenced service redesign and pathway development are:

- South Devon Partnership Integrated Care Pathway for dementia
- Healthcare for London Dementia Services Guide: Integrated Care Pathway
- Torbay Care Trust – Integrated Care for Older People

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

In North Kent we have a number of active forums that have been the vehicle for delivering changes in the dementia pathway. These are listed below:

- Dementia Strategic Oversight Group (People with dementia and Carers)
- Dementia Forums
- Kent Dementia Action Alliance
- Practice Participation Groups
- Dementia Friendly Communities forums

The feedback from people living with a dementia type illness and people who care for them .gives a valuable insight into the perceptions of the local community as well as their ideas on how to improve things.

Many of those who had either first hand or experience as a carer of someone with a dementia type illness expressed concern about how there is no obvious pathway to guide those affected. Some people had struggled to manage and cope, often only getting assistance at a crisis point.

This is reinforced in the Dementia in Kent 2010, Public Health Annual Report which highlighted that 37% of admissions of patients with dementia resulted from patient and/or carer being unable to cope (in conjunction with fall with no bone injury, poor mobility and/or increased confusion). This is supported by results released by Kent County Council (Personal Social Services Research Unit, 2008) highlighting that carer breakdown was a contributory factor in 31% of all care home admissions.

We will continue to work with these groups and the improvements will be evaluated by

the use of questionnaires to both staff within the hospitals and community services and families of people with dementia.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

A range of key performance indicators will be developed for regular monthly reporting, and there will be monthly meetings between the commissioner and provider to monitor performance against these. Baseline measures on all indicators will be collated to accurately measure quantifiable benefits. A central database has been developed to enable regular monitoring of performance and activity against agreed key indicators, assist resource planning, support service audit (e.g. equity of service) and evaluation. The metrics for monitoring the impact of the integrated care pathway are contained in service specifications and information is provided on a monthly basis to measure the success of the contract and to control spend and measure savings. The metrics form part of an overall dashboard measuring achievement against all BCF projects to achieve a 10% reduction in admissions to Acute Hospitals and support the key performance indicators relating to the Integrated Discharge Team and Integrated Primary care teams in reducing unplanned admissions and reducing lengths of stay and includes the following:

Metrics for dementia service improvements include:

- Reduced lengths of stay for non-elective >65s
- Reduction in admissions to Acute Hospital for people with cognitive impairment
- Reduction in the number of patients presenting monthly at A&E with cognitive impairments
- Reduction of crisis episode
- Reduction in people progressed to permanent support (Residential/Nursing care)
- Increase in dementia diagnosis rate to 60% predicted prevalence25% people with confirmed diagnosis of dementia with a shared integrated care plan

To assess the qualitative impact of the service improvements, patients, carers and staff (managerial and clinical) views will be sought to help shape the services, develop the protocols and meet the needs of the community whilst operating to national frameworks and standards. Each provider must complete regular surveys, act upon the results, feedback to the patients and provide opportunities for patients to become involved in service improvement.

Systems are in place to involve the following stakeholders in the ICP development process:

- multi-agency and multidisciplinary workforces (including advocacy services and
- voluntary organisations)
- service users, and
- informal carers.

What are the key success factors for implementation of this scheme?

The development of the Integrated Care pathway follows the 8 pillars of care from raising awareness through to early diagnosis, living well in the community to end of life care. The pathway will be developed in a phased approach with the initial phase focussing on integrated community care establishing mental health expertise in Integrated Primary care teams in the community, effective interventions in times of crisis and timelier discharge from acute hospitals by the provision of home care, night sitting

and support for the carer.

The three areas of initial focus were identified from collaborative working between health, social care, Acute hospitals, Community services and voluntary sector organisations. A process mapping exercise was conducted in the early stages of the ICP development to:

- identify current patterns of service delivery and available resources
- examine the journey of care for service users and informal carers
- establish the strengths and weaknesses of current service provision
- quantify demands on the services
- identify the gaps in services
- identify gaps in staff skills and competencies, and
- identify how the journey of care can be improved

A range of case studies highlighted gaps and fragmentation within the current system
Agreement was reached on a number of service improvement standards and the introduction of revised processes as people move through the care system.
The introduction of a fully operational service user held care plan shared between agencies underpins the development of the integrated pathway.

North Kent Clinical Commissioning Groups

Scheme ref no.

3a

Scheme name

Integrated Discharge Team, Medway and Swale

What is the strategic objective of this scheme?

Our vision for health and care services is to deliver the right care at the right time in the right place, providing seamless integrated care for patients, particularly those with complex needs.

Evidence shows that patients with complex needs often stay longer than necessary in an acute hospital bed. By providing appropriate care outside of the acute hospital setting, patients can be discharged more timely and supported in the community, in or as close to their homes as possible, with effective personalised care plans.

To deliver our vision, the strategic objective of the Integrated Discharge Team (IDT) is to facilitate safe, timely discharge while reducing emergency admissions by working to a 'home is best' philosophy.

The service delivers a multi-agency approach to facilitate discharge for complex patients from acute care whilst ensuring:

- The best possible outcome for the patient
- Timely access to a range of community based health and social care services
- Optimum use of acute/community and social services resources.

By working with the 'home is best' principle, the IDT ensures patients are discharged home, wherever possible, with the appropriate care package to maximise independence and empower people to manage their own health and wellbeing.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The Integrated Discharge Team (IDT) was introduced towards the end of 2013 to support complex discharges at Medway Foundation Trust. This is a multidisciplinary team comprising of health and care professionals working together to facilitate safe and timely discharges for patients with complex needs, 7 days a week.

The team brings together the Community Navigation Team, Social Care Teams, Rapid Response, Community Nursing, Hospital Discharge Team, Acute Fragility and the Swale In-Reach Team.

The population focus is mainly, but not restricted to, those over the age of 65 with one or more long term condition, with the aim of facilitating 15 discharges per day. Providing a 7 day service, this equates to 5475 per year.

The aim of the IDT is to:

- deliver a multi-agency approach to facilitate timely discharge for patients whilst ensuring the best possible outcome
- provide optimal care packages in the community to support patients on discharge in retaining independence in their usual place of residence,
- where possible
- avoid premature admission of patients to acute care and transfer them to where care can be delivered in a more appropriate environment that is conducive to patient's need. Admission to acute hospital care will not be prevented, where it is clinically required.
- avoid the premature admission of patients into long-term care, where clinically appropriate.
- reduce the number of re-admissions of patients with chronic long term conditions.

Hosted by Medway Community Healthcare, the IDT sits within Medway Foundation Trust and facilitates the co-ordinated admission, navigation and transfer of care across the Medway and Swale health economy.

The team expedites all complex patient discharges across all hospital wards, Emergency Department (ED) and the assessment/observation units 7 days a week - 8.00am-8.00pm Monday to Friday, 8.00am-4.00pm weekends and Bank holidays.

The IDT is structured in three cluster teams supporting ward staff with discharge planning. A fourth cluster is responsible for the emergency wards, including A&E, Observation ward, CDU, AMU and SAU, focussing on admission avoidance, where appropriate, by assessing and implementing care packages to support a return to home with support. A physiotherapist, occupational therapist and dedicated care manager are part of the forth cluster.

Planned discharges that do not take place are reviewed and shared daily with hospital managers to understand what the delay is attributable to, enabling improvements to be identified and actioned.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The IDT is jointly commissioned by Medway and Swale Clinical Commissioning Groups

and implemented and hosted by Medway Community Healthcare (MCH). The team consists of members of staff from the following organisations:

- Medway Foundation Trust
- Medway Council
- Kent County Council
- Medway Community Health Trust
- Kent Community Health Trust

Kent and Medway Partnership Trust provide in reach mental health support.

The team is overseen by the IDT Clinical Service Lead, employed by MCH with each employing organisation responsible for the management of their staff.

The team operate within agreed criteria ensuring the whole discharge pathway is considered and patients are actively managed post discharge.

All Parties are responsible for meeting the outcomes and Key Performance Indicators set down by the CCG and work together to address all issues that arise.

Overall operational performance is reported weekly by the Operations Director of MCH through the whole system executive conference call. The weekly executive conference call, chaired by the Chief Operating Officer of the Medway Clinical Commissioning Group, has representation from all key provider organisations across Medway and Swale therefore operational issues requiring whole system input or support are addressed at executive level.

KPIs are reported on a monthly basis to the commissioners with the strategic governance of the IDT being led by the Medway and Swale Executive Programme Board.
Any operational issues requiring whole system input or awareness are reported through the weekly executive conference call.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Driven by an increasing number of delayed discharges and transfers of care from Medway Foundation Trust, a whole system discharge process planning workshop was hosted in June 2013 by Medway and Swale CCGs. The aim of the workshop was to bring together the organisations that play a role in facilitating discharge from both the acute and community hospitals. 50 delegates (operational and strategic leads) representing all key stakeholders were involved in the workshop.

Delegates reviewed the existing processes to identify the ‘As Is’, starting from the time a patient presented in the emergency department to the time of their discharge home or transfer to an alternative care setting. From this necessary steps and key actions to support effective and rapid discharge from hospital, for patients deemed medically fit, were determined.

A number of recommendations from the workshop were signed off by the Medway and Swale Executive Programme Board. Priority was given to the rapid development of single integrated discharge team, hosted by Medway Community Health Trust, working within MFT, to support proactive admission avoidance and timely effective discharge planning for complex patients.

In recent months, the Emergency Care Intensive Support Team (ECIST) have undertaken work with the local health economy both at a Trust and whole system level and continue to provide support to improve timely discharges 7 days a week.

The Emergency Care Intensive Support Team (ECIST) have undertaken work with the local health economy both at a Trust and whole system level in recent months and continue to support key whole system pieces of work.

In addition to the work with ECIST, the Oak Group were commissioned in the latter part of 2013 to undertake audits of acute (admissions and beds) and Community (beds) across North Kent. At a headline level the audits demonstrated:

Acute (patients already in a hospital bed)

- 44% of non-qualified admissions could have been prevented by providing a variety of services at home.
- 46% of all continuing days of care could have been provided at home with a variety of services
- A discharge plan was present in 37% of records.
- 95% of these were started post admission and documentation was poor.
- An estimated date of discharge (EDD) was listed for 13% of patient records.
- 41% of patients with an EDD were in hospital beyond the EDD.

Acute admissions (All patients who were admitted though A&E or the assessment units during the prior 24 hours were retrospectively examined)

- 21% could have been prevented with only GP or other routine follow-up.
- 78% of patients came through A&E of which 27% were non-qualified.
- 21% came through GP referral of which 37% were non-qualified.

An audit of A&E attendances was undertaken in August 2014, the results of which will help to identify gaps in community service provision to manage people better in the community in future.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

KPIs have been developed for the IDT which are monitored by the Urgent Care group to measure outcomes of the scheme. The agreed KPIs will enable success in admission avoidance and the discharge planning process to be highlighted and quantified.

The current measures are:

- % of patients with EDD set within 24 hours of admission
- % of patients discharged within 24 hours of planned EDD
- % of patients with DTA who have baseline assessment
- Reduction in the number of patients on the medically stable list
- % patients on medically stable list with a discharge plan Reduction in the

number of patients with a length of stay > 15 days, >30 days
- Reduction in the number of placements into social care
- Reduction in the number of readmissions
- Reduction in the number of high cost packages
- Increase in the number of early discharges facilitated by Continuing Health care

This is existing data, generated automatically, which has been reported on previously through various existing data systems.

Dashboards tracking the local metrics are being developed and will also be monitored by the Executive Programme Boards for DGS and Swale.

What are the key success factors for implementation of this scheme?

For patients, success factors are defined by improved patient experience as a result of high quality, seamless care. Being aware of and supported to work towards an expected date of discharge. Feeling supported to live at home with appropriate enablement services

Success factors for the workforce are defined by improved partnership working which breaks down organisational barriers to enable them to deliver optimum care to patients.

North Kent Clinical Commissioning Groups

Scheme ref no.

3b

Scheme name

Integrated Discharge Team - DGS

What is the strategic objective of this scheme?

The objective of the scheme is to reduce emergency admissions ensuring people are treated in the right place at the right time by the appropriate person.

There is empirical evidence that too many patients are inappropriately staying in hospital beds. It is believed that care can and should be more appropriately delivered in the community rather than in an acute hospital bed, using highly responsive, effective and personalised services outside of hospital and in or as close to people's homes as possible.

The aim of the service is to deliver a multi-agency approach to facilitate discharge for patients from acute care whilst ensuring:
- The best possible outcome for the patient
- Timely access to a range of community based health and social care services
- Optimum use of acute/community and social services resources.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

The IDT is a team made up of Nurses, Doctors, Therapists, Pharmacists, Care Managers and Mental Health Specialists working across the acute and community settings. The team operates 8am – 8pm, 7days a week.

The goal is to ensure that patients receive the most appropriate treatment, delivered by the most relevant health care worker in the most appropriate setting – all the time.

The aim of the IDT is:

- to deliver a multi-agency approach to facilitate timely discharge for patients whilst ensuring the best possible outcome
- ensure timely access to a range of community based health and social care services and optimum use of acute/community and social services resources.
- avoid the premature admission of patients to acute care and transfer them to where care can be delivered in a more appropriate environment that is conducive to patient's need. Admission to acute hospital care will not be prevented, where it is clinically required.
- avoid the premature admission of patients into long-term care, where clinically appropriate.
- reduce the number of re-admissions of patients with chronic long term conditions.

This is achieved through the following objectives:

- that Discharge Planning begins at the point of admission to acute care.
- providing ward staff with support, advice and training regarding discharge planning of both simple and complex patient discharges.
- working collaboratively with community agencies such as Intermediate Care, Continuing Health Care, Therapists, Social Services and Community Matrons to ensure patient needs have been correctly assessed and are appropriately met on discharge.
- ensuring the development of existing discharge services and transfer of care into community settings by developing key relationships with Mental Health, Alcohol Liaison Nurses, Nursing and Residential Homes and Community Nursing Services.
- providing all groups of staff with education and training with regard to discharge planning.
- developing and produce discharge information and literature for patients regarding the discharge process to assist them and prevent delays in their discharge.
- the assessment of complex patients' needs prior to discharge
- development of a "one team" approach

The population focus is mainly over 65's with 1 or more, long term condition although not restricted to.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

There is an SLA in place between all providers – see attached

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Pressure on local hospitals particularly in winter results in substandard care of patients and evidence shows that In the UK up to one million emergency admissions were avoidable last year.

Work carried out for DGS CCG by the Oaks Group in October 2013 identified that within

Darent Valley Hospital:

- 58% of acute admissions could have been avoided by providing a variety of services at home.
- 15% of acute admissions could have been provided for on sub-acute wards.
- 8% of all admissions required supported living environments.
- 36% of continuing stay days were due to discharge planning issues.
- 37% of continuing stay days could have been avoided by providing a variety of services at home.

Examples of successful Integrated Discharge teams and models of provision were identified including, Mid Cheshire, East Cheshire, Nottinghamshire and Glasgow, St Helens.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Comprehensive KPIs have been developed for this scheme and are monitored by the Urgent Care Group. Data is compiled to highlight and quantify the successes in admission avoidance. There are Whole health Economy KPIs and the IDT has a set of proxy measures that have been developed to identify success and also where the delivery model may need changing.

Current measures are:

- % of patients discharged within 24 hours of planned EDD
- Reduce number of patients on medically stable list
- Reduce patients with Length of Stay > 15 days
- % patients on medically stable list with a discharge plan
- % of patients on medically stable list with diagnosis of dementia / Mild Cognitive Impairment
- % of patients with a LoS > 15 days on the medically stable list
- % of patients reviewed by the IDT (exclude IDT GP) in A&E
- % of patients reviewed by IDT (exclude IDT GP) in A&E and discharged back to usual place of residence
- Patients seen by IDT GP
- Total number of patients seen by IDT GP appropriate for Primary Care
- Decrease in readmissions to an acute bed for same condition within 30 days
- Decrease in readmissions to an acute bed with an exacerbation of a Long Term Condition (HF/COPD/Diabetes)
- Numbers admitted to long term care

Dashboards tracking the local metrics are being developed and will be monitored by the Executive Programme Boards for DGS and Swale:

What are the key success factors for implementation of this scheme?

Success factors are defined by patient experience reporting high quality seamless integrated care, a reduction in emergency admissions and admissions to long term care.

Increase in the number of people living at home with enablement services.

South Kent Coast Clinical Commissioning Group
Scheme ref no.
1
Scheme name
Integrated Teams and Reablement
What is the strategic objective of this scheme?
Integrated teams available 24 hours a day seven days a week will be contactable through single access points. Patients will know who they should contact within these teams whenever they need advice and support. The teams will undertake single assessments and coordinate onward referrals and comprehensive care planning and will provide enhanced rapid response to patients at high risk of hospital admission providing intermediate care and rehabilitation in the community. The teams will integrate with the hospital discharge planning and referral processes seven days a week and coordinate post-discharge support into the community linking with the community based Neighbourhood Care Teams, primary care and the voluntary sector.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Integrated Intermediate Care Pathway & flexible use of community based beds • Integrated pathway to coordinate referral management, admissions avoidance and care coordination across health and social care, supported by single access points; • Integrated assessments 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); • Intermediate care provision to be provided at patients own home wherever possible by professional carers or by a multidisciplinary team of therapists and nurses; • Community hospital beds only to be used for comprehensive assessments, for patients needing 24/7 nursing rehabilitative care and for carer respite; • Community based beds (in any local setting) will provide 60% step down from hospital and 40% step up to support timely hospital discharge and prevent avoidable hospital admissions and re-admissions. These beds will be used flexibly to effectively respond to changes in demand. **Enhanced Rapid Response – supporting acute discharge/preventing readmission** • Enhanced Rapid Response teams supporting admissions avoidance as part of intermediate care provision as well as respond directly to A&E referrals; • The teams will be integrated with Emergency Care Practitioners to ensure enhanced skills are available and supporting the ability to keep sub-acute patients at home; • The teams will include medicine management support as well as medical leadership and input from hospital consultants to enable continuous support at home; • The teams will integrate with the Dementia Crisis Service which can receive

referrals 24/7 providing support 24/7 to patients with Dementia and carers of people with Dementia to prevent hospital or care home admissions.

Integrated rehabilitation & Non Weight Bearing Pathway

- Integrated approach to support timely hospital discharge, rehabilitation and intermediate care for patients including non-weight bearing patients;
- Proactive case management approach to support timely transfer of patients from acute beds into the community and preventing admissions into acute from the community;
- Integrated step up and step down beds supported by a dedicated multi-disciplinary team, including therapists, social care and primary care input, to ensure timely patient flows.

Patient Cohorts (examples of client group this scheme will target)

- Patients requiring sub-acute whose condition has exacerbated in the community (such as a fall or a UTI) or following treatment in hospital, for time limited periods who would otherwise face unnecessary prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential/Nursing care or continuing NHS inpatient care;
- Patients whose carers are in crisis;
- Patients requiring rehabilitation (Occupational Therapy or Physiotherapy) in the community or within a care home/intermediate care facility;
- Adults aged 18 and over, although primarily older people, residing in their own homes or in an intermediate care facility with the ultimate aim of returning to their own home to maximise independence and recovery including patients requiring neurological rehabilitation.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Enhanced teams will be developed through workforce reconfiguration across KCHT and secondary care. Scoping of staffing reallocation and cost savings is underway, led by SKC CCG in collaboration with service providers.

Delivered by KCHT, ambulance services, EKHFUT, KCC

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Schemes were selected based on evaluation of high impact schemes identified by the Kings Fund and other best practice evidence, supported by evaluation of Public Health England information on long term conditions and where impact would be most effective in South Kent Coast.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduced emergency admissions by 3.5%;
- Reduced A&E attendances;
- Reduced hospital admissions and re-admissions for patients with chronic long term

conditions and Dementia;
- Improve patient experience by 4%;
- Improve health outcomes;
- Reduced length of stay;
- Improved transfers of care;
- Reduced long term placements in residential and nursing home beds by 5%;
- Reduced need for long term supported care packages;
- Increase patients returning to previous level of functionality in usual environment

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The following indictors will be used to monitor success of the scheme:

- Reduce unplanned admissions by 250 through prevention of readmissions.
- Improve the step-down and step-up ratio for community hospital beds (target 60/40).
- Development of cross service clinical audit is in progress. This work will monitor multi-agency contacts to ensure effectiveness of integrated teams.
- Increase in Community Services admission avoidance (targets to be agreed)

These KPIs will be monitored by the Intermediate Care group.

What are the key success factors for implementation of this scheme?

This scheme will build on existing teams, but will redevelop fragmented pathways to create streamlined care from prevention to treatment through to end of life. Integrated enhanced services will be developed with clear and prescriptive deliverables and strengthen definitions of required skills mix within team. Providers and clinicians are currently engaged in agreement of redesigned specifications and pathways.

South Kent Coast Clinical Commissioning Group

Scheme ref no.

2

Scheme name

Enhance Neighbourhood Care Teams and Care Coordination

What is the strategic objective of this scheme?

This model builds a team around the patient who focus holistically on the patients overall health and well-being and pro-actively manages their needs. These teams will be further enhanced to ensure wider integration with other community and primary care based services as well as hospital specialists working out in the community and mental health teams to ensure people can be cared for locally and in their own homes wherever possible and using technology for virtual ward rounds or consultations and remote guidance for GPs rather than patients attending hospital. The teams will be aligned to every GP practice, will undertake Multi-disciplinary Team meetings and will include designated care coordinators for all patients.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Risk Profiling to enable Proactive Care of patients who are at both high and low risk of hospital admission to deliver more coordinated patient care in the community (see section d below for further details of the South Kent Coast Pro-Active Care Programme)

- Aligned to every GP practice the Neighbourhood Care Teams will be accessible 24 hours a day seven days a week and will coordinate integrated proactive care 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;
- The Neighbourhood Care Teams function as integrated teams and provide continuity of care for patients who have been referred for support in the community and form the main structure in providing post hospital discharge care and some pre-admission interventions as well as seamless coordination and delivery of End of Life care;
- The Neighbourhood Care Teams will form the main structure in providing post hospital discharge care and some pre-admission interventions and will be integrated with pathways to asses a patients home environment;
- Access into and out of the Neighbourhood Care Teams will be coordinated through clinically supported single access points. Patients who require assistance by more than one professional will receive coordinated integrated assessments. This single point of access will be integrated with social services and will be linked with secondary care via a flagging system to report when patients known to the teams have been admitted into secondary care;
- Each Neighbourhood Care Team will include input from the wider community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, and Social Care 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 Neighbourhood Care Team will be able to access the relevant care package required to support the person for the time required.

Specialists to integrate into community based generalist roles

- The enhanced Neighbourhood Care Team model requires specialist input from acute in the community to enable the management of care for more patients in the community for a range of specialisms (respiratory, diabetes, heart failure and COPD) 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 could include actual and remote approaches supported through the use of technology, such as video conferencing with acute specialists.

Patient Cohorts (examples of client group this scheme will target)

- Adults aged 18 years and over with long term conditions, including respiratory, diabetes, heart failure and COPD, and advising their carers;
- Patients who require general nursing input and those that are housebound.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Enhanced teams will be developed through workforce reconfiguration across KCHT and secondary care. Scoping of staffing reallocation and cost savings is underway, led by SKC CCG in collaboration with service providers.

Provided by KCHT, KCC, and GPs

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Schemes were selected based on evaluation of high impact schemes identified by the Kings Fund and other best practice evidence, supported by evaluation of Public Health England information on long term conditions and where impact would be most effective in South Kent Coast.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

- Reduced emergency admissions;
- Reduced A&E attendances;
- Improve patient experience;
- Increase levels of patient self-management of long term conditions;
- Improve health outcomes;
- Reduced spend on drugs;
- Reduced duplications across the health and social care system;
- Reduce the needs for long term placements in residential and nursing homes.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The following indictors will be used to monitor success of the scheme:

- Reduce unplanned admissions by 108 through proactive care.
- Reduction of long term placements (10)
- Increase in Community Services admission avoidance (targets to be agreed)
- Development of cross service clinical audit is in progress. This work will monitor multi-agency contacts to ensure effectiveness of integrated teams and quality of anticipatory care plans.

These KPIs will be monitored by the Proactive Care & Primary Care Groups.

What are the key success factors for implementation of this scheme?

This scheme will build on existing teams, but will redevelop fragmented pathways to create streamlined care from prevention to treatment through to end of life. Integrated enhanced services will be developed with clear and prescriptive deliverables and strengthen definitions of required skills mix within team. Providers and clinicians are currently engaged in agreement of redesigned specifications and pathways.

South Kent Coast Clinical Commissioning Group

Scheme ref no.

3

Scheme name

Enhance Primary Care

What is the strategic objective of this scheme?

- Integrated community models of care centred on GP practices requires significant change in primary care working patterns.
- Different models need to be developed to ensure the right levels of support and capacity is available within general practice and to support the development of sustainable local communities.
- This will include a primary care hub in each town linking all practices around the local hospitals that will host primary care services 7 days a week from 8am to 8pm and work closely with the existing MIU to develop integrated working.
- A pilot will commence in two towns with a view to including a 'hub' of practices in every community to improve access to a full range of local health and social care services which will support the move from a medical focused model of care and shifting towards a health and well-being focus.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

- Integration of all GP practices within a community offering extended primary care service 8am – 8pm 7 days per week, linked to the local hospital
- A GP clinical system would be installed at the hospital and consulting rooms established for GP's and nurses.
- The system would be linked via the Medical Interoperability Gateway (MIG) to all local practices and software installed to enable data entry onto multiple systems.
- An integrated telephone system would be installed that enables all practices to have calls re-directed and to offer telephone appointment booking.
- There will be an urgent visiting service provided by paramedics and supported by GP's.
- In some cases patients may be transported to the 'hub' either by paramedics or other local transport services.
- There will be primary care mental health specialist offering assessments either at the hospitals or at home. They will also provide support to GP's with mental health queries.
- The service will be available to all patients within the CCG with an aim of increasing capacity within primary care and reduce burden on acute services

Develop primary care based services with improved access and integrated with other community and specialist services

- GPs have started to undertake proactive case management of patients including regular medication reviews, proactive working with patients to avoid admissions. This will require closer working with social services working with at risk patients to avoid crisis and better use of carer support services. This could also include virtual ward rounds of at risk patients following hospital discharge;
- GP practices to be clustered in hubs and configured in a way that enables different access opportunities for patients to include open access and access to other practices in the hub to improve responsiveness of service provision;

- Develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by primary care. This will require stronger integration with the Neighbourhood Care Teams as well as stronger links with and signposting to the voluntary sector;
- Integrated primary care provision will have greater support from specialist hospital teams to ensure on-going medical care for patients after hospital discharge by creating shared on-going care plans to avoid hospitals readmissions and stronger links with rapid response services to enable patients to remain out of hospital;
- GP practices to link with the support to care homes pathways to provide more intensive support.

Primary care service will support and empower patients and carers to self manage their conditions

- Professionals in primary care 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;
- Primary care and the Neighbourhood Care Teams will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the community.
- The Neighbourhood Care Teams will educate patients about preventative services such as weight management and alcohol services as part of the multidisciplinary assessment;
- Patients will be supported by the Neighbourhood Care Teams and primary care to inform and take ownership of their care plans. Care plans have started to be shared via MIG functionality between health and social care professionals and this will be rolled out over the coming months.
- Improved signposting and education and access to 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. GPs will signpost patients with early signs of mental health concerns to the right services
- 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.
- Plans in place to implement enhancements in care for over 75's which includes anticipatory care planning for a range of cohorts: patients in care/nursing homes, patients in the community that have an ambulatory sensitive condition as well as patients that are housebound with long term conditions.

Patient Cohorts (examples of client group this scheme will target)

- All patients accessing services who have a primary care need, particularly those at risk of hospital admission and those who can self-care in the community setting.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

- The providers within this scheme are essentially our GP Practices who work as independent contractors
- The integration aspect of this scheme is being supported by a nationally funded pilot to test this approach within two local communities and if successful will be rolled out across the entire CCG
- Initially this will be delivered by a local Community Interest Company (Invicta Health) and commissioned by NHS England but with support and guidance being inputted by

the CCG
- If the pilot demonstrates the required enhancements to primary care, South Kent Coast CCG will commission the service going forward and with a view to rolling out across the CCG
- Many other providers will be involved as the integration work is accelerated that will include South East Coast Ambulance NHS Trust, East Kent Hospitals NHS Foundation Trust, Kent Community Health NHS Trust, Out of Hours providers, Mental Health providers, 111 as well as social services and voluntary sector providers.

The evidence base

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

1. mprove the patient experience by:
   - mproving access to general practice by providing 7 day opening
   - nhancing care through service integration
   - roviding more GP input for patients with complex needs
2. ddress GP recruitment and retention issues by:
   - ddressing workload concerns
   - eveloping alternative career structures
3. evelop service and system integration by:
   - rapping GP services around community services
   - ederating models of provision
   - eveloping hub and spoke arrangements (the hubs will be located in two community hospitals and other hubs will be developed in other communities)
   - ntegrating IT systems and shared access to medical records
   - ore patients will be managed at home with greater community support.

The will improve access for patients by providing 7-day primary care and enhance the care for elderly and frail patients by increased availability of GPs and improved co-ordination and continuity. This is intended, in conjunction with other local schemes, to reduce demand on A&E and OOH.

It also allows practices to trial an alternative provision for OOH in collaboration with 111. The introduction of primary care mental health assessments will improve care for patients presenting with urgent mental health needs and reduce demands on secondary mental health.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduced emergency admissions;
- Reduced A&E attendances;
- Improve patient satisfaction and well-being;
- Increase levels of patient self-management of long term conditions;
- Increase levels of patients with personal health budgets and integrated budgets;
- Improve health outcomes by better use of prevention services.
- Increased levels of capacity within primary care
- Increased level of integration between healthcare professionals and providers

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The following indictors will be used to monitor success of the scheme:

- Reduce unplanned admissions by 259 admissions in year through over 75s schemes impact on ambulatory care sensitive conditions and urinary tract infections.
- Development of cross service clinical audit is in progress. This work will monitor quality of anticipatory care plans.
- Increased GP opening hours
- Medication reviews

These KPIs will be monitored by the Primary Care Development group.

What are the key success factors for implementation of this scheme?

- Creating enhanced access and capacity within primary care
- Integration of services against delivery of certain requirements e.g. MH, IT
- Improved system efficiency to reduce A&E and OOH activity and improve patient outcomes and experiences

South Kent Coast Clinical Commissioning Group

Scheme ref no.

4

Scheme name

Enhance support to Care Homes

What is the strategic objective of this scheme?

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 can 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 and to improve those patients care and support in the community.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

An integrated local community based Consultant Geriatrician and specialist nursing team providing support to care homes

- The integrated team for older people can be referred to directly and is aligned to the Neighbourhood Care Teams and the Integrated Intermediate Care teams to undertake reviews all care home discharges from hospital and A&E and ensure appropriate community based services are in place to support patients as part of their discharge planning. 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;
- 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, primary and community services in the management of older people;
- Access to specialist services such as Dementia Crisis will be available to support care homes, through the integrated working model of, 'Enhanced Support to Care Nursing Homes'

Patient Cohorts (examples of client group this scheme will target)
Adults residing within a care home setting (nursing and residential) including patients with Dementia.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The delivery chain is managed by CCG Commissioning comprised of clinical commissioner input and commissioning management support.
The CCG has commissioned a Consultant Geriatrician and part of the specialist nursing, element to date from our local Community Provider KCHT and is in process of commissioning two further posts from a CIC Invicta with an agreed start date for one post Nov 1st and the second post within the same timescale. The service specification sets out that the providers will work in a MDT, integrated way building on the existing integrated team structures currently in place.

The CCG has commissioned the Geriatrician Services from an independent organization, with a service specification in place that requires a model of integrated working.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The ratio of care nursing home beds per CCG capita (we have the highest in Kent)
An earlier pilot of the Enhanced support to Care Nursing Homes demonstrated a reduction in A&E attendances and subsequent financial savings. A 54% of all clients reviewed in care homes had their medications reduced or changed and there was an increase in the number of Care Management/ACPs initiated for patients in care nursing homes.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduced emergency admissions from care nursing homes; comparing admission rates before and after the pilot
- Reduced A&E attendances from care nursing homes comparing admission rates before and after the pilot
- Reduce unnecessary prescribing; patients seen by the Consultant Geriatrician reviews medications and stops, reduces or changes prescriptions
- Improve patient satisfaction through personalised care planning; patients (and their families) have improved awareness of understanding of their care, what is required of them and what to expect from the provider(s). Indirectly communication is improved around, capacity and DNAR information.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

• Admissions data feedback loop will be via the established CCG care nursing home dashboard, that sets out nos. of admissions from care homes (rate of beds), top diagnosis rates, HRGs and Primary Diagnosis

• While social care performance monitors individual care nursing home contracts, the CCG and LA meet every 6 weeks to triangulate performance/quality data and information to agree comes to target to provide support, advice and guidance in the care of the patients supported.

These KPIs will be monitored by the Care Homes group.

What are the key success factors for implementation of this scheme?

The following indictors will be used to monitor success of the scheme:

- Reduce unplanned admissions from care homes by 90.
- Development of cross service clinical audit is in progress. This work will monitor quality of anticipatory care plans.
- Medication reviews

Scheme ref no.

5

Scheme name

Integrated Health and Social Housing approaches

What is the strategic objective of this scheme?

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 condition in a safe home environment.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

An integrated approach to local housing and accommodation provision to enable, supported by a joint Health and Social Care Accommodation Strategy, to enable

more people to live safely in a home and other environments and to enable people to be discharged from hospital in a timely manner into the appropriate environment.

- Current bed based facilities (step up and step down) to be flexible and broadened to use housing schemes;
- Promote developments of wheelchair accessible housing to support the reduction of costly adaptations;
- Responsive timely adaptations to housing;
- Preventative pathways to enable patients and service users to return to (following hospital and care home admissions) and remain in their homes safely including full holistic home safety checks;
- Flexible housing schemes locally;
- Increased provision of extra care housing locally, including a facility to support patient rehabilitation or carer respite for short periods of time with clear criteria and processes for accessing such facilities;
- Different types of supported accommodation for those with learning disabilities and mental health needs.

Patient Cohorts (examples of client group this scheme will target)

- Patients who require additional additional support to enable them to remain their own homes or to be rehoused in a suitable facility that meets their needs. This includes disabled patients, those in wheelchairs and those requiring adaptations to support their rehabilitation.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

To be delivered by KCC, Shepway and Dover District Council, KCHT, and KMPT.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Plans developed due to evidence of lack of appropriate accommodation facilities resulting in delayed transfers of care and reduced quality of life.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduction in emergency hospital admissions by 3.5%;
- Reduced A&E attendances;
- Reduced residential care admissions by 5%;
- Reduced care packages;
- Increased personalisation;
- Reduced delayed transfers of care by 25%;
- Increased patient experience by 4% as more people maintain level of independence in their own home.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand

what is and is not working in terms of integrated care in your area?

The following indictors will be used to monitor success of the scheme:

- Reduced length of stay
- Reduced delayed transfers of care by 2.5%.

These KPIs will be monitored by the Integrated Commissioning Group.

What are the key success factors for implementation of this scheme?

Improvement in discharge process and improved access to appropriate housing options

South Kent Coast Clinical Commissioning Group

Scheme ref no.

6

Scheme name

Falls prevention

What is the strategic objective of this scheme?

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.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Development of a local specialist falls and fracture prevention service

- This service will work closely with the Neighbourhood Care Teams, Rapid Response and Intermediate Care teams to 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

The existing falls pathway will be refreshed to reflect the various settings the patient could present, e.g. GP, MIU, Walk in Centres. The pathway will clearly show the appropriate action professionals should take when dealing with a potential faller or patient that has already fallen. The pathway will include signposting to vision screening, hearing tests, medication reviews, exercise groups and environmental such as housing assessments.

- Level of current services across locality 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, audiologists and the voluntary sector;
- Develop an Integrated Ambulance Falls Response Service;
- Improve availability and awareness of therapeutic exercise programmes (postural stability classes) via community classes and domiciliary based.

Patient Cohorts (examples of client group this scheme will target)

- Patients who are at risk of or have fallen. Patients at most risk include the elderly, those with muscle weakness, cardiovascular problems, medication education needs and those living in poor housing environments.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

South Kent Coast CCG has been working with colleagues from EKHUFT, KCHT, the voluntary sector, CCG GPs together with patient representative to develop falls pathway. The commissioners involved from the CCG are Sue Baldwin and Hilary Knight.

Investment in specialised falls and fracture prevention service is contingent on savings identified by schemes 1 and 2.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

South Kent Coast CCG has seen a rise in the number of non-elective admissions due to falls over the last 3 years. There were 894 new attendances at the outpatient fracture clinics in East Kent Hospitals University Foundation Trust (EKHUFT) for South Kent Coast patients aged 65+ for the period 1 April 2012 - 31 March 2013. By focussing on falls prevention the CCG hopes to see a decrease in these numbers. The development of a robust falls prevention pathway and scoping of relevant services will inform patients and professionals of what is available to them, e.g. Active for Life, walking groups etc.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduction in falls and secondary falls by 10%;
- Reduction in hip fractures;
- Improve patient experience and levels of self-management by 4%;
- Reduced emergency admissions by 3.5%;
- Reduced A&E attendances.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The CCG should see a reduction in falls related attendances in secondary care, we will be able to measure this by comparing activity data prior to and after the refreshed pathway. We will engage with patients to understand their experience of the falls prevention service.

The following indictors will be used to monitor success of the scheme:

- Reduce admission from falls by 10%

These KPIs will be monitored by the Falls group.

What are the key success factors for implementation of this scheme?

The main key to success will be for the refreshed pathway to be adopted by the relevant agencies to ensure that patients are signposted appropriately to the correct service, providing the patient with a positive experience and seamless service.

Thanet Clinical Commissioning Group

Scheme ref no.

THA01

Scheme name

Enhanced Primary Care

What is the strategic objective of this scheme?

The strategic objective of this scheme is to improve access to a full range of local health and social care services to support the move from a medical focused model of care and shifting towards a health and social care well-being focus. Integrated community models of care centred on GP practices requires significant change in primary care working patterns. New models need to be developed to ensure that the right levels of support and capacity are available within primary and community care settings. This will include alliances of GP practices working together in every community.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

- GP practices will work together in a way that enables different access opportunities for patients to include extended access via access to other practices in the town to improve responsiveness of service provision;
- We will develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by primary care. This will require stronger integration with the integrated community care teams as well as robust links with and signposting to a range of services provided by the voluntary sector;
- Integrated primary care provision to have greater support from specialist hospital teams and stronger links with rapid response services to enable patients to remain out of hospital.
- GP in Accident and Emergency at the acute hospital in Margate will forge links between the acute hospital staff and Primary care colleagues, this will also provide challenges to colleagues where appropriate if the need for hospital admission is questionable. Equally this will also challenge why people may be admitted if primary and community care plan is sufficient to look after the patient in their own home.
- The Integrated Discharge Team based on the acute site will also assist in managing attendances at A&E/ Clinical Decision Unit to liaise with primary and community care colleagues to avoid unnecessary admission and facilitate safe discharge at the most appropriate point in the care pathway.
- Professionals in primary care 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;
- Primary Care and the Integrated Care Teams will increase the use of technology, such as tele-health and tele-care, to assist patients to manage their long term conditions in the community;
- Patients will be given the opportunities to be educated about their long term condition as well as about preventative services such as weight management and alcohol services as part of the multidisciplinary assessment;

- Patients will be supported to inform and take ownership of their care plans which includes electronic sharing of care records with the patient and between health and social care professionals;
- Primary Care will work with the local community to ensure the correct information, advice and guidance is available to help manage long term conditions
- 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.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This will be delivered primarily by the 20 GP practices in Thanet.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Self-care interventions can reduce hospitalisations, improve outcomes and reduce costs for the system. For example, one study found that supported self-management had the strongest effect on clinical outcomes of all integrated care interventions, and reduced hospitalisations by 25-30%.

The evidence base highlights the following techniques:

- Involving patients in co-creating personalised self-care plans
- Telephone health coaching
- Tailoring interventions to the condition (e.g. structured education for
- diabetes self-care, behavioural interventions for depression)
- Programmes to encourage lifestyle and behavioural change

Further evidence on self-care:

- Naylor et al (2013) 'Long term conditions and mental health – the cost of comorbidities'
- Purdy S (2012) Avoiding hospital admissions: what does the research evidence say? London: the King's Fund
- De Silva D (2011) Helping people help themselves: a review of the evidence considering whether it is worthwhile to support self-management. London: The Health Foundation
- A NICE Local Practice example is available at: Self-care support for long term conditions
- For guidance on making a local business case for self-care, please see the work done by the NESTA people powered health programme: 'The business case for people powered health'

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance Measurement of agreed KPIs. Regular meetings and reviews with providers

What are the key success factors for implementation of this scheme?

Outcomes

- Improved ability for patients able to access primary and out of hospital care
- Improved responsiveness of service provision
- More patients seen by the right person in the right place
- Reduced hospital admissions

Metrics

- Access to primary care
- Patient satisfaction
- **%** of patients able to access hospital care in the community

Thanet Clinical Commissioning Group

Scheme ref no.

THA02

Scheme name

Integrated Health and Social Care teams including enhancing community teams and care co-ordination

What is the strategic objective of this scheme?

- The strategic objective is to deliver access to services seven days a week, contactable through a single access point via a Local Referral Unit. Links between services will be facilitated by greater use of technology (BT Cloud, MIG, Share my care) to share clinical information to assist with clinical decision making out of hospital – using a care navigation approach to manage and signpost referrals appropriately.
- Access to a rapid response service will be available to patients at high risk of hospital admission and coordinate intermediate care and support in the community, including the use of community beds. This model builds community care teams wrapped around the patient at the centre to support and pro-actively manage their needs. The teams will be further enhanced to ensure integrated working between GP practice, community and social care with specialist input from hospital, mental health and community services as required in order to keep people in their own homes. The teams will be aligned to every GP practice, will undertake Multi-disciplinary Team meetings and will include designated care coordinators for all patients.
- The team will also develop a robust integrated discharge process and coordinate post-discharge support in the community. Patients will know who to contact in the team whenever they need advice or support.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

- Aligned to every GP practice the Community Integrated Care Teams will be available 24 hours a day seven days a week and will coordinate the integrated proactive care 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;

- The Community Integrated Care Teams function is to provide continuity of care for patients who have been referred for short term or long term support in the community.
- They will provide post hospital discharge care and rehabilitation and some pre-admission interventions as well as seamless coordination and delivery of End of Life care.
- Access into and out of the Care Teams will be coordinated through a clinically supported single access points. Patients who require assistance by more than one professional will receive coordinated integrated assessments.
- Each Care Team will include input from the community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, Social Case Managers and the voluntary sector as part of the multi-disciplinary approach
- The community services nursing model will ensure continuity of care by training the core team as “universal nurses” who will manage the majority of individual patient nursing needs, ensuring that specialist input is appropriate and timely
- Patients with complex needs will be supported 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.
- Integrated pathway to coordinate referral management, admissions avoidance and care coordination across health and social care and voluntary sector, supported by single access point(s) Links between services will be facilitated by greater use of technology (BT Cloud, MIG, Share my care) to share clinical information to assist with clinical decision making out of hospital – using a care navigation approach to manage and signpost referrals appropriately. A single access point for Thanet would streamline access to alternative care pathways for a range of referring professionals ,including GPs, SECAMB, AHPs, IDT .providing a “one stop shop” approach for access and/or referral to a range of community based services including community, care management and voluntary services.
- Care coordination will be in place to co-ordinate appropriate support such as information, advice and guidance, befriending, medicines management, rehabilitative or enablement short term support as appropriate (care co-ordinators will be in place where appropriate to do this)
- Integrated assessments to ensure responsive onward referral to either rapid response services or intermediate care services in patients own home where possible and only if necessary ensuring transfer to most appropriate care setting Rehabilitative or Enablement Intermediate care provision to be provided at patients own home wherever possible by professional carers or by a multidisciplinary team of therapists and nurses;
- The team will support the integrated discharge team in the hospital and ensure that they will be available to support people in their own home in response to patients in A&E within 2-4 hours of referral and initiate a co-ordinated admission avoidance intervention.
- The team will work closely with paramedic practitioners to support care homes to assess, diagnose and treat patients as an alternative to non-elective admission via A&E. Enhanced Rapid Response teams supporting admissions avoidance as part of intermediate care provision as well as respond directly to A&E referrals.
- Integrated discharge teams will be in place in the acute hospital that will link with the community services, this team will know what the patients care plan and wishes are, they will link with primary care to work with the primary care plan.
- Develop a robust integrated discharge referral service to support the patient in the

first 5-7 days post discharge, by integrating with the hospital discharge planning processes and coordinating post-discharge support in the community.

- Medicines use will also be assessed in the first 5-7 days post discharge as this is a major cause of readmission.
- The teams will include medicine management support as well as medical leadership and input from hospital consultants to enable continuous support at home.
- The teams will integrate with the Dementia Crisis Service which can receive referrals 24/7 providing support 24/7 to patients with Dementia and carers of people with Dementia to prevent hospital or care home admissions
- The enhanced Community Integrated Care Team model requires specialist input from acute in the community 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 could include actual and remote approaches supported through the use of technology.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The CCG will commission this through its contracts with EKHUFT, KCHT, and KMPT. KCC will deliver support through Social Care Teams

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Multidisciplinary teams (MDTs) bring together the relevant professionals needed to care for someone with complex needs. MDTs should include everyone required to look after the physical, mental and social health and care needs of the individuals they serve. The aim is to manage the complexity of individual cases and facilitate the delivery of the best possible care.

The evidence base highlights the following techniques:

Multi-disciplinary teams
MDT meetings about every person admitted to hospital
Hire specialists to work in community settings rather than hospitals
Expanded hours for GPs and coordinators
Dedicated housing workers for SEMI/vulnerable groups
Allow nurses or nurse practitioners to prescribe certain drugs
Mental health liaison teams
Direct phone/email access from GPs to MH experts
Further evidence on MDTs:
Holland et al, Heart, 2005, 91, 899-906
Proactive care partnership
http://www.sussexcommunity.nhs.uk/Downloads/services/proactive_care/proactivecare_coastal_leaflet.pdf

Case study examples: NHS North West London, Torbay, Towers Hamlets

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance Measurement of agreed KPIs. Regular meetings and reviews with providers

What are the key success factors for implementation of this scheme?

Outcomes

- Reduced hospital admissions
- Fully integrated team responding appropriately to the patient's needs

Metrics

- Single access point into the team known to all patients with long term conditions
- Measurement of ability to obtain timely support
- % of care provision undertaken at patient's own home
- Response to known patients presenting to A&E within 2-4 hours of referral
- % patients with long term conditions known to the team
- % of admissions avoided from A&E
- Pre and post evaluation of cardiac rehab programme
- Pre and post evaluation of pulmonary rehab programme

Thanet Clinical Commissioning Group

Scheme ref no.

THA03

Scheme name

Flexible use of Care Homes and Westbrook House

What is the strategic objective of this scheme?

To deliver an improved community solution which offers a flexible service that reduces the need for hospital admission and supports the early discharge of patients from hospital.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

- Care home beds (previously GP step-up beds) to be used as step-up beds for patients requiring a short-term intervention that would prevent them being admitted to secondary care. These beds will be used flexibly to effectively respond to changes in demand and may also be used as step-down beds to enable maximum occupancy.

- Westbrook house will be further developed as an enhanced step down facility to

support patients for 6-8 weeks post discharge so that they can be returned, where possible, to their own bed and avoid social care placement or re-admission. The Westbrook House team will be supported by a dedicated multi-disciplinary team, including therapists, social care and primary care input, to ensure timely patient flows.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The CCG currently commissions GP step up beds from a number of private sector care homes through contracts with local GP Practices. Westbrook House is a jointly funded facility with KCC

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Health Act 1999 provided the "flexibilities" that allow qualified nursing staff to be seconded into local authority/County Council Registered Care Centres to deliver improved outcomes in nursing care and clinical input to meet the needs of those individuals identified to receive nursing care, in addition to their individual personal care and spiritual needs. The Department of Health (DH) has stated that effective and efficient joined up working between the NHS and Local Government is an essential part of how the care system works to meet patients' needs and public expectations at all times and particularly when increased demands are made of the services.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance Measurement of agreed KPIs. Regular meetings and reviews with providers

What are the key success factors for implementation of this scheme?

Outcomes
- Reduced hospital admissions
- Reduced hospital readmissions
- Avoidance of long term social care placements

Metrics
- % occupancy of step-up beds
- % occupancy of Westbrook House (Victoria Unit)
- % of readmissions of patients seen by the team
- % patients returning to their own home
- Measure of response times
- Patient satisfaction

Thanet Clinical Commissioning Group

Scheme ref no.

THA04

Scheme name

Falls Prevention

What is the strategic objective of this scheme?

To reduce the number of unplanned admissions due to falls.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

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.

SCHEME REQUIREMENTS:

Development of a local specialist falls and fracture prevention service

- This service will work closely with the Neighbourhood Care 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 Ambulance Falls Response Service;
- Improve availability and awareness of therapeutic exercise programmes (postural stability classes) via community classes and domiciliary based.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

CCG and KCC will jointly commission KCHT, EKHUFT, Primary Care and the Voluntary Sector to deliver the proposed Falls Framework.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Falls Prevention a Framework for Kent – Thanet CCG v2.1

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB

Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Performance Measurement of agreed KPIs. Regular meetings and reviews with providers
What are the key success factors for implementation of this scheme?
• Reduction in non-elective admissions due to falls. • Improved patient outcomes and improved efficiency of care after hip fractures through compliance with core standards. • Response to a first fracture and prevention of the second – through fracture liaison service in acute and primary care settings. • Early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries. • Prevent frailty, promote bone health and reduce accidents – through encouraging physical activity and healthy lifestyle and reducing unnecessary environmental hazards.

Thanet Clinical Commissioning Group
Scheme ref no.
THA05
Scheme name
Support for carers
What is the strategic objective of this scheme?
To improve the support to carers through a more integrated approach to commissioning.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
KCC and Thanet CCG currently fund a number of carers support schemes through two strands. Carers Support and Carers Short breaks. These include Planned Respite, Crisis Support and Respite for Carers. Through improved integration we intend to: • Improve the Support to carers of those with dementia. • Provide Support to carers who are elderly and/ or have their own health needs and for whom the caring role is particularly intensive, for example living with the person they care for, or spending over 100 hours a week caring. • Support carers within new emerging BME communities.

- Ensuring easy access to information, advice and guidance for both known and unknown carers, particularly in deprived areas.
- Address the predicted decline of female 'mid life' carers when developing services for the future.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Combining resources from KCC and Thanet CCG to commission services from the Private and Voluntary Sector.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Kent Carers JSNA 2013/14

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance Measurement of agreed KPIs. Regular meetings and reviews with providers

What are the key success factors for implementation of this scheme?

- Increased number of carers supported through each of the three programmes.
- Access to crisis support
- Access to planned care respite
- Access to respite for carers

Thanet Clinical Commissioning Group

Scheme ref no.

THA06

Scheme name

Improving End of Life Care

What is the strategic objective of this scheme?

To improve the overall co-ordination of end of life care ensuring that patients' wishes are recorded and patients are given their choice of place of death wherever possible.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

A major opportunity to address some of the key issues for EOLC is through adoption of the new Long Term Conditions Agenda that incorporates the themes of risk-stratification, integrated teams and self-care. The vision is for a unified data hub that integrates activity across all health and social care and a fully functional system which will enable early identification for those at risk of death, enable more accurate EOLC planning across a population and ensure health and social care are better coordinated and integrated with each other. End of Life Care (EOLC) should support people to remain independent where possible, allowing the final stages of life to be as comfortable as possible. The preferred location of death should be discussed with family and carers, with the choice being adhered to wherever possible. Many people do not wish to die in hospital and would prefer to die at home, but often this does not happen. Two-thirds of people would prefer to die at home, but in practice only about one-third of individuals actually do.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

CCG commission services from Pilgrims Hospices, KCHT, EKHUFT and GP Practices.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

East Kent End of Life Strategy May 2014

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance Measurement of agreed KPIs. Regular meetings and reviews with providers

What are the key success factors for implementation of this scheme?

Outcomes
- To enable end of life care in patients own home

Metrics
- To reduce the number of secondary care admissions for patients receiving end of life care
- % of patients dying in their place of choice

West Kent Clinical Commissioning Group
Scheme ref no.
WK001
Scheme name
Joint Health and Wellbeing System Approach
What is the strategic objective of this scheme?
A coordinated whole system approach in which all health and wellbeing partners use their individual and collective efforts to tackle the root causes of health and wellbeing problems.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
A coordinated whole system approach for West Kent in which all health and well-being system partners use their individual and collective efforts to tackle the root causes of health and wellbeing problems (including alcohol and tobacco use and addiction and obesity). The change levers include health education, environmental health improvements, housing eligibility and maintenance, trading standards, licensing and the standards and specifications of health and social care contracts and community development support. It includes efforts to encourage and support people so that they take more responsibility for their health and to make the healthy choices easier for people to make. It also includes an asset based approach, enhancing the capacity of communities and individuals to support themselves and each other 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.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council. The providers will include the NHS Acute Provider, the NHS Community Provider, the private sector, the following local authorities (Kent County

Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council) as well as the voluntary and community sector. As this programme develops this will be specified further.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Mapping the Future exercise conducted in West Kent CCG has identified the financial impact of expected levels of demand growth arising from the change in demography of West Kent. This has been based upon ONS population growth forecasts by age band. The charts set out in the West Kent CCG Strategic Commissioning Plan show the anticipated growth in expenditure on services as a result of demographic pressures. Significant cost growth is anticipated in the following areas: People who have multiple Long Term Conditions; People who are aged 70 and over; People who would require services in: Urgent care, Community services, Continuing Care and Funded Nursing Care services.

The Mapping the Future programme sets out a planned redistribution of resources across settings of healthcare. Over a five year period, WKCCG aims to deploy a greater share of its resources towards investment in New Primary Care services, and relatively less in the acute care setting.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£8,708,000 to deliver BCF outcomes

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

System Requirements

- Campaign team
- Co-ordinating team to reach out to all agencies and to drive for consistency of programmes
- Campaign to increase people's willingness to take on responsibility for own care (culture change)
- Suitable information content and communications channels
- Education/campaign team
- Information materials
- Volunteer and informal carer support

Expected Benefits

- Integrated working and co-commissioning
- Services developed are person centred, are part of integrated provision and procured through integrated commission
- A reduction in health inequalities
- Increase in patients feeling supported to manage their long term condition

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group

providing advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within Whole System Boards, the HWB and on the Integration Pioneer Steering Group. At a local CCG, care economy and system wide level there will be monitoring of the financial flows and achievement of the metrics associated with implementation of the Better Care Fund.

What are the key success factors for implementation of this scheme?

- Co-ordinated campaigns across health, social care, general public work, with consistent messages
- Consistent prioritisation across all agencies avoiding fragmentation of efforts
- Holistic approach that tackles underlying causes for ill-health
- People become true partners in care: manage parts of pathways themselves, take part in active prevention and make healthy lifestyle choices
- Greater awareness of health/social needs and more looking out for each other in community (neighbours and volunteers helping)
- Increase in patients feeling supported to manage their long term condition
-

West Kent Clinical Commissioning Group

Scheme ref no.

WK002

Scheme name

Self and Informal Care

What is the strategic objective of this scheme?

The Mapping The Future 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.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

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 and the development of a self-care/self-management model. 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

- People are supported to take responsibility for their health and care. This includes intensive education about their conditions and how they can manage them, peer support, information and supported signposting to find appropriate voluntary and community options, fast and easy access to daily living aids
- People are kept fully informed about the need for changes to health and care and are encouraged to take part in discussions about future plans
- People are encouraged to make early decisions about treatment options and end of life preferences: they are active partners in planning their care
- People are supported to stay independent and at home for as long as possible,

e.g., using telehealth, patient held records and personal health budgets

- Supported housing and domiciliary care is commissioned in a way that enables people to remain in the home as long as possible: short term stays are possible for those that have immediate needs
- Local communities and voluntary organisations are encouraged to provide health and care support to people and carers

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council.

The providers may include the NHS Acute Provider, the NHS Community Provider, the private sector, the following local authorities (Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council) as well as the voluntary and community sector. As this programme develops this will be specified further.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Mapping the Future exercise conducted in West Kent CCG has identified the financial impact of expected levels of demand growth arising from the change in demography of West Kent. This has been based upon ONS population growth forecasts by age band. The charts set out in the West Kent CCG Strategic Commissioning Plan show the anticipated growth in expenditure on services as a result of demographic pressures. Significant cost growth is anticipated in the following areas: People who have multiple Long Term Conditions; People who are aged 70 and over; People who would require services in: Urgent care, Community services, Continuing Care and Funded Nursing Care services.

The Mapping the Future programme sets out a planned redistribution of resources across settings of healthcare. Over a five year period, WKCCG aims to deploy a greater share of its resources towards investment in New Primary Care services, and relatively less in the acute care setting.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£3,092,000 to deliver BCF outcomes

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

System Requirements

- People willing to take on responsibility for own care (culture change)
- Suitable, easily accessible information
- Accessible, responsive and reliable support 24/7 when questions and issues arise
- Incentives (?)

- Easy access to easy-to-understand information
- Access to up-to-date care plans and care records
- Info about EOLC service options
- Cultural acceptance of “natural” death
- 24/7 responsive and reliable support service for crises
- Well-co-ordinated social/domiciliary care services
- Culture of helping each other
- Info/education for volunteers and community at large

Expected Benefits outlined in Part 2 Tab 4 HWB Benefits Plan

- 104 reduction in A&E attendances
- 104 integrated care at home packages provided
- Increase in patients feeling supported to manage their long term condition

Feedback loop

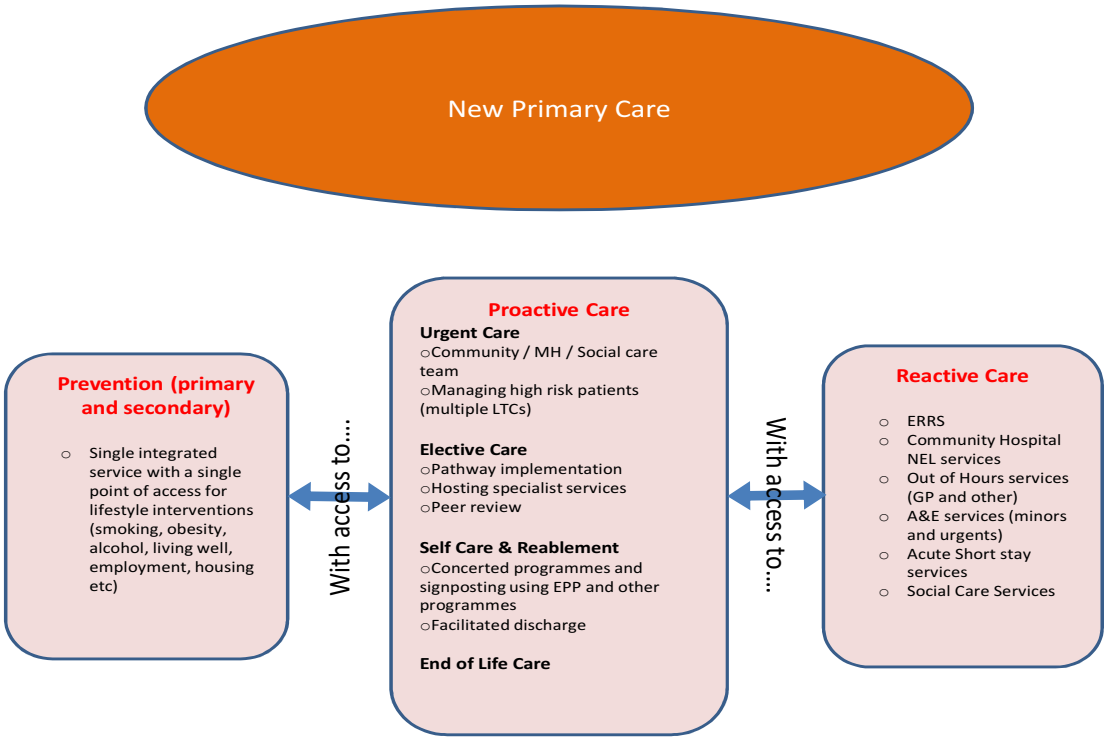
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group providing advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within Whole System Boards, the HWB and on the Integration Pioneer Steering Group. At a local CCG, care economy and system wide level there will be monitoring of the financial flows and achievement of the metrics associated with implementation of the Better Care Fund.

What are the key success factors for implementation of this scheme?

- People become true partners in care: manage parts of pathways themselves, take part in active prevention and make healthy lifestyle choices
- Avoiding unnecessary and ineffective care
- People take more of their own care decisions
- Earlier discussion on EOL patient preference with reduction of excessively aggressive treatments
- Reduce avoidable hospitalisations
- Ability to receive treatments that otherwise would have needed hospital (greater convenience for patients)
- Avoid unnecessary admissions for “social” reasons
- Healthier homes (e.g., less cold/damp, less falls risk)
- Support at home by neighbours and volunteers and within the community by volunteers
- Overall greater awareness of “look out for each other”
- Increase in patients feeling supported to manage their long term condition

West Kent Clinical Commissioning Group
Scheme ref no.
WK003
Scheme name
New Model of Primary Care
What is the strategic objective of this scheme?
A new model of Primary Care focusing on three distinct but interlinked areas of care (preventative, proactive and reactive care) creating larger scale GP led multi-disciplinary teams which are wrapped around a suitably sized group of practices.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?



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

This will include:
- Comprehensive New Primary Care responds 24/7
- Practice clusters that offer diagnostics and other extended services
- Easier access 24/7
- Universal electronic record system
- MDT-teams based around health centres, or community hospitals
- Risk profiling and proactive outreach to people at risk of deterioration
- OOH is integral part of New Primary Care
- Dedicated processes for scheduled and unscheduled care
- Population health is part of NPC's responsibilities
- NPC 'owns' their patients along the entire pathway
- NPC can access intermediate care
- Integrated assessments
- Care coordinators for patients with complex needs
- Access to specialist opinion without referral

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council.

The providers will include the NHS Acute Provider, the NHS Community Provider, the private sector, and the following local authorities (Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council).

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Mapping the Future exercise conducted in West Kent CCG has identified the financial impact of expected levels of demand growth arising from the change in demography of West Kent. This has been based upon ONS population growth forecasts by age band. The charts set out in the West Kent CCG Strategic Commissioning Plan show the anticipated growth in expenditure on services as a result of demographic pressures. Significant cost growth is anticipated in the following areas: People who have multiple Long Term Conditions; People who are aged 70 and over; People who would require services in: Urgent care, Community services, Continuing Care and Funded Nursing Care services.

The Mapping the Future programme sets out a planned redistribution of resources across settings of healthcare. Over a five year period, WKCCG aims to deploy a

greater share of its resources towards investment in New Primary Care services, and relatively less in the acute care setting.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£14,335,000 to deliver BCF Outcomes

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

System Requirements

- Call handling protocols
- Call centre
- Sufficiently senior clinicians (e.g., GPs) on call
- Suitable facilities (within some GP practices or community centres?)
- Call handling protocols
- Data protection protocols
- Access to suitable IT system
- Shared record and care plan
- MDT processes
- Risk stratification tool
- Processes and team capacity to respond
- Call handling protocol and call centre
- Access to GP records (IT systems)
- Adequate staffing levels (if GP and community staff deliver part of OOH)
- Dedicated practice capacity for unscheduled care
- Active working with Public Health
- Clinical governance for lead clinicians
- Communications protocols for 'lead'
- Intermediate care beds
- Clinical governance
- Suitable joint protocols and skilled staff
- Skilled care coordinators
- Clinical governance
- "On phone" specialists

Expected Benefits outlined in Part 2 Tab 4 HWB Benefits Plan

- 104 reduction in permanent residential admissions
- 1185 reduction in non-elective (general + acute only)
- 730 reduction in delayed transfers of care
- 104 reduced use of commercial beds
- Reprocurement of an integrated loan and equipment store
- Reprocurement of integrated therapy services
- Increased effectiveness of reablement/104 readmissions avoided
- Increase in patients feeling supported to manage their long term condition
-

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group providing advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within Whole System Boards, the HWB and on the Integration Pioneer Steering Group. At a local CCG, care economy and system wide level there will be monitoring of the financial flows and achievement of the metrics associated with implementation of the Better Care Fund.

What are the key success factors for implementation of this scheme?

- The new primary care teams comprise GP practices, community services, social work and mental health support working as an integrated team that can respond to patient needs round the clock
- All members of the New Primary Care have a clear understanding of each other's role
- All practices networked into clusters so that patients can receive a consistent range of services wherever they live in West Kent. The clusters have local access to essential diagnostics, where this is cost effective for the population size: quality assurance, calibration and training provided by hospital services reduces the need for tests to be repeated in different settings
- The new primary care teams make it easy for people to see them, e.g., by offering consultations by telephone, longer opening times and efficient appointments systems. For the patient it feels seamless whether they contact during the day or at night, although night and weekend care may be offered by another organisation
- All members of the primary care team use the same unified electronic patient records – these are also available to mobile clinical services and to other specialist services
- The multi-professional and multi-skilled teams may be virtual or based around larger health centres or community hospitals
- Primary and community teams use risk profiling and disease registers to plan the team's work: they are proactive in targeting people at risk of developing conditions or of deteriorations in their condition. They call people who might be at risk in to see them rather than waiting for them to seek help
- The traditional out-of hours services are redesigned and integral to the new primary care rather than a separate element. They may take on a wider range of functions supporting GP practices
- The teams plan their work so that they offer both planned and urgent care - these elements may need to be separately organised to provide greatest efficiency
- The new primary care teams see population health as their responsibility. They 'own' their patients and follow them up when they need specialist care, planning their return home as quickly as possible. They are supported by real time information about available services and system performance
- The teams can access intermediate/step up care where adults or children can get short term observation and treatment
- The teams have advanced skills in the diagnosis and treatment of patients with long term conditions and use agreed pathways of treatment and care to plan the support for individual patients – these are designed around the principles of encouraging self-management and early intervention to prevent conditions from

getting worse
- The MDT enables interdisciplinary overlap and partial substitution so that one professional can cover potentially multiple specialities' services
- Use agreed assessment protocols the teams have reduced duplicated assessments for some conditions
- Within the team there are professionals that take a care management and coordination role for patients with the most complex health needs
- The new primary care teams can access consultant opinion and advice to enable them to support patients without the need to send them to hospital
- Increase in patients feeling supported to manage their long term condition

West Kent Clinical Commissioning Group

Scheme ref no.

WK004

Scheme name

Mobile Clinical Services

What is the strategic objective of this scheme?

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.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

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 and where appropriate clear referral pathways to non-clinical partners.

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.

- NHS 111 call centre gives helpful advice and is supported by GPs
- Call handlers know what local services are available and when
- See-and-treat by paramedics in the field
- MCS are integrated part of NPC team (same care protocols/processes and medical records), or at least integrated operationally

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council. The providers will include the NHS Acute Provider, the NHS Community Provider, Ambulance Service and the private sector.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Mapping the Future exercise conducted in West Kent CCG has identified the financial impact of expected levels of demand growth arising from the change in demography of West Kent. This has been based upon ONS population growth forecasts by age band. The charts set out in the West Kent CCG Strategic Commissioning Plan show the anticipated growth in expenditure on services as a result of demographic pressures. Significant cost growth is anticipated in the following areas: People who have multiple Long Term Conditions; People who are aged 70 and over; People who would require services in: Urgent care, Community services, Continuing Care and Funded Nursing Care services.

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Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£94,000 to deliver BCF outcomes

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

System Requirements

- Qualified and sufficiently senior staff answering phones
- Call centres and call management protocols
- Clinical governance
- Process to keep directory of services up-to-date and manageable
- Access to medical records and care plans
- Processes to keep Paramedics/MCS clinicians involved
- Integrated care records
- Designed and formally agreed protocols and processes

Expected Benefits outlined in Part 2 Tab 4 HWB Benefits Plan

- 938 journeys avoided
- Increase in patients feeling supported to manage their long term condition

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group providing advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within Whole System Boards, the HWB and on the Integration Pioneer Steering Group. At a local CCG, care economy and system wide level there will be monitoring of the financial flows and achievement of the metrics associated with implementation of the Better Care Fund.
What are the key success factors for implementation of this scheme?
• The NHS 111 number provides valuable advice and help to patients and carers on line and by phone. The call handlers are supported by GPs and well supervised so they feel part of an accountable system not individually responsible • Call handlers have a strong understanding of local services in West Kent and what they can offer: this plus access to the real time information means they are confident in the advice they give • Mobile Clinical Service clinicians (could be paramedics, doctors, specialist nurses, etc.) provide direct care to people at the point where they become ill – this is a more common approach than taking the patient to hospital, or to intermediate beds (e.g., in community hospitals) • MCS clinicians work as a complementary workforce to the new primary care teams. They use similar pathways and protocols, have access to the unified electronic patient records and provide systematic handovers of patients back to the primary care team • Increase in patients feeling supported to manage their long term condition

West Kent Clinical Commissioning Group
Scheme ref no.
WK005
Scheme name
Urgent Transfer Service
What is the strategic objective of this scheme?
To transfer patients with urgent care needs to the best setting (this may not necessarily only to A&E), to provide a range of treatments and diagnostic tests to patients on the way and to make more use of transport services by voluntary and community organisations.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
• Enhanced assessments and diagnostics/start more care enroute • Urgent care protocols the same regardless of care setting

- All care professionals have access to universal records all the time
- A&E is not automatic destination but patients could be taken to GP practice or other community-based care setting
- More non-urgent patient transport to be provided by others than ambulance e.g. volunteer and community support teams

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council.
The providers will include the NHS Acute Provider, the NHS Community Provider, the Ambulance Service and the private sector.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Mapping the Future exercise conducted in West Kent CCG has identified the financial impact of expected levels of demand growth arising from the change in demography of West Kent. This has been based upon ONS population growth forecasts by age band. The charts set out in the West Kent CCG Strategic Commissioning Plan show the anticipated growth in expenditure on services as a result of demographic pressures. Significant cost growth is anticipated in the following areas: People who have multiple Long Term Conditions; People who are aged 70 and over; People who would require services in: Urgent care, Community services, Continuing Care and Funded Nursing Care services.

The Mapping the Future programme sets out a planned redistribution of resources across settings of healthcare. Over a five year period, WKCCG aims to deploy a greater share of its resources towards investment in New Primary Care services, and relatively less in the acute care setting.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

No direct funding identified but included for completeness of Mapping the future vision.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

System Requirements
- Qualified staff
- Protocols and clinical governance
- Suitable equipment
- Agreed, standardised protocols
- Suitable record system

- Urgent care services outside of A&E
- Clear protocols for triage
- Suitable transport organisations/capacity

Expected Benefits outlined in Part 2 Tab 4 HWB Benefits Plan

- 130 journeys avoided
- Increase in patients feeling supported to manage their long term condition

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group providing advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within Whole System Boards, the HWB and on the Integration Pioneer Steering Group. At a local CCG, care economy and system wide level there will be monitoring of the financial flows and achievement of the metrics associated with implementation of the Better Care Fund.

What are the key success factors for implementation of this scheme?

- The traditional ambulance services transfer patients with urgent care needs where necessary. They may provide a range of treatments and diagnostic tests to patients on the way, providing effective handover to specialist hospital services
- Protocols accepted and understood across the system guide transfers
- Access to unified electronic patient records enables the paramedics to know which patients have complex conditions who might benefit from taking their prescribed medicines with them to hospital
- The transfer service may not transfer just to acute hospitals, but also to community hospitals or care homes or other appropriate venues
- More use is made of transport services provided by voluntary and community organisations
- Increase in patients feeling supported to manage their long term condition

West Kent Clinical Commissioning Group

Scheme ref no.

WK006

Scheme name

New Secondary Care

What is the strategic objective of this scheme?

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.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

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.

- Concentration of highly specialised services in larger centres
- Hospital-based urgent care is integrated with NPC and mobile services , providing access to senior clinical input as early as possible when needed and ensuring rapid response and rapid turnaround so that patients can be supported in most appropriate setting
- Specialists and GPs work as one team with one lead clinician
- Ongoing monitoring and rapid learning to adjust care supply to demand so that provider capacity responds to demand, rather than supply inducing demand
- Proactively link physical and mental health, with psych liaison services at hospitals
- Coordinated and simplified care for patients with complex needs

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council.

The providers will include the NHS Acute Provider, the NHS Community Provider, the private sector, and the following local authorities (Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council).

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Mapping the Future exercise conducted in West Kent CCG has identified the financial impact of expected levels of demand growth arising from the change in demography of West Kent. This has been based upon ONS population growth forecasts by age band. The charts set out in the West Kent CCG Strategic Commissioning Plan show the anticipated growth in expenditure on services as a result of demographic pressures. Significant cost growth is anticipated in the following areas: People who have multiple Long Term Conditions; People who are aged 70 and over; People who would require services in: Urgent care, Community services, Continuing Care and Funded Nursing Care services.

The Mapping the Future programme sets out a planned redistribution of resources across settings of healthcare. Over a five year period, WKCCG aims to deploy a greater share of its resources towards investment in New Primary Care services, and relatively less in the acute care setting.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

No direct funding identified but included for completeness of Mapping the future vision.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

System Requirements

- Large enough provider units to keep both scheduled and unscheduled care areas above critical mass
- Sufficient capacity at specialist centres
- Specialist centres at still acceptable distance
- Adequate NPC-based urgent care capacity
- Clinical governance
- Quality monitoring
- Clear protocols
- Close intelligent activity monitoring
- Contractual flexibility
- Adequate expertise and capacity in NPC to take on care
- Referral protocol
- Responsive prevention and health promotion service and capacity
- Psych liaison service
- Agreed referral guidelines
- Clinical governance
- Tertiary advisory service
- Clinical governance
- Competent clinician who can synthesise treatment regimens into one simplified care plan

Expected Benefits

- Greater cooperation across acute and community sectors
- Coordinated and simplified care for patients with complex needs
- Increase in patients feeling supported to manage their long term condition

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group providing advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within Whole System Boards, the HWB and on the Integration Pioneer Steering Group. At a local CCG, care economy and system wide level there will be monitoring of the financial flows and achievement of the metrics associated with implementation of the Better Care Fund.

What are the key success factors for implementation of this scheme?

- Hospital based urgent and planned care services can complement each other

but they are managed as separate entities to provide optimum efficiency
- Some consultant led services are concentrated in larger centres where there is evidence that they can improve quality and offer more cost effective care
- Hospital based urgent care works as part of a total system connected with primary and community services and mobile clinical services. Together they work to optimise patient flows to deliver the most cost effective service
- There are clear agreements between primary care and specialist teams among them about their respective patient care responsibilities and ways of managing organisational and professional risks (agreement is between providers but also with clear transparency to commissioner for quality control)
- Constant analysis of how urgent care demand and service delivery enables fast learning and resources deployed to the right place
- Hospital based MDTs facilitate proactive follow up of patients through explicit handover back to primary and community teams and use unified electronic patient records to track patients and keep each other informed
- Have a health promotion role, using opportunistic encounters with patients to encourage positive changes in healthy behaviour. They are supported by 7 day on site advice services, e.g., smoking and alcohol
- Proactively work together to link physical and mental health treatment and support
- Develop shared understanding between primary/specialist clinicians about when it is clinically appropriate to refer patients to specialist centres outside West Kent
- West Kent specialists develop clear agreements with tertiary centres and can access consultant advice by phone to enable local care for patients
- Develop coordinated care around people with complex care needs such as physically frail older people making the care and support for the individual and carer quicker and simpler
- Increase in patients feeling supported to manage their long term condition

West Kent Clinical Commissioning Group

Scheme ref no.

WK007

Scheme name

System Enablers

What is the strategic objective of this scheme?

- Information sharing protocols as first step towards universal medical records, allowing all care professionals access to real-time patient record and care plans from anywhere.
- Improved communications and relationships amongst professionals of different organisations
- Clear risk management agreements
- Culture of personalised care, collaboration and joint ownership of effectiveness of care.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?

- Which patient cohorts are being targeted?

- Data sharing protocols
- Suitable record system
- Remote access to such system
- Communications platform
- Availability of care professionals to respond rapidly
- Communications processes
- Funding model that incentivises best outcomes at minimum costs
- Shared culture and incentives

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council. The providers will include the NHS Acute Provider, the NHS Community Provider, the private sector, and the following local authorities (Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council).

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Mapping the Future exercise conducted in West Kent CCG has identified the financial impact of expected levels of demand growth arising from the change in demography of West Kent. This has been based upon ONS population growth forecasts by age band. The charts set out in the West Kent CCG Strategic Commissioning Plan show the anticipated growth in expenditure on services as a result of demographic pressures. Significant cost growth is anticipated in the following areas: People who have multiple Long Term Conditions; People who are aged 70 and over; People who would require services in: Urgent care, Community services, Continuing Care and Funded Nursing Care services.

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Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£165,000 to deliver BCF outcomes

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not

captured in headline metrics below

- Data sharing protocols
- Suitable record system
- Remote access to such system
- Communications platform
- Availability of care professionals to respond rapidly
- Communications processes
- Funding model that incentivises best outcomes at minimum costs
- Shared culture and incentives

Expected benefits

- Introduction of an integrated care plan management system
- Increase in patients feeling supported to manage their long term condition

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group providing advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within Whole System Boards, the HWB and on the Integration Pioneer Steering Group. At a local CCG, care economy and system wide level there will be monitoring of the financial flows associated and achievement of the metrics with implementation of the Better Care Fund.

What are the key success factors for implementation of this scheme?

- Electronic patient records using a common IT platform may be over ambitious in the short term but information sharing protocols and risk sharing agreements can be a pragmatic first step
- Improved communications and relationships between professionals working in different organisations/sectors
- More use is made of electronic communications (e.g., email, SMS) between professionals and between professionals and people who need health care and support
- Risk management arrangements and agreements that work across the system contribute to more efficient and effective care
- The new system of health care is underpinned by a shift in culture that emphasises personalised care, collaborative working between providers and joint ownership of optimising patient flows and effective care
- Increase in patients feeling supported to manage their long term condition