South Kent Coast
Clinical Commissioning Group

High Level Better Care Fund Plan
NHS South Kent Coast Clinical Commissioning Group

No	Scheme	Description of Scheme	Outcome Measures	High Risks
1	**INTEGRATED TEAMS, RAPID RESPONSE & REABLEMENT**	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 will coordinate post-discharge support into the community linking with the community based Neighbourhood Care Teams, primary care and the voluntary sector. **SCHEME REQUIREMENTS:** **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;	• Reduced emergency admissions; • Reduced A&E attendances; • Reduced hospital admissions and re-admissions for patients with chronic long term conditions and Dementia; • Improve patient experience; • Improve health outcomes; • Reduced length of stay; • Improved transfers of care; • Reduced long term	• Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability. • Flexibility of community based beds requires constant monitoring to ensure system copes with changing demand; • Integrated performance monitoring of pathways needs to support the level of integration required;

		• Community hospital beds only to be used for comprehensive assessments , for patients needing 24/7 nursing 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; • The teams will integrate with the Mental Health Crisis Service which provides support 24/7. **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.	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	• IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring.

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2	**ENHANCE NEIGHBOURHOOD CARE TEAMS AND CARE COORDINATION**	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. **SCHEME REQUIREMENTS:** **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** • 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 and care in the community, including within care homes, 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	• 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.	• Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability; • Detailed modelling required to fully understand impact on acute capacity and requirements of community capacity to inform transition over a defined period of time including investment and dis-investment requirements; • Large scale organisational change to ensure the whole health and social care system has shared vision and values to enable the delivery of required changes;

		interventions and will be integrated with pathways to assess a patients home environment; • Access into and out of the Neighbourhood 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. 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 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 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 the acute trust in the community to enable the integrated assessment and 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.		• Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring.

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3	**ENHANCE PRIMARY CARE**	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 hub of practices in every community 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 well-being focus. **SCHEME REQUIREMENTS:** **Develop primary care based services with improved access and integrated with other community and specialist services** • GPs 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 be co-produced in tandem with public engagement. This will require stronger integration with the Neighbourhood Care Teams and the Intermediate Care Teams and ensuring that all community pathways signpost people as appropriate to the voluntary sector; • Integrated primary care provision will have greater support from specialist hospital teams and stronger links with rapid response services to enable	• 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.	• Extensive workforce reconfiguration in the community to ensure the workforce has the required skills and training to deliver all elements of the scheme; • Large scale organisational change to ensure the whole health and social care system has shared vision and values to enable the delivery of required changes. This includes ensuring the voluntary sector are aware of the direction of travel; • Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and

		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, alcohol services and community mental health prevention 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 and anticipatory care plans this includes electronic sharing of care records and plans with the patient and between health and social care professionals; • 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. GPs will signpost patients with early signs of mental health 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.		support integrated outcome measurement and monitoring.

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4	**ENHANCE SUPPORT TO CARE HOMES**	This model supports older people with a range of needs including physical disabilities and dementia will align specialists across multiple teams, including secondary care, to ensure patients in care homes have anticipatory care plans in place and those that are admitted to hospital have robust discharge plans in place before they are discharged in order to prevent re-admissions. **SCHEME REQUIREMENTS:** **An integrated local community based Consultant Geriatrician and specialist nursing team providing support to care homes** • The integrated team 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. • Access to specialist services such as Dementia Crisis will be available to support care homes; • Care homes will be given access to additional skills development to support improving quality of care and outcomes for the management of residents with long term conditions, compassionate care needs, mental health and wellbeing and management of End of Life care.	• Reduced emergency admissions; • Reduced A&E attendances; • Reduce unnecessary prescribing; • Improve patient satisfaction through personalised care planning.	• Workforce capacity to deliver the scheme is limited considering the large number of care home beds (approximately 3,000) in South Kent Coast; • Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring. • Workforce in care homes needs support to increase skills to support more complex patients.

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5	**INTEGRTAED HEALTH AND SOCIAL HOUSING APPROACH**	To develop and 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. **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 and to enable people to be discharged from hospital in a timely manner into the appropriate environment.** • Current bed based facilities (both 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 admissions to hospital or care homes, or 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.	• Reduction in emergency hospital admissions; • Reduced A&E attendances; • Reduced residential care admissions; • Reduced care packages; • Increased personalisation; • Reduced delayed transfers of care; • Increased patient experience as more people maintain level of independence in their own home.	• Policy and legislation for housing and Disabled Facilities Grants need to support the level of integration required.

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6	**FALLS MANAGEMENT AND PREVENTION**	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, domiciliary based and within care homes.	• Reduction in falls and secondary falls; • Reduction in hip fractures; • Improve patient experience and levels of self management; • Reduced emergency admissions; • Reduced A&E attendances.	• Different skills and training required across multiple professionals and organisations; • Integrated performance monitoring of pathways needs to support the level of integration required as will be challenging to monitor improvements linked to falls prevention; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring.