South Kent Coast CCG Better Care Fund Update

Introduction

Our five year strategy has a strong focus on the management of long term conditions and the subsequent impact these conditions have on the local health and social care systems. Our plans for integration focus on considerable changes to the current ways of working and the existing workforce across multiple organisations. In our drive towards an Integrated Care Organisation (ICO) we will be required to begin work on re-shaping the provider market to enable delivery of our plans.

South Kent Coast CCG has developed an Integrated Commissioning Strategy in partnership with the Integrated Commissioning Group (a subgroup of the South Kent Coast Health and Wellbeing Board). This Strategy identified four shared aims toward which we are working together:

- To improve the health and wellbeing of people in Dover and Shepway living with long term conditions, enabling as many people as possible to manage their own condition better;
- People with disabilities and older people will be supported to actively participate in the lives of their local communities, enabled by environments that are inclusive, accessible and safe for all;
- To support families and carers in their caring roles and enable them to actively contribute to their local communities and;
- To ensure that the best possible care is provided at the end of people's lives.

Summary of Progress to Date

Approval of plan
The Kent-wide Better Care Fund plan, including all local CCG BCF plans, has now been classified as "Approved". NHS England has reported that the plan is clear and ambitious and supports implementation of the plan.

BCF funding will be made available subject to the following standard conditions which apply to all BCF plans:

- The Fund must be used in accordance with the final approved plan and through a section 75 pooled fund agreement;
- The full value of the element of the Fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. However, CCGs may only release the full value of this funding into the pool if the admissions reduction target is met as detailed in the BCF Technical Guidance . If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG that it be spent in a particular way.

NHS England has advised, through the BCF Approval statement as well as through recently published planning guidance, that CCGs may wish to revise their ambitions for the level of reduction of non-elective admissions (currently set at 3.5% reduction by March 2016). BCF ambition targets must be in line with 2015/16 operational plans at both CCG and provider level. Revision of the target must include appropriate involvement from local authorities and

be approved by HWBs. NHS England will assess the extent to which any proposed change has been locally agreed in line with BCF requirements, as well as the risk to delivery of the ambition, as part of its assurance of CCGs' operational plans.

Section 75 agreement
Considerable work has been done to develop an affective framework for integrated working under the BCF. An approach based on the importance of local decision making has been agreed. Legal agreements are being drafted and implementation is expected on 1st April 2015.

The key principles agreed are:-

- Joint working between health and social services will be at the local level.
- Local services will be managed by Local Partnership Boards linked to local HWB Boards. These will have equal CCG and social services voting membership.
- Local Partnership Boards will be supported by local working groups which will be based on strong local relationships between health and social services.
- The legal relationship between the NHS and KCC will be via a formal s75 agreement. This agreement will have 7 sets of schedules, one for each CCG area.
- Each Local Partnership Board will be responsible for improving services through joint work between the partners. Where services need improvement this will be through better integrated working with finite resources.
- KCC will pull together data and where relevant finances as the "Pooled Fund Manager" for the agreement and will provide summary reports to the county HWB Board and NHS England as required.

The timescale for full implementation on 1st April 2015 is short. The process outlined by the working party is as follows:

1. Agreement in principle by CCG Governing Bodies of the approach being taken – Jan 2015
2. Agreement by the County Health and Wellbeing Board of the approach – 15 Jan 2015
3. Completion of legal drafting – Jan 2015
4. Development and implementation of Local Partnership Boards and Support Teams – Jan / Feb / Mar 2015
5. Completion of legal agreement – Feb/Mar 2015
6. Cabinet sign off by KCC – Mar 2015
7. Governing Body Agreement by CCGs – Mar 2015

BCF Schemes Summary of Progress to Date

All the following elements will underpin the development of the Integrated Care Organisation supporting the out of hospital agenda.

Integrated Teams, Rapid Response, Reablement – Plans for integration of health, social care, and mental health integration, including domiciliary carers involving education for early intervention and alternative care pathways in the community (to include all health and social care beds accessed through one point within the Integrated Discharge Team) with the aim to reduce unnecessary admission to hospital are underway and have agreement from all parties involved. This community health and social care model will be jointly commissioned with an integrated budget, using the local joint health and social care Learning Disability model as the template. The service will be supported by the community Geriatrician. The plan is as follows and is currently in progress:

November 2014 – June 2015:

- Learning Disabilities Model to be reviewed for application to Integrated Intermediate Care and Kent Enablement at Home to include finance (KEAH)
- Triage of referrals to Intermediate care and KEAH to reduce duplication and hand offs between services
- Education of KEAH staff in additional health interventions
- Identify good practice models locally and nationally
- Scoping service model to include
  - Carers/voluntary/befriending organisations (including CARM)
  - Potential use of technology
  - Use of step-up beds (including Dementia)
  - Use of day services
  - Community Geriatrician
- Staffing establishments across all services to be reviewed for similarities and capacity modelling
- Continuous evaluation model to be developed
- GP practices sign up to providing data for modelling by Public Health

Enhance Neighbourhood Care Teams & Care Coordination-
Redesign of the existing community nursing services comprising, district nursing, specialist nursing and practice nursing is under way currently working closely with Kent Community Health NHS Trust for nursing and social care services wrapped around General Practice supported by the community Geriatrician. The plan is as follows:

Phase 1: February – May 2015

- Practice teams will be in place as per the proposed alignment and names of staff in those teams known by the practice - **beginning of February**
- Practices and KCHT to sign off the final Memorandum of understanding
- Practice teams will be moved to the practices where it is possible during phase 1
- The Clinical Care Coordinator role will be embedded into the lead nurse (band 7) role (as per the Clinical Care Coordinator role being tested in Deal)
- Start with new specification March / April 2015 -Monitor model going forward- via performance meeting
- Start education of nurses according to the service specifications – (community nursing & specialist nursing)
- Work to reduce the inappropriate work for community nursing (ie: clexanes, eye drops etc) and use of practice clinic rooms to run clinics for non -house bound patients who need the skills of community nurses with GP support to the new teams
- Oversee implementation of the model via the Community Nursing Redesign Group Meeting (includes KCC)

Phase 2: June – October 2015

- Work towards the change in hours to 8am – 8pm (day)– ensure that reduction in the inappropriate work that the nurses are doing has ceased
- Work towards the change in hours to 8pm – 8am (nights) – to align with OOH model
- Continue with education of staff according to the service specification (community & specialist nurses)
- Continue to monitor model via performance meeting and to oversee implementation of the model via the Community Nursing Redesign Group Meeting (broaden member ship to include mental health etc as we build the teams around general practice)

Phase 3: November 2015 – August (2016)

- Work towards integrating the practice nurses with the community nursing teams (where agreed with practices)

- Continue to monitor model via performance meeting
- Continue with education of staff according to the service specification (community & specialist nurses)
- Continue to oversee implementation of the model via the 'community nursing redesign group meeting'

Enhance Primary Care- 8am – 8pm primary care building on the Prime Ministers Challenge Fund (PMCF) model in South Kent Coast areas The PMCF is in place in Folkestone currently rolling out to Dover in March. There is the opportunity to bid for 2nd Wave funds and Practices across SKC CCG area are developing their bids currently. This element links to the enhanced neighbourhood care teams, care coordination and the integrated teams – Rapid Response, Reablement and Mental Health pathway for proactive management of high risk patients and though the Multi-Disciplinary Team approach and support from a community Geriatrician . This will include the continued development of various schemes to support over 75s. Work to date is as follows:

- Integration of all GP practices within a community offering extended primary care service 8am – 8pm 7 days per week, linked to the local hospital – currently being tested via the PMCF
- 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 – Phase 1 already in place-acute is now linked to primary care, Phase 2 is to roll this out to other providers ie: SECamb, KCHT, KMPT IC24
- An integrated telephone system would be installed that enables all practices to have calls re-directed and to offer telephone appointment booking.
- There is 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 currently being tested via the PMCF
- Primary care mental health specialist are in place offering assessments either at the hospitals or at home. They will also provide support to GP's with mental health queries
- Patients in nursing and residential homes have an anticipatory care plans in place ,using the same principles as the Unplanned Admissions Enhanced Service around personalised care planning and having regular contact with the patient.
- A review of patients who are housebound has been undertaken who have at least one long term condition using the same principles as the Unplanned Admissions Enhanced Service around personalised care planning
- Patients with more than 4 medications are having a medication reviewed it is planned that, over two years the number of medications in total will be reduced by 10%.
- Patients who are not in nursing or residential care are being targeted if they are known to have an ambulatory sensitive condition as defined by the Kings Fund and provide them with self-care plans.
- Over 75's are having a Falls – Assessment in Home Environment.

Enhance Support to Care Homes – There is already in place, proactive work with local care homes providing support and education from the Older Peoples Specialist Nurse Team and Community Geriatrician together with Social Care colleagues with a focus on care homes with high attendance at A&E and admission to hospital. There is also a focus on quality through support and education. This model is already showing results in reducing A&E attendances with an approximate reduction of 8%. In addition, increased out of hours community nurses have been recruited until the end of March 2015 under the resilience funding, taking a proactive approach to supporting care homes with complex patients to ensure the proactive support of the 24 hour period.

Integrated Health & Social Housing Approach - An integrated approach to local housing and accommodation provision to enable, supported by a joint Health and Social Care Accommodation Strategy, 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. This work is being supported via the Integrated commissioning group and will be progressed from January 2015, work has already started on the centralisation of availability of the intermediate care beds across health and social care for step up and step down via the Integrated Discharge Team. Environmental assessments are being planned for use by domiciliary visiting health services in order that poor environments that may affect peoples health and wellbeing can be identified for improvement. See embedded document for Integrated Commissioning group draft work plan.

Integrated Commissioning Group

Falls Management & 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. The existing falls pathway is being refreshed together with public health and providers 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 and will include signposting to vision screening, hearing tests, medication reviews, exercise groups and environmental such as housing assessments. Work to date is as follows:

- Level of current services across locality has been scoped so that they 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;
- The development of an Integrated Ambulance Falls Response Service, being led by KCC has been put on hold currently due to lack of funding. SKC has a copy of the full business plan however, a decision will need to be made whether to take this piece of work forward in this financial year.
- The east Kent falls group will be agreeing the pathway to ensure consistency across localities. Once this has been done, each CCG will ensure this is embedded across professions to maintain equity of access and inform agencies, GPs etc. of the local services / preventions available for their patients.
- Improve availability and awareness of therapeutic exercise programmes (postural stability classes) via community classes and domiciliary based is being worked through
- Key performance indicators have been drafted and added to the Intermediate Care Service, service specification for consideration by KCHT