Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Kent County Council**
Clinical Commissioning Groups	**Dartford Gravesham and Swanley**
	Swale
	West Kent
	Ashford
	Canterbury and Coastal
	South Kent Coast
	Thanet
Boundary Differences	**There are some boundary differences between CCGs and District authorities. Swale CCG has a 20% flow from Swale to Medway Foundation Trust. In developing the plan discussions with these areas has taken place to ensure consistency of outcomes.**
Date agreed at Health and Well-Being Board:	**17/09/2014**
Date submitted:	**19/09/2014**
Minimum required value of BCF	**£5.136m**

pooled budget: 2014/15	
2015/16	**£101m**
Total agreed value of pooled budget: 2014/15	**£5.136m**
2015/16	**£101m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**Dartford Gravesham and Swanley**
By	Patricia Davies
Position	Accountable Officer
Date	19 September 2014
Signed on behalf of the Clinical Commissioning Group	**Swale**
By	Patricia Davies
Position	Accountable Officer
Date	19 September 2014
Signed on behalf of the Clinical Commissioning Group	**West Kent**
By	Ian Ayres
Position	Accountable Officer
Date	19 September 2014
Signed on behalf of the Clinical Commissioning Group	**Ashford**
By	Simon Perks
Position	Accountable Officer
Date	19 September 2014
Signed on behalf of the Clinical Commissioning Group	**Canterbury and Coastal**
By	Simon Perks
Position	Accountable Officer
Date	19 September 2014
Signed on behalf of the Clinical Commissioning Group	**South Kent Coast**
By	Hazel Carpenter
Position	Accountable Officer

Date	19 September 2014
Signed on behalf of the Clinical Commissioning Group	**Thanet**
By	Hazel Carpenter
Position	Accountable Officer
Date	19 September 2014
Signed on behalf of the Council	**Kent County Council**
By	Andrew Ireland
Position	Corporate Director, Social Care, Health and Wellbeing
Date	19 September 2014

Signed on behalf of the Health and Wellbeing Board	**Kent Health and Wellbeing Board**
By Chair of Health and Wellbeing Board	Roger Gough
Date	19 September 2014

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Joint Strategic Needs Assessment	**http://www.kmpho.nhs.uk/commissioning/needs-assessments/**
Kent Health and Wellbeing Strategy	**http://www.kmpho.nhs.uk/commissioning/needs-assessments/**
Kent Integrated Care and Support Programme Plan	Kent IP Programme Plan v2.docx
HWB Assurance Framework	**https://democracy.kent.gov.uk/documents/s45113/Item%206%20Assurance%20Framework%20mv%202.pdf**
Kent HWB BCF Mapping Exercise	**Summary included** HWB analysis template.xlsx
Kent Summit Schedule	Summit Schedule.docx

Kent HWB Paper 26 March 2014	140326 BCF HWB report v2.docx
Social Care Benefits Report - This document outlines some of the key benefits realised within Social Care Transformation and how they relate to associated schemes within the Better Care Fund to protect Adult Social Care.	Appx B Kent social care benefits summar

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

The Kent Vision

Kent supports the vision as outlined by The Narrative in *Integrated Care and Support, Our Shared Commitment, May 2013*:
"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

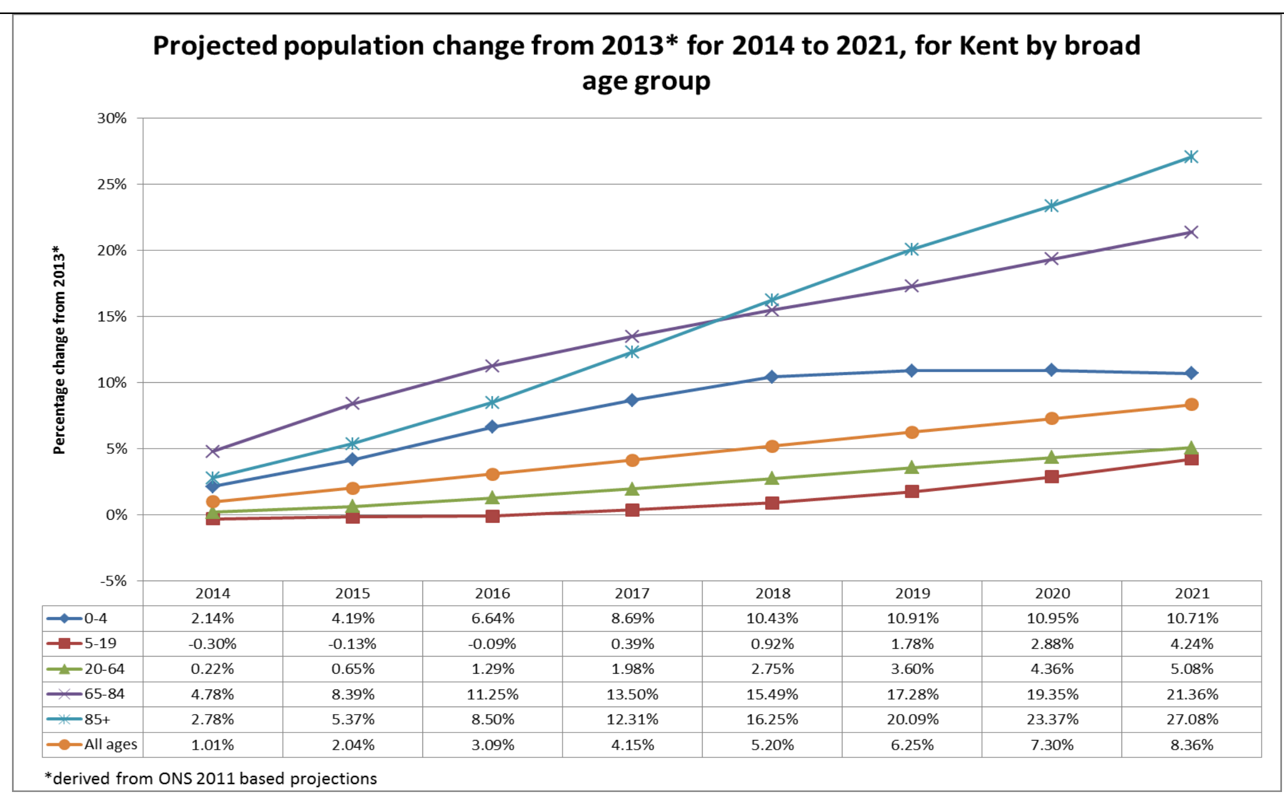
The Kent JSNA states "*Integrated care is an organising principle for care delivery that aims to improve health and social care integration in Kent. It is about improving outcomes for our 1.5 million population by transforming services within the community so they support independent living, empower people and place a greater emphasis on the role played by the citizen and their communities in managing care. Kent will continue to be bold in developing new and different solutions to the challenges facing health and social care and as an Integrated Care and Support Pioneer, continue to work through partnerships that support integrated commissioning and deliver the provision of integrated services*"

By 2018 we want to achieve an integrated system that is sustainable for the future with improved outcomes for people and includes the "Kent £" across the entire health and social care economy. Patient and service user outcomes will be measured against I Statements, using The Narrative (developed by Making it Real) – we expect to see improvements in the confidence of the public to receive care in their communities at the times they need it.

The Kent Context

The county council is largely responsible for adult and children social care services, it currently works in partnership with 7 Clinical Commissioning Groups and 12 District Authorities that commission health care and housing services respectively. The provider landscape is also extensive, with 4 acute trusts spread over 7 hospital sites, 1 pan county community health care trust, 1 mental health and social care partnership trust, 1 ambulance trust and many third sector and voluntary organisations including 4 hospices.

Kent has a population of 1.5 million. Overall, the population of Kent is predicted to grow by 8.4% over the next seven years, representing an extra 123,000 people. The biggest increases are to be expected in the older age groups; 65 to 84 and over 85. The 65 to 84 growth is anticipated to be 21.4%, an extra 49,000 people, but the largest increase will be in the over 85 age band, at 27.1%. This represents an additional 10,000 people. This makes the work within Kent's Pioneer Programme and delivery of the Better Care Fund a key priority in ensuring a sustainable health and social care system.



	2014	2015	2016	2017	2018	2019	2020	2021
0-4	2.14%	4.19%	6.64%	8.69%	10.43%	10.91%	10.95%	10.71%
5-19	-0.30%	-0.13%	-0.09%	0.39%	0.92%	1.78%	2.88%	4.24%
20-64	0.22%	0.65%	1.29%	1.98%	2.75%	3.60%	4.36%	5.08%
65-84	4.78%	8.39%	11.25%	13.50%	15.49%	17.28%	19.35%	21.36%
85+	2.78%	5.37%	8.50%	12.31%	16.25%	20.09%	23.37%	27.08%
All ages	1.01%	2.04%	3.09%	4.15%	5.20%	6.25%	7.30%	8.36%

What changes will be made

Our vision is to be providing person centred care with easy to access, 24/7 accessible services wrapped around them that crosses the boundaries between primary, community, hospital and social care with services working together, along with voluntary organisations and other independent sector organisations. The GP neighbourhood practice will be at the heart, directing the suite of community health and social care services – providing a neighbourhood team around the patient and a neighbourhood team around the GP to forge common goals for improving the health, wellbeing and experiences of local people and communities.

It was recognised in becoming an Integration Pioneer that Kent has a proven track record of delivery and a plan for achieving integration by 2018. We recognise that the system needs whole system transformation to develop integrated commissioning of integrated provision. As part of this we will use the Better Care Fund to accelerate transformation and:

- Deliver the ‘right care, in the right place at the right time by the right person’ to the individual and their carers that need it. Reducing the pressure on the acute hospitals by ensuring the right services are available and accessible for people when they are required.
- Support people to stay well in their own homes and communities, wherever possible – avoiding both avoidable and where appropriate some currently unavoidable admissions by developing “hospitals without walls”.
- Enable people to take more responsibility for their own health and wellbeing.
- Get the best possible outcomes within the resources we have available.
- Create an integrated intelligence system for integrated commissioning led by Public Health, supported by commissioner and provider organisations that enable integrated commissioning and evaluate the benefits of integrated care across the system in real time at population level.

The use of the Better Care Fund will contribute to improving the following outcomes identified within the Health and Wellbeing Strategy:

- Effective prevention of ill health by people taking greater responsibility for their health and wellbeing.
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.
- People with mental ill health issues are supported to live well.
- People with dementia are assessed and treated earlier.

b) What difference will this make to patient and service user outcomes?

Putting the Citizen at the Centre

Patients and service users will see a fundamental difference in the way out of hospital care is delivered. The focus will be on supporting people to self-manage and coordinate their own care as much as possible, facilitated by integrated electronic records and care plans.

GPs will lead community based multi-disciplinary teams, with access to outreach from specialists, mental health, dementia support as required to provide targeted, proactive care and support to those people identified as being of highest risk of hospital attendance or increasing use of care services.

We will work in partnership with the voluntary and community sector and District Authorities recognising the contribution they make in ensuring we achieve the levels of transformation required.

Making a Difference Now

Significant work has taken place in engaging with public across Kent to ensure we understand their needs and the outcomes they want to achieve. The people of Kent have told us that they want to be able to stay in their own homes for as long as possible, not wanting to have to go into hospital or long term care. *"They want to keep us in our home, we want to stay in our own home – and we're going to be!"* Patients and service users would like the professionals involved in their care to talk to each other and to include them in their care planning.

Through a number of initiatives already happening in Kent such as Proactive Care in South Kent Coast, the Integrated Discharge Team in North Kent and Health and Social Care Co-ordinators in Canterbury and West Kent and the use of anticipatory care plans we have already seen better patient and service user outcomes. The Better Care Fund plans will look to build on and accelerate progress.

"My anticipatory care plan ensured that the community matron was able to provide me with the correct clinical support. Without this both my family and I were sure I would have had to go back into hospital"

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Kent as an Integrated Care and Support Pioneer

Kent has a number of outcomes it wants to achieve over the next five years as an Integration Pioneer:

Integrated Commissioning:

- Together we will design and commission new systems-wide models of care that ensures the financial sustainability of health and social care services in Kent. These services will give people every opportunity to receive personalised care at, or closer to home to avoid hospital and care home admissions.
- We will use an integrated commissioning approach to buy integrated health and social care services where this makes sense.
- The Health and Wellbeing Board will be an established systems leader, supported by clinical co-design and strong links to innovation, evaluation and research networks.
- Integrated Commissioning will be achieve the shift from spend and activity in acute and residential care to community services, underpinned by JSNA, Year of Care financial model and risk stratification. We will have a locally agreed tariff system across health and social care commissioning based on the year of care funding model, allocating risk adjusted budgets, co-managed and owned by the integrated teams and patients.
- We will see integrated budget arrangements through section 75s as the norm alongside Integrated Personal Budgets.
- New procurement models will be in place, such as alliance, lead provider, key strategic partner and industry contracts, delivering outcome based commissioned services.

Integrated Provision:

- A proactive model of 24/7 community based care, with fully integrated multi-disciplinary teams across acute and community services with primary care playing a key co-ordination role. The community / primary / secondary care interfaces will become integrated.
- We will have a workforce fit for purpose to deliver integrated health and social care services. To have this, we need to start planning now and deliver training right across health, social care and voluntary sectors.
- An IT integration platform will enable clinicians and others involved in someone's care, including the person themselves, to view and input information so that care records are joined up and seamless. We will have overcome information governance issues. Patient held records and shared care plans will be commonplace.
- We will systematise self-management through assistive technologies, care navigation, the development of Dementia Friendly Communities and other support provided by the voluntary sector.
- New kinds of services that bridge current silos of working where health and social care staff can "follow" the citizen, providing the right care in the right place.

How the Better Care Fund will Deliver Change

The Better Care Fund will be used across Kent to implement new secondary care models to manage urgent and planned care as separate entities for optimum efficiency. Hospital based urgent care will work as part of the total system connected with primary and community services. Together they will optimise patient flows to deliver the most cost effective service with coordinated care around people with complex needs.

By 2016 we will have reduced the need for hospital acute admissions by 3.5% by having co-ordinated health, social and community services that meet the needs of our Kent citizens 24 hours a day, seven days per week. We will have shared information systems with integrated care plan sharing, monitoring people in their own home including self-monitoring which fully supports independent living

By 2016 the Kent citizen can expect fast community responses within 4 hours to mirror the targets and pressures in the acute trusts. This will be achieved by changes in workforce based around the GP practices working together in neighbourhoods as part of the integrated care teams, co-ordinating care and accountable for delivering this 24/7 care backed up by consultants and specialist nurse working in the community.

Using the Year of Care to redesign payment and contracting systems
The YOC programme also uses person level linked datasets to generate information but for a more specific purpose – understanding the cost of providing integrated care across the whole pathway, evaluation of effectiveness and efficiency and designing the appropriate contractual and risk sharing arrangements.

Public Health Intelligence will continue to work with health and social care organisations across the 3 Kent Economies (starting with East Kent) in utilising existing information systems to monitor and evaluate the YOC programme, through its shadow testing phase in 14/15 and its anticipated implementation from 15/16 alongside national rollout. The same system can and will also be used to help evaluate integrated care models across different CCGs and understand their impact on the whole system.

Latest results gives us a useful baseline understanding of how high intensive users of hospital services, mostly the complex frail elderly with multiple morbidities, also impact on services in the community. This shows commissioners the potential of benefits and savings of acute care over time if integrated care was implemented at pace and scale, targeted towards the right population group at the right time. Details of results and analyses described at both CCG and Kent level profiles are available at www.kmpho.nhs.uk/jsna.

Falls and Fracture Prevention in the elderly – a case study
Kent has seen increasing numbers of hospital admissions for falls and fractures over a number of years. A number of reasons have attributed to this but more so the historically fragmented way health and social care services work together, and the lack of an integrated pathway of care, starting from when an ambulance is called out to an elderly faller, all the way to a person being assessed and referred to a community based exercise programmes to prevent falls.

An integrated intelligence approach will help us collect and utilise information from the key service providers along the pathway to evaluate their effectiveness, but also incentivise and capitalise opportunities for prevention. For example, person level linked datasets which includes information from home safety checks carried out by Kent Fire & Rescue will enable commissioners to understand and quantify their benefits and whether initiatives such as exercise programmes and home adaptations have been targeted to the right persons.

On a much broader note, commissioners can also understand the relative impact of falls and fracture prevention versus other important programme areas such as dementia care and end of life, which are also concentrated around the same group of persons who happen to be the complex frail elderly with multiple long term conditions. This will help commissioners move towards integrated commissioning of these services in the long term and optimise limited resources with each of them by bringing them together to address frailty as a whole and improve quality of care.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Identifying the Population

Improvement of health and wellbeing in the population through integrated care depends on the at risk group being targeted. In Kent, much of the integration agenda has been focused on the health and wellbeing of the complex frail elderly with multiple long term conditions. A Public Health led longitudinal study using risk stratified (based on a local version of the King's Fund tool) Kent whole population person level linked datasets has demonstrated variation in service utilisation (and costs) over time, across different services and different risk stratified groups. A recent poster presentation to Public Health England conference illustrates the broad headlines of this (http://www.kmpho.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=368717).

Focus on long term conditions

The most important pattern analysed was annual variation in unscheduled admission activity attributed to 'crisis' amongst the high intensive users. Much of this activity is very related to 3 programme areas that affect the complex frail elderly – falls and fractures, dementia and end of life.

Illustrating this difference in activity attributed to 'crisis' in high intensive users gives us a better understanding how and when to target them using an integrated model of care. GPs in Kent currently use the locally developed risk stratification / prediction tool (same as the above) to help identify next year's Band 1 patients before they enter 'crisis'. By multidisciplinary team working and anticipatory care planning, integrated health and social care teams can align all necessary preventative interventions efficiently and economically as early as possible to prevent the 'crisis' from happening.

The Benefits of an Integrated Approach

The difference in activity attributed to the 'crisis' helps us also to determine realistic benefits of a proactive integrated care approach. For example, if the integrated model of care approach was implemented to the top 5% at risk population, at a Kent & Medway (CCG) level the estimated savings as a result averting non elective admission activity due to 'crisis' is approximately £75 million, or more than a quarter of the total unscheduled care activity for the whole population, based on 2010/11 activity.

A more recent analysis has been carried out by the National Year of Care team on the updated Kent whole population longitudinal dataset http://www.nhsiq.nhs.uk/resource-search/publications/population-level-commissioning-for-the-future.aspx . It not only reaffirmed some of the earlier results described by Public Health but also generated some additional conclusions:

- Total health and social care costs are strongly related to risk score and multimorbidity (Figure A1&2)
- Multi-morbidity appears to be more strongly related than age to total health and social care costs (Figure B)
- Acute non-elective costs contribute most to the increased cost for people with multimorbidity.(Figure B)
- Both the risk score or multimorbidity population segmentation methods show a 'crisis curve', where people move into and then out of a period of higher health and social care need (Figure C1&2)
- Following the crisis curve, the health and social care needs of patients change, such that nearly 50% of services were delivered by non-acute providers (compared with 2/3 of cost before the crisis curve)
- People move into and out of the 'very complex' health and social care need person cohort rapidly, with only 20% of people remaining in this cohort from 1 year to the next.

Figure A1 Average annual cost per patient by multi-morbidity

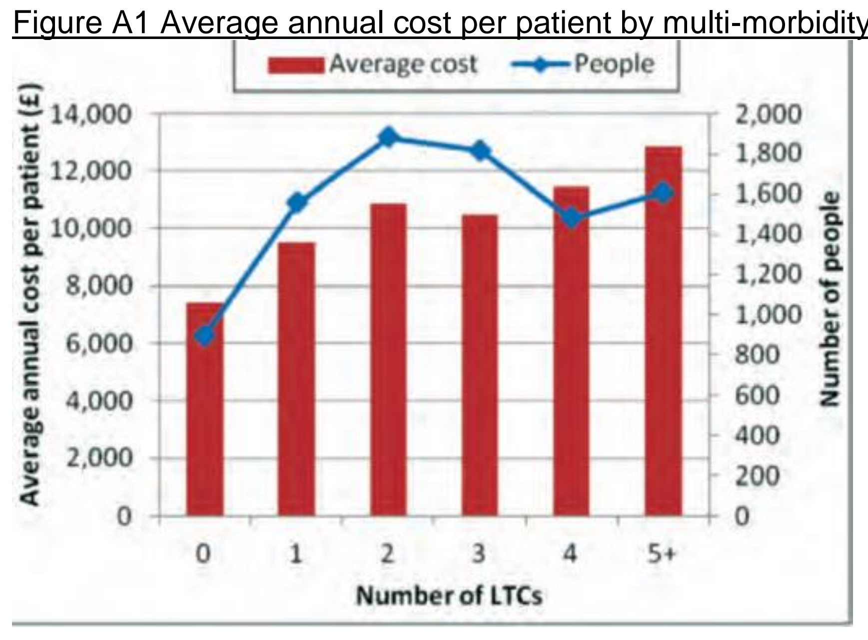


Figure A2 Average annual cost per patient by Risk Band

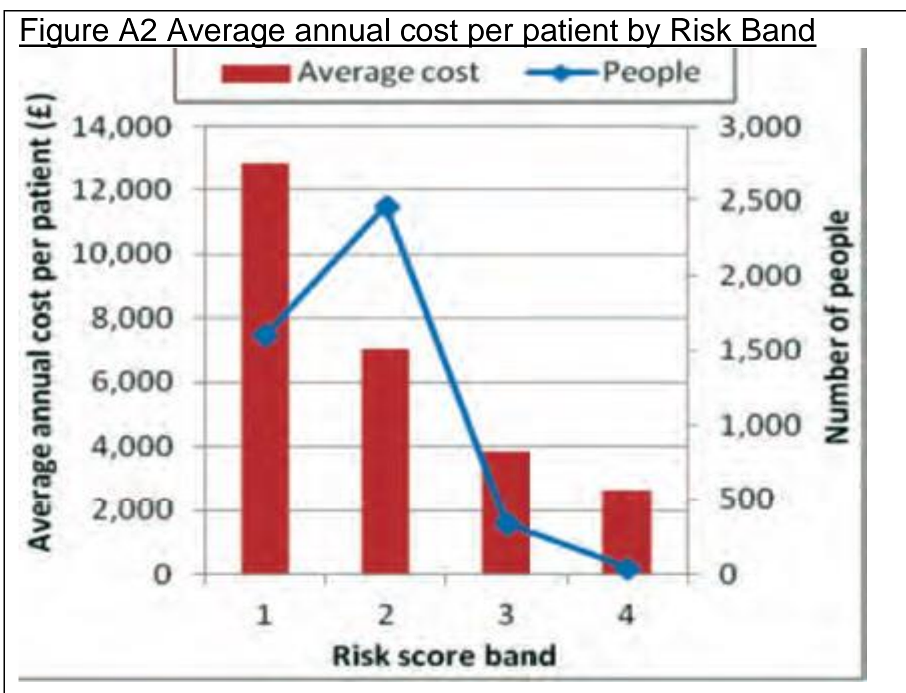


Figure B Breakdown of average annual cost per patient by multi-morbidity

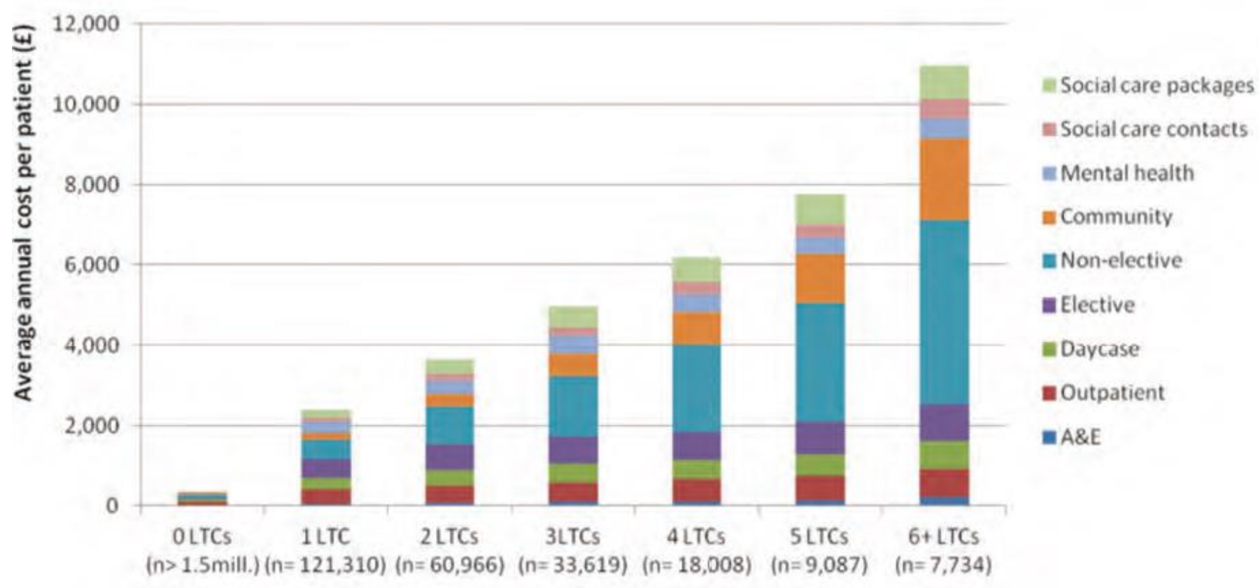


Figure C 1 Average annual cost per patient over time

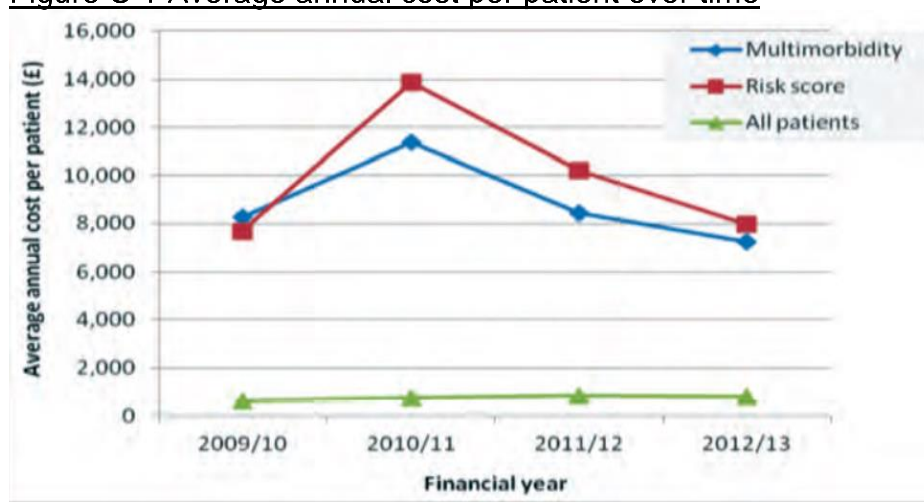
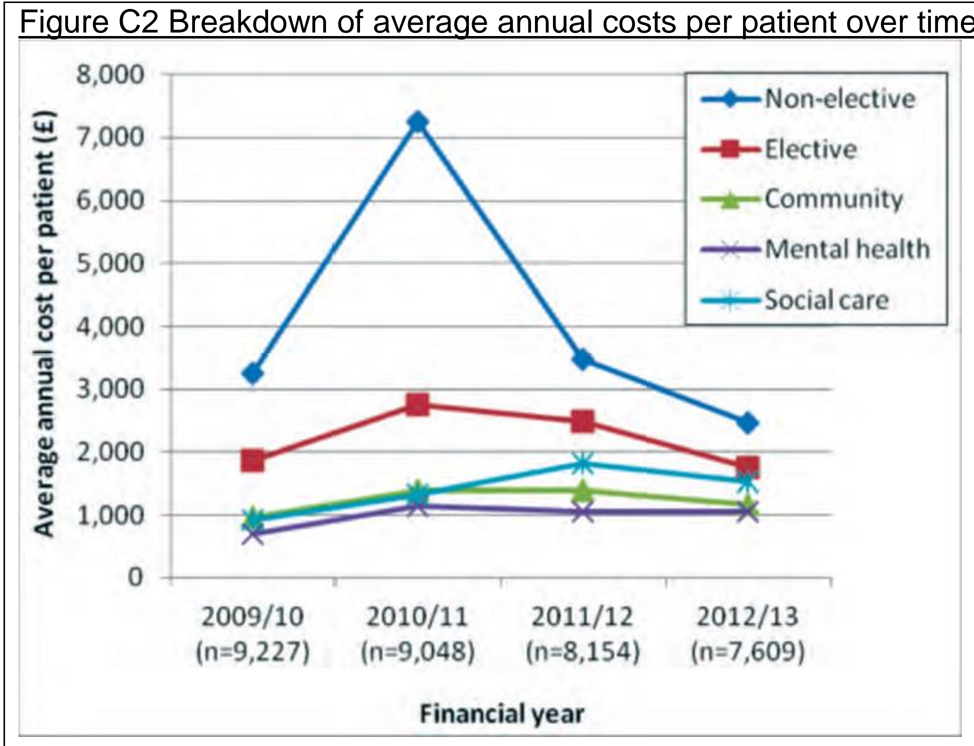


Figure C2 Breakdown of average annual costs per patient over time



The above analyses form the bedrock of evidence required for a robust funding model to deliver integrated care. For example, Figure B illustrates the differences in costs between different patient groups by numbers of multi-morbidity. Figure C2 shows variation in costs across care settings over time, which helps us understand different impact across each setting and where cost savings (mainly from unscheduled care) could be achieved.

What does this mean for the people of Kent?

More people are living with multiple long term conditions, this is a challenge locally and nationally to the public's health but also an opportunity to deliver services in a way that improves outcomes, improves experience of care and makes best use of resources. Using the Better Care Fund the citizens of Kent can expect:

- Better access – co-designed integrated teams working 24/7 around GP practices.
- Increased independence – supported by agencies working together.
- More control – empowerment for citizens to self-manage.
- Improved care at home – a reduction for acute admissions and long term care placements, rapid community response particularly for people with dementia.
- To live and die safely at home – supported by anticipatory care plans.
- No information about me without me – the citizen in control of electronic information sharing.
- Better use of information intelligence – evidence based integrated commissioning

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The Building Blocks

The Better Care Fund is seen as one of the fundamental building blocks to achieving whole system transformation of health and social care by 2018. These building blocks were highlighted by the HWB in March 2014 as:

- The Better Care Fund – 2016
- The Health and Wellbeing Strategy – 2017
- Kent's Pioneer Programme – 2018
- CCG Strategic Plans – 2019
- KCC's Adult Social Care Transformation Plan

A Phased Approach to Implementation

The schemes outlined within the Better Care Fund form part of the overall programme delivery plan for Kent as an Integrated Care and Support Pioneer (attached as supplementary information). The Pioneer programme has been developed as a phased approach across 3 overlapping waves, which supports taking the whole system to the integrated commissioning of integrated health and social care provision by 2018. The key themes of delivery are underpinned by the Better Care Fund and are presented as:

Wave 1 Systems and Partnerships	Wave 2 Breadth of Services	Wave 3 Integrated Commissioning of Integrated Provision
Principle of culture change and shared vision	Leadership	Outcomes based contracts
Health and Wellbeing Board performance dashboard	Contracting model	New procurement models
Evaluation Framework	Year of Care / Tariff & Pricing	New kinds of services
Innovation Hub	Integrated budgets	Co-production of services
Risk stratification	Integrated care	24/7 Care
I Statements	Integrated contacts and referrals (SPA)	Workforce
Optimisation /Productivity Health and Social Care	Personal Health Records	Integrated IT
Multi-disciplinary team meetings	Systemised self-care	Outcomes based evaluation
Workforce	Housing	Financial risk sharing models/ incentives
Information Governance	End of Life Care	
Urgent Care	Voluntary Sector	
Establish principle of co-production		

Interdependencies

The schemes within the Better Care Fund build on existing projects within the Kent Health and Social Care Integration Programme and are aligned with the objectives of the Kent Health and Wellbeing Strategy as detailed above, which in turn are derived from the key health priorities identified within the Joint Strategic Needs Assessment. The schemes form part of CCG Commissioning Plans and the Kent Families and Social Care Adult Transformation Plan.

Kent is also part of the Year of Care programme, Going Further Faster and is expressing interest in the Integrated Personal Commissioning Programme. Interdependencies across these programmes are managed through the Integration Pioneer Programme.

CCG Area Implementation

Discussions have taken place across CCG areas with providers on the impact of implementing the schemes within the Better Care Fund plan. Further work has taken place across each care economy to develop the detailed actions required for delivery, through a series of workshops and summits.

West Kent

As projects plans continue to developed and full implementation plans are rolled out the system leadership group will retain overall management of the BCF programme to ensure key interdependencies and critical path activities are identified and completed. This includes specifying and delivering the necessary supporting infrastructure, including IT, governance, and organisation development, as well as communications and engagement plans linked to key milestones within the programme. West Kent have identified the timelines for their delivery within their Template 1 Appendix.

North Kent

North Kent have embarked on two major transformational programmes for Community Services re-procurement and Urgent Care (24/7 service) and these will ensure that the development of the integration work with social care and public health is taken forward contractually. Projects leads continue to develop their detailed plans for full implementation of the main service developments, i.e. dementia integrated pathways, IPCTs, IDT and single point of access, management of the BCF programme will ensure key interdependencies and critical path activities are identified and completed. This includes specifying and delivering the necessary supporting infrastructure, including IT, governance, and organisation development. Communications and engagement plans are also linked to key milestones within the programme.

East Kent

South Kent Coast, Thanet and Ashford and Canterbury have identified timelines for delivery and key milestones within their Template 1 Appendix. Each area has developed implementation plans and shared governance to oversee delivery, this includes the development of integrated health and social care programme management posts.

b) Please articulate the overarching governance arrangements for integrated care locally

Kent's governance for delivering as an Integrated Care and Support Pioneer has been set out in the cover paper. The responsibility and management of the Better Care Fund sits within this by using existing governance structures with the Kent Health and Wellbeing Board as systems leaders, informed by local governance arrangements. 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 with implementation of the Better Care Fund. It will be possible to identify what is working well and where schemes should be driven forward at greater pace, or where schemes are not achieving desired outcomes and need to be amended or

stopped.

Any additional local governance for delivery of area plans is outlined in appendices.

C) Please provide details of the management and oversight of the delivery of the Better Care Fund plan, including management of any remedial actions should plans go off track

The Kent HWB will retain a county wide oversight of delivery of the BCF in line with CCG plans attached and local governance structures.
A county wide performance and finance group supported by the Area Team and involving all CCGs and KCC will be established in September 2014 to support development of the pooled fund and area section 75 agreements. This group will retain responsibility for regularly reviewing progress on the BCF and making recommendations to the Kent HWB as appropriate. Terms of Reference will be established in October 2014.

The Kent HWB agreed next steps to establish principles to underpin robust risk sharing on 17 September 2014 and agreed risk sharing agreements will be in place as part of developing the section 75 agreement by 1 April 2015. This will include agreement on the governance arrangements if performance targets are not met.

The Kent Integration Pioneer Steering Group facilitates discussions at a Kent wide whole system level the implementation of integration, sharing learning and barrier busting to enable local systems to make informed decisions about ongoing progress. This is seen as a key support mechanism for the management of delivering BCF plans.

CCG Area Summary

West Kent
A review of existing partnership governance structures in which the BCF sits is being undertaken across West Kent to ensure there is a clear and transparent governance framework in place which has responsibility for regularly reviewing progress on the BCF and making recommendations to the Kent and West Kent Health and Wellbeing Boards as appropriate. It is envisaged this will be completed by the end of September 2014.

North Kent
The BCF Delivery Group is accountable to the Executive Programme Board for delivery programme. Issues that cannot be resolved by individual projects or by the BCF Delivery Group are taken to the EPB. Where necessary, EPB members will then seek resolution within their own organisational governance structure.

East Kent
The plans will be governed jointly by the CCG and the local authority using joint metrics. The CCG will report delivery of the plans through existing assurance frameworks.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

The schemes below are a summary from the CCG level plans – Annex 1 detailed descriptions are available in the local area plans.

2015/16 Schemes – Themes of Delivery within CCG Plans	Description – full details are contained with CCG level plans	HWB outcomes and national conditions supported by the scheme
Integrated working through local models that deliver 7 day access:	West Kent: Enhanced rapid response service. Integrate LTC teams, with GPs coordinating care and involving mental health and dementia services. Integrated contacts and referrals, workforce implications and access to specialist input such as community geriatricians. Ensure provision of mental health and dementia is within all services. North Kent: Integrated Primary Care Teams, local referral unit, crisis response, integrated discharge team. Ensure provision of mental health and dementia is within all services East Kent: Integrated Teams and reablement, enhanced rapid response, enhanced primary care, neighbourhood care teams and care-coordination. Integrated urgent care centre. Ensure provision of mental health and dementia is within all services.	• 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 • Joint approach and coordinated care planning. • Better data sharing between health and social care. • 7 day services to support discharge and prevent unnecessary admissions. • Plans jointly agreed.
Enhanced support to residential and nursing homes	West Kent: Ensuring people have anticipatory care plans in place. Enable consultant access via technology. North Kent: Crisis response service, use of anticipatory care plans. East Kent: Anticipatory care plans, discharge plans and Community Geriatrician projects – to support care homes out of hours and at weekends. Peer support and medicines management programmes.	• 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 • Joint approach and coordinated care planning.

2015/16 Schemes – Themes of Delivery within CCG Plans	Description – full details are contained with CCG level plans	HWB outcomes and national conditions supported by the scheme
Develop models that support integrated working	West Kent: Support the principle of unequal investment to close the health inequality gap by addressing specific needs in specific areas to improve health outcomes. Minimise use of physical resources i.e. hospital buildings and maximise use of human resources i.e. skilled workforce with a multi-disciplinary health and social care approach. North Kent: Community Hospital re-design and estate configuration using evidence from the Oaks Group and Kings Fund. Development of skilled workforce with a multi-disciplinary health and social care approach. East Kent: Integrated approach to local housing and accommodation. Development of a community network model. Development of skilled workforce with a multi-disciplinary health and social care approach.	• Joint approach and coordinated care planning. • Plans jointly agreed.
Self-Management	West Kent: Co-produce with patients, service users, public and voluntary and community sector improvements in self-care. Including care navigators, advanced assistive technology, patient held records and the development of Dementia Friendly Communities. North Kent: United approach to advice and information on community and public sector, investment in community capacity and the further development of Dementia Friendly Communities. East Kent: Falls prevention services, integrated personal budgets, care-coordinators and Health Trainers, use of the voluntary sector and development of Dementia Friendly Communities.	• Effective prevention of ill health by people taking greater responsibility for their health and wellbeing. • The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.

2015/16 Schemes – Themes of Delivery within CCG Plans	Description – full details are contained with CCG level plans	HWB outcomes and national conditions supported by the scheme
Protection of Social Care	Enabling people to return to/or remain in the community. Ease of Access to Services /extended working hours/ Access to health and social care information. Enabling Prevention and Self Care. Expand integrated commissioning of schemes that produce joint outcomes. Falls prevention exercise classes.	• The quality of life for people with long term conditions is enhanced and they have access to good quality care and support. • Effective prevention of ill health by people taking greater responsibility for their health and wellbeing. • 7 day services to support discharge and prevent unnecessary admissions. • Joint approach and coordinated care planning. • Protection of social care services.
Disabled Facilities Grant	Equipment and adaptations are a key enabler to maintaining independence we will work with Districts to consider future actions required in delivering DFG.	• The quality of life for people with long term conditions is enhanced and they have access to good quality care and support. • Effective prevention of ill health by people taking greater responsibility for their health and wellbeing. • 7 day services to support discharge and prevent unnecessary admissions.
ASC Capital Grants	Home support fund and equipment.	• The quality of life for people with long term conditions is enhanced and they have access to good quality care and support. • Effective prevention of ill health by people taking greater responsibility for their health and wellbeing. • 7 day services to support discharge and prevent unnecessary admissions • Protection of social care services.
Implementation of the Care Act	Carers assessments and support services; Safeguarding Adults Boards; and national eligibility.	• The quality of life for people with long term conditions is enhanced and they have access to good quality care and support. • Effective prevention of ill health by people taking greater responsibility for their health and wellbeing.

2015/16 Schemes – Themes of Delivery within CCG Plans	Description – full details are contained with CCG level plans	HWB outcomes and national conditions supported by the scheme
		• 7 day services to support discharge and prevent unnecessary admissions Protection of social care services.
Carers support	Continue to develop carer specific support – including carers breaks.	• The quality of life for people with long term conditions is enhanced and they have access to good quality care and support. • Effective prevention of ill health by people taking greater responsibility for their health and wellbeing. • People with mental ill health issues are supported to live well. • People with dementia are assessed and treated earlier

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact . And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions – owners and timelines**
Increased pressure on Acute care could result in additional long term placements or long term social care input. Lack of rapid response for health and social could result in additional admissions to hospital and long term care.	4	5	20	BCF plans and Kent's Pioneer Programme designed to develop service models to mitigate risk. KCC Adult Social Care Transformation phase 2 also targeting this risk. *To be implemented within 15/16 and owned through local governance.*
Shifting of resources will destabilise existing providers, particularly in the acute sector.	3	5	15	The development of our plans will be conducted within the framework of our Kent Pioneer Programme. This facilitates whole system discussions and further work on co-design of, and transition to future service models. *Ongoing monitoring required and owned by HWB.*
The introduction of the Care Act will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	3	4	12	The implementation of the Care Act is part of the schemes within the BCF; further work is required to outline impact and mitigation required. *Further development on timelines and owned by Kent County Council.*
Primary care not at the centre of care-coordination and unable to accept complex cases.	2	5	10	Engagement with clinical leads and primary care providers essential as part of implementation of the BCF and Pioneer programme.

				To be implemented within 15/16 and owned through local governance.
Cost reductions do not materialise arising from: • a reduction in urgent care admission • a reduction in occupied bed days • a reduction in admission to residential and care homes • reductions in delayed transfer of care.	2	5	10	2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications. Implementation supported by Year of Care as an early implementer site. *To be implemented within 15/16 and owned through local governance.*
Protection of social care is not achieved.	2	5	10	Reduction in Section 256 monies would result in gap in social care budget. 2014/15 will be used to test and refine assumptions and develop clear outcome based performance measures, for improved monitoring of protection of social care funding. *To be implemented within 15/16 and owned through local governance.*
Lack of demand management, investment in voluntary sector and equipment will result in additional NHS and social care admissions.	3	3	9	BCF schemes highlight partnership working with voluntary sector and self-management schemes. Further work to take place within Kent's Pioneer Programme on community capacity building. *Ongoing monitoring required and owned by HWB.*
Workforce and Training – The right workforce with the right skills will be required to deliver integrated models of care. A shift in the model of care delivery will impact on training requirements. Additional risk is presented by age demographics of GPs and future resources impacted by retirement.	2	3	6	Workforce and training is a key objective of Kent's Integration Pioneer Programme. A programme of work is structured to explore the requirements of future workforce and implement changes to meet these requirements. *Ongoing monitoring required and owned by HWB.*

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The Role of the Health and Wellbeing Board

All partners across health and social care within Kent are committed to delivering the outcomes required of the Better Care Fund plan and the wider deliverables as part of Kent's Integrated Care and Support Pioneer programme. The Health and Wellbeing Board at a Kent and local levels will be responsible for monitoring outcomes being achieved and identifying further system changes that will be required to achieve success.

This will include reviewing areas that are working well and increasing the pace of delivery, or collectively deciding what should be stopped or amended.

A county wide performance and finance group supported by the Area Team and involving all CCGs and KCC will be established in Sept 2014 to support development of the pooled fund and area section 75 agreements. This group will retain responsibility for regularly reviewing progress on the BCF and making recommendations to the Kent HWB as appropriate. Terms of Reference will be established in October 2014.

Developing Risk Sharing Agreements

The Chair of the Kent HWB has been leading discussions with HWB members on progress of the development of the plan, discussions on expected targets and ongoing monitoring and implementation. In line with this the Kent HWB agreed next steps to establish principles to underpin robust risk sharing on 17 September 2014 and agreed risk sharing agreements will be in place as part of developing the section 75 agreement by 1 April 2015. This will include agreement on the governance arrangements if performance targets are not met.

To facilitate this NHS Area Team have supported the development of a CFO group including representation from all CCGs and Kent County Council to develop the section 75 agreement. This will report to the HWB in January 2015 with the recommended approach for risk sharing, governance and any further actions required to implement by April.

The Kent plan has identified £7,641,070 will be at risk if targets are not met. Regular review through identified governance structures will be required to ensure whole system buy-in and there will be additional overview through contract monitoring and balance as outlined in CCG level plans.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Delivery of the Better Care Fund is a workstream within Kent's Integration Pioneer Programme. This ensures that outcomes identified by Kent as a Pioneer are aligned with delivery of the BCF. It also enables the plans to link to other existing care and support initiatives taking place as part of Kent's Pioneer such as Year of Care and Going Further Faster.

Within Kent's Pioneer members of the Integration Pioneer Steering Group are acting as Senior Responsible Officers, to provide local leadership on delivery of workstreams. This role includes a Senior Responsible Owner for the Better Care Fund who will be able to oversee sharing of good practice across Kent.

West Kent

The West Kent Better Care Fund (BCF) Plan is a critical part of, and aligned to, the NHS West Kent Clinical Commissioning Group (CCG) two year operational plan and five year strategic plan. The BCF will act as an enabler in West Kent helping to support the delivery of Mapping the Future that underpins the West Kent contribution to the county-wide Integrated Care and Support Pioneer Programme and supports delivery of the 5 outcomes identified within the Kent Health and Wellbeing Strategy.

North Kent

The CCGs have identified the BCF initiatives in their 5 year Strategic Plans and 2 year Operating Plans. Additional aligned initiatives that support the BCF schemes are detailed in their local plan attached.

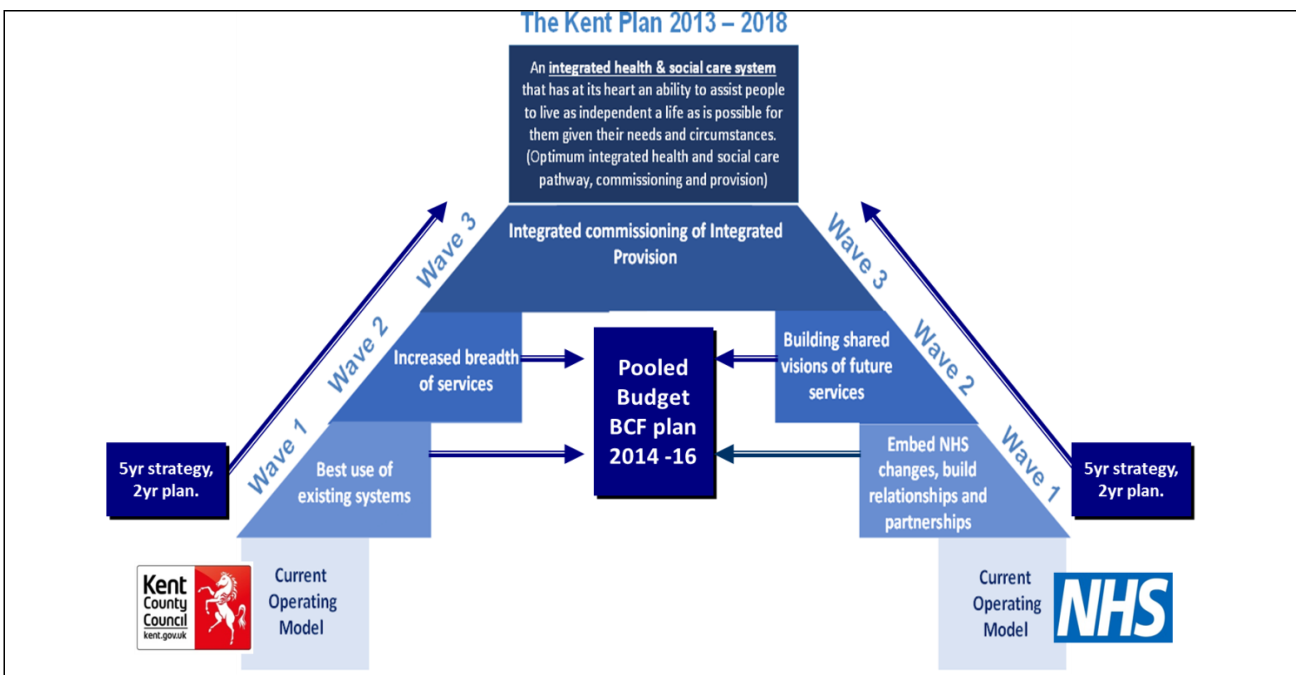
East Kent

There are a number of schemes already being developed or underway within East Kent which will have an impact on the health and social care system. SKC and Thanet have a detailed alignment plans within their local area plans attached. For Ashford and Canterbury and Coastal CCGs the pioneer lead is Simon Perks, the Accountable Officer. Supported by Lorraine Goodsell, the Transformation Programme Director.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Alignment within the Kent Pioneer Programme

Within the Kent Pioneer Programme the deliverables of integration were aligned to operating and strategic plans of CCGs and Adult Social Care. This was presented as a stepped approach to delivering integrated commissioning of integrated provision, supported by implementation of the Better Care Fund.



Alignment with CCG Plans

West Kent
The West Kent Better Care Fund (BCF) Plan is a critical part of, and aligned to, the NHS West Kent Clinical Commissioning Group (CCG) two year operational plan and five year strategic plan. The BCF will act as an enabler in West Kent helping to support the delivery of Mapping the Future that underpins the West Kent contribution to the county-wide Integrated Care and Support Pioneer Programme and supports delivery of the 5 outcomes identified within the Kent Health and Wellbeing Strategy.

North Kent
The Five Year Strategy and Operational Plan shows the key priorities for the period of 2014 to 2019. It was produced after listening to the public, our GP members and those that provide our services. The plan makes clear that the BCF offers an important opportunity to transform the system in North Kent to meet the needs of a rapidly ageing population better.

The BCF schemes are aligned to the 2 year Operational Plan and there are no additional risks. For reference, they can be seen in the 2 year plan (Plan on a page) and are all under the 'Top priorities' and 'Priority Initiatives' for year 1.

The plan is clear that system transformation is required, so that it is focused on supporting people, wherever possible, with person-centred and professionally-led care, with the goal of living as independently as possible. This plan was developed between CCGs and Kent County Council, to ensure more integrated health and care around the patient.

East Kent
The East Kent plans are aligned to the CCG two year operational and five year strategic plans. The schemes outlined in this plan have been developed in partnership with social care commissioners and public health experts. The schemes, along with the CCG's overall commissioning plans, will support addressing the needs identified in the local Joint Strategic Needs Assessment, particularly around the care of people with long term conditions and for those families and individuals supporting them.

Alignment with Local Government Plans

Kent County Council's Adults Transformation Programme identifies that by 2018 we will have:

- a sustainable model of integrated health and social care which offers integrated access, provision and commissioning.
- improved outcomes for people across Kent by maximising people's independence and promoting personalisation.
- maximised value for money by optimising our business, managing demand and shaping the market through strategic engagement with key suppliers.

This is being delivered across several phases, which align with both CCG plans (as identified above) and delivery of the BCF.

In addition as a Pioneer Kent has an integration action plan for housing, which is overseen by the Joint Policy and Planning Board – they will be reviewing future delivery of the Disabled Facilities Grant within the BCF. Further work is also taking place to develop an integrated Technology Strategy and Kent has submitted a shared Integrated Digital Technology Fund bid (hosted by West Kent CCG) to implement shared care plans.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

West Kent

West Kent CCG has both a Clinical Strategy Group and Practice Engagement Committee that meet monthly feeding into the Governing Body meetings. The intention for West Kent CCG not to apply for primary care co-commissioning status in the first round of bids (commencing 2015/16) was discussed with lead clinicians through these forums. The Governing Body has tasked the Practice Engagement Committee, which has the responsibility for membership engagement, to make recommendations on the next steps for the CCG with regards to co-commissioning and it is envisaged that this will be a topic of debate at the January meeting of the Committee.

North Kent

DGS and Swale CCGs have not applied for primary co-commissioning status. Both Swale CCG and DGS CCG have their own Primary Care Strategy Group meetings for the purpose of developing, in conjunction with the LMC and NHS England and member practices, the vision of primary care for their respective health economies. The groups' links into the respective subcommittees of each CCG's structure for public and membership engagement and will be the vehicle to work through the programme for co-commissioning for DGS and Swale CCG. This work will also be linked to membership events held throughout the year. The plans and time frame for development towards joint commissioning arrangements and possible pooled budgets is being developed through the primary care strategy groups; these will act as the steering group for progression

East Kent

SKC CCG has submitted an Expression of Interest to undertake commissioning of primary care services for our local area and are very supportive of taking on co-commissioning arrangements locally. The BCF is integral to the CCGs in Canterbury and Ashford's co-commissioning plans. They see the path to integrated care as needing to fully involve General Practice both as a provider and a commissioner and the ability to co-commission services on a population needs basis will be crucial to the delivery of better care for patients. Thanet CCG has submitted an Expression of interest to undertake commissioning of primary care services for our local area.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Protection social care services in Kent means ensuring that people are supported to maintain their independence through effective reablement (including the appropriate use of assistive technology), preventative support such as self-management, community resilience and support for carers, mental health and disabilities needs in times of increase in demand and financial pressures and the effective implementation of the Care Act.

Significant numbers of people with complex needs, who live in their own homes, want to stay and be supported in their own homes. They do not require daily support from health but have needs that would change and deteriorate without social care contribution to their support. This includes support for loss of confidence and conditions that have changed but do not require acute intervention from hospital or GP but do require enablement services from social care to regain their previous levels of independence. By providing effective enablement where a person has either been discharged from an acute setting or is under the care of their GP, admission or readmission can be prevented.

Social care is also responsible for commissioning of carer support services which enables carers within Kent to continue in their caring role, often it is the carer who may have health needs that deteriorate.

Kent will maintain its eligibility criteria at the ‘moderate’ until such time that the national minimum threshold come into effect. In keeping with its corporate priorities such as prevention and partnership working, it will continue to invest in voluntary and community sector organisations that have a role to play with demand management.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

To deliver whole system transformation social care services need to be maintained as evidenced through Year of Care. Current funding under the Social Care Benefit to Health grant has been used to enable successful delivery of a number of schemes that enable people to live independently.

For 14/15 and 15/16 these schemes will need to continue and be increased in order to deliver 7 days services, increased reablement services, supported by integrated rapid response and neighbourhood care teams. Further emphasis on delivering effective self-care and dementia pathways are essential to working to reduce hospital readmissions and admissions to residential and nursing home care.

In partnership with CCGs through local governance arrangements as identified in appendices detailed work on the implementation of schemes and the involvement and

role of social care within this will be developed. These will be completed in advance of implementation of the BCF in April 2015.

The Better Care Fund also identifies the social care support required for the implementation of the Care Act as identified below.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

Kent total for protection of social care £28.254m

Kent total for The Care Act £3.552m – for example to support carers assessments and support services, safeguarding adults boards and national eligibility

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The new legal framework introduced by the Care Act 2014 will be implemented for the most part from April 2015 but some of the key changes (care costs cap and raising of the capital threshold) do not start until April 2016. In many cases existing duties are simply consolidated into the new legislation. However the Act does introduce a number of new duties and powers and makes some changes to existing duties and processes. On 6 June the Government released for consultation the draft regulations and guidance for the 2015 changes and KCC has submitted a formal response to these. The final versions will be issued in October this year. The draft regulations and guidance for the 2016 changes are expected to be issued for consultation later this year. We therefore do not yet have the final details of how the reforms will work.

In order to prepare for the significant changes being introduced by the Care Act, KCC has a Care Act Programme which encompasses several workstreams/projects. From 2015 the most important changes concern eligibility, the new duties to provide support to carers, duties towards self-funders, powers to delegate most adult social care functions, new duties towards prisoners and the enhanced duties to provide information, advice and advocacy. From 2016 the introduction of the lifetime cap on care costs and the extended means-test are the two most significant changes. We anticipate that these 2016 changes in particular will involve assessing significant numbers of people who in the current system are self-funders and unlikely to be known by the local authority. We are therefore examining various mechanisms for this including the role of self-assessment and partner organisations in the statutory and voluntary sector.

It is expected that decisions on several of the above issues will be taken by the Cabinet Member in December this year or early 2015, following discussion at the Adult Social Care and Public Health Cabinet Committee. Until certain decisions have been taken, it is difficult to be more specific about our plans.

v) Please specify the level of resource that will be dedicated to carer-specific support

Kent total to develop specific carers support, including carers breaks: £3.443m

Further details of specific schemes are outlined in the appendices and clear action plans relating to carers will be developed in line with the implementation of the BCF from April 2015.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There has not been significant change to budget from the original BCF plan, however failure to deliver all or part of the required Better Care Funding mentioned above (£28.254m), would require Adult Social Care to begin to slow down other commitments to stay on course to meet its requirements for Transformation to 2016.

As part of developing the risk sharing agreements in line with the section 75 further quantification of the potential impact on Kent County Council's budget will be identified and agreed.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

As part of our Kent Pioneer programme we are committed to not only providing seven-day health and social care services but also furthering this to a proactive model of 24/7 community based care. Adult Social Care has recently shifted working hours to be 8-8, 7 days per week as standard. Further work is taking place within the Adult Social Care Transformation Programme to identify the steps required to achieve extended working hours in all areas of delivery. This will be completed by April 2015.

A summary across the care economies on development of 7 day services is:

West Kent

Committed to effective reablement to ensure people remain at home or are facilitated to return home, supported by enhanced rapid response and urgent care services to further support admission avoidance and timely discharge.

North Kent

Multiagency Executive Programme Boards are in place where programmes have been agreed and are monitored. This includes delivery of schemes to reduce emergency admissions and facilitate discharge of patients – including implementation of an integrated discharge team, based within the local acute Trusts 7 days per week to reduce emergency admissions and facilitate discharge. In the 2014/15 contracts significant work was done on incentivising the providers through CQUINs to work together to improve integrated working. As part of the commissioning and contract negotiations for 15/16, integrated 7 day working will be a key requirement and outcome for delivery with incentives and penalties included. This will assist in ensuring that the right resources and services are provided in the community that will support the reduction in non-elective attendances and admissions.

East Kent

All schemes within the local CCG plans require accessible 7 day a week service to support patients being discharged from hospital and prevent unnecessary admissions at weekends. In

Thanet the Universal Care Team is the main structure for providing post hospital care for any reason and some pre-admission intervention in the community. In South Kent Coast the enhanced multidisciplinary Neighbourhood Care Team is the main structure for providing post hospital care for any reason and some pre-admission intervention in the community. Ashford and Canterbury will develop a detailed plan for a 7 day service during 2014/15 as part of capacity modelling for implementation in 2015/16.

Kent is also committed to effective reablement to ensure people remain at home or are facilitated to return home, supported across Kent by enhanced rapid response and urgent care services to further support admission avoidance and timely discharge. This includes a commitment to community responses within 4 hours to mirror the targets and pressures in the acute trusts. It is expected implementation of the schemes outlined will produce significant improvements in line with the metrics outlined in Template 2.

Detailed plans on implementation of 7 day services are currently being developed and will be completed in line with the BCF implementation from 1 April 2015. This will include methodology to ensure monitoring of 7 day services on admission and discharge.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The prime identifier across health and social care in Kent is the NHS number.

A small proportion of NHS numbers are held within KCC's Adult Social Care System SWIFT. Monthly batches of client records are sent to the NHS matching service (MACS) and if they can match to a single record on their system they return the NHS number which is uploaded into SWIFT.

Within KCC the NHS number is predominately used to facilitate the matching of data sets for Year of Care and Risk Stratification, it is currently not for correspondence or to undertake client checks, the numbers are too low. Social Care would currently use name: address and date of birth as the key identifiers at present.

KCC achieved approx. 80% matching of records to NHS numbers when started. The MACS service is due to close at some point (no date given yet) so KCC are in the process of transferring to the Personal Demographics Service (PDS). This is expected to be completed in early 2015.

Further work will need to take place to ensure NHS number is used in all correspondence. The BCF will be used to further support this shift and Adult Social Care has made a commitment to use NHS number within all correspondence during 2015.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

There is system wide agreement to information sharing. KCC and the Kent CCGs are working together on the development of an information sharing platform and Adult social care staff all have access to GCSX secure email.

Public Health will lead on an integrated intelligence initiative, linking data sets from various NHS & non NHS public sector organisations across health and social care which will underpin the basis for integrated commissioning. This work is currently ongoing and supported by the Pioneer Informatics workstream, further information on implementation timelines is expected by April 2015.

The BCF will be used to help further this work and enable real time data sharing across health and social care and with the public. This work will begin in line with the implementation of the BCF in April 2015.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

Kent has a clear information governance framework and we are committed to ensuring all developments take place within established guidelines.

Work has already taken place to develop information governance arrangements between social care, community health and mental health providers and further work is taking place to adopt the NHS information sharing clause in all social care contracts.

Kent has recently revised the multi-agency information sharing agreement and will be refreshing sign up with all partner organisations, as a part of the refresh of the agreement Standard Operating Procedures will be refreshed or written as required to support safe sharing of personal sensitive information.

Within Year of Care Kent has provided an IG brief to the national YOC team explaining the past and proposed methodology of data sharing.

As a Pioneer Kent is a participant in a number of national schemes reviewing information governance and supporting national organisations to "barrier bust" this includes the 3 Million Lives IG workstream, a Department of Health lead workshop on Information Governance on 28 February and contributing to the work of Monitor on exploring linking patient data across providers to develop patient population resource usage maps.

Within our Better Care Fund plan and as a Pioneer Kent will continue to ensure that IG does not act as a barrier to delivery of integrated health and social care. The Pioneer programme in Kent will support the culture change, as highlighted within Caldicott 2, required to encourage the sharing of relevant personal confidential data among registered and regulated health and social care professionals. Kent recognises the importance of information sharing to support the integration of services and the programme will consider the new duty to share and will implement this as part of the planned strategy.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

The GP will be the co-ordinator of people's care, with the person at the centre and

services wrapped around them. This is already being delivered through an MDT approach across Kent, and health and social care using common assessment documentation and the development of a shared anticipatory care plan.

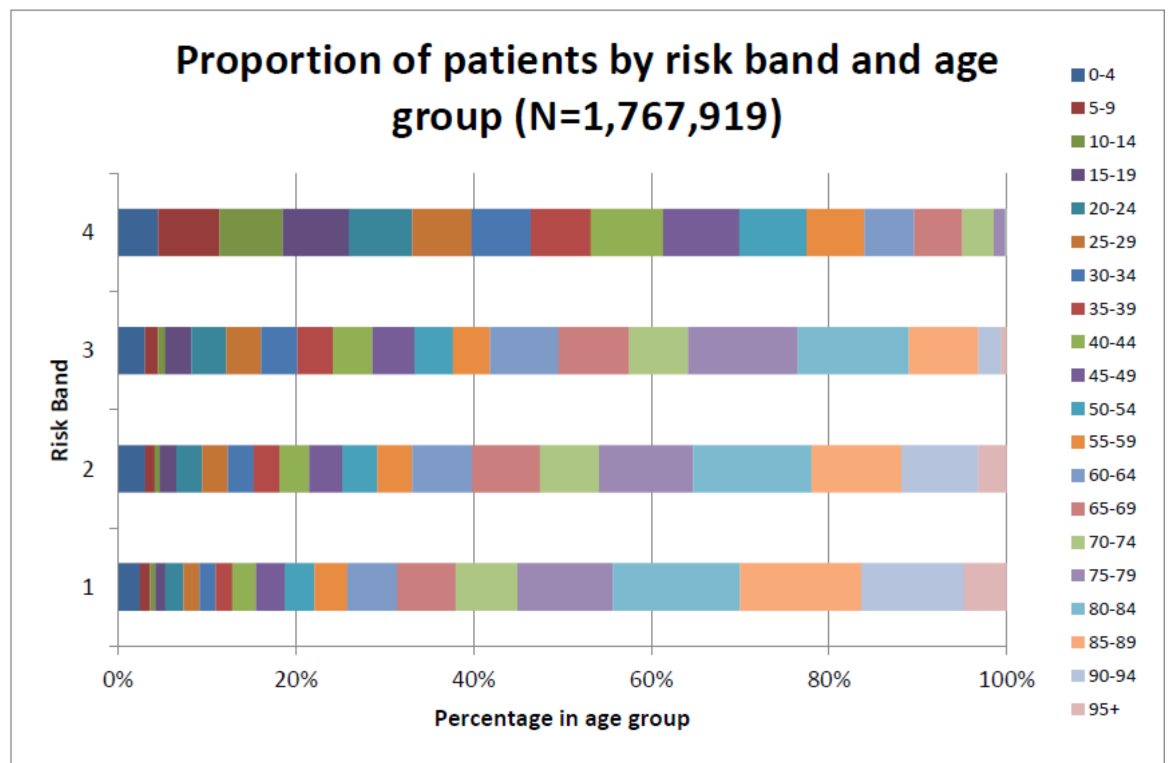
During 2013/14 95% of GP practices are using risk stratification across Kent. Currently across Kent there is a range of between 11-75% of GP practices holding multi-disciplinary team meetings. In areas with schemes such as pro-active care up to 100% of those coming through an MDT have a joint care plan.

The Better Care Fund will be used to further deliver this and achieve the following:

- All people in care homes to have agreed care plans including EOL understood by the citizen and the relatives where appropriate.
- Citizens and health and social care professionals to have access real time to agreed health and social care information.
- Consultants (in long term conditions) to outreach to support primary care to deliver high quality complex care.
- Expanded and co-ordinated community capacity to meet the citizen's priorities without necessarily having to utilise NHS and social care services and resources.

Kent's whole system risk stratification identified the top 0.5% of the population classified as the very high risk, represented 20% of total unscheduled admission spend during their year of crisis. There was a higher proportion of elderly people with multiple morbidities in the top 5% and over 90% of deaths were found in bands 1, 2 and 3.

<u>The age distribution of the population analysed is shown in Figure below:</u>



From the chart it is estimated that approximately 6-7% of the total adult population (aged 20 yrs. and above) would be considered as high risk (falling into bands 1 and 2 or top 5% of risk scored population).

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

West Kent
The GP will be the co-ordinator of people's care, with the person at the centre and services wrapped around them. This is already being delivered through an MDT approach across West Kent, and health and social care using common assessment documentation and the development of a shared anticipatory care plan. West Kent have HSCC in place who help to coordinate the care of individuals on behalf of GPs between health and social care.

North Kent
We are developing single health and social care assessments that will require a much closer level of integration between primary care (GPs), community health (e.g. district nursing, physiotherapy), mental health (e.g. primary care mental health workers, dementia nurses), social care (support to live independently), and local authority (housing, benefit services) so that these services can identify, support and intervene much earlier to prevent a crisis occurring or someone feeling they are unable to access the support they need. The primary vehicles to achieve this will be the integrated Primary Care Teams (iPCTs).

East Kent
Multi-disciplinary health and social care teams undertake joint assessments, clinically led by a GP, and jointly agreeing anticipatory care plans for every patients going through the programme. A pharmacist offers a review of their medicines, a health trainer supports them to develop a healthier lifestyle and signposts the patient to other services in the community. Physiotherapists and Occupational Therapists review the patient's needs. Social Services and Mental Health services also visit to offer advice and services if required. The GP remains the accountable professional for their patients.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

In 2013/14 a manual review across CCGs indicated that the number of multi-disciplinary team meetings taking place across Kent ranged from between 11%-75%, within this those with a care plan in place varied significantly. Currently it is identified that GP Practices through the Risk Stratification tool are identifying around 2% of the population.

As part of the Year Of Care programme, a systematic effort is being made within the Pioneer Programme to clarify the definition of integrated care for the purposes of monitoring and evaluation. Kent Community NHS Trust have initiated discussions to finalise a data code that could be entered by professionals in their IT system. Currently there are no specific codes in place that could determine if patient has undergone integrated care. This code would simply flag if a patient has had an integrated care plan in place or not, and is expected to be finalised and introduced in September 2014. By this way, patients having a care plan can be properly identified and then evaluated looking at impact on service utilisation across all care settings and determine impact where applicable.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

The blueprint for Kent becoming an Integrated Care and Support Pioneer is based on detailed engagement with patients, service users and the public. Kent Healthwatch has assisted in the development of the Kent Pioneer Delivery plan and is assisting in outlining the evaluation of objectives and outcomes against "I Statements". As a Pioneer Kent has signed up to Think Local Act Personal Making it Real and will be developing an action plan in partnership with Healthwatch, National Voices, local community groups and the public to ensure that what we do makes a real difference to the way people experience health and social care here in Kent.

Individual elements of the BCF plan have been consulted upon as required at CCG level and are informed through public engagement activity around strategic plans such as Mapping the Future, Integrated Commissioning Strategies and CCG engagement plans.

As summarised:

West Kent

Mapping the Future is a programme of work which has been started in West Kent to describe what the system needs and what a modernised health and care service for West Kent will look like. To help develop the Mapping the Future programme workshops have been held involving patient representatives, clinicians, health and care professionals and managers.

North Kent

The plans are aligned with commissioning plans, which are informed by stakeholder engagement via a series of open forum workshops. Further patient engagement took place during a review of community services in 2013. Outcomes from this have been used to inform the BCF proposals. Specifically, hard to reach communities such as the gypsy community in Swale and the BME communities in Dratford, Gravesham and Swanley, were targeted by community development workers to ensure that we had representation from hard to reach groups.

East Kent

Elements of the BCF include schemes already in included in CCG operational plans for 2014/15 and a range of local engagement activities have been undertaken in preparation for this. This included in South Kent Coast a Health Reference Group (HRG) to extend reach - including community representatives, local volunteers who work with the seldom heard such as homeless people, disability groups, mental health service users, children and young people as well as Healthwatch and other groups. For elements that are an enhancement or an addition to the operational plans ongoing engagement activities will be undertaken to ensure our clinically led plans are tested on the patients and service users the plans impact upon.

The Kent and Medway Commissioning Support Unit worked with CCG patient participation groups to explore how the "I Statements" relate to integrated care currently being received and future developments. This has informed the development of CCG plans.

On a local level there is sustained involvement with the public through patient participation groups and the local health and social care integration implementation groups. The Health and Social Care Integration Programme Steering Groups on a local

level have patient and service user representatives and as part of the operational integration programme regular surveys on integrated care are undertaken with patients by Kent Community Health NHS Trust and inform operational implementation and strategic planning.

The NHS Call to Action has provided an additional platform to further strengthen our engagement with the public. It gives health and care leaders the opportunity to explain the unique pressures facing the NHS and Social Care, and build understanding and broader engagement into future strategy and plans.

Adult Social Care is currently undertaking a survey with service users on their current experiences of integrated care and support. The outcomes of this survey will be used to inform further development within integration and can help inform implementation of the BCF plan. Adult Social Care also produces the Local Account on a quarterly basis, this provides an update on work within social care (including integration) and a direct link to the performance monitoring of outcomes for people.

Kent is committed to meaningful engagement and co-production with the public and wider stakeholders and as a Pioneer will use ICASE (www.icase.org.uk) as a mechanism to provide updates on our progress within integration and the implementation of the Better Care Fund. The communication leads from across all partners are working together to develop and integrated communication strategy. This will include specific actions relating to the engagement of hard to reach groups.

Following the Kent Health and Wellbeing Board on 12 February 2014 the Kent plan has been shared via www.kent.gov.uk/pioneer with a link to the HWB webcast, the draft plans, a summary presentation and questionnaire on the contents of the plan. Kent Healthwatch have assisted in the promotion of the feedback mechanism for the draft BCF plan and are engaged on developing an action plan to further involve the public on design and delivery of the schemes within the plan, this will include working with patients and service users in understanding the outcomes required from the BCF and supporting metrics to monitor this.

There is a link to Kent's BCF plan from within the JSNA on the Public Health Observatory website http://www.kmpho.nhs.uk/jsna/

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

The Kent Integrated Care and Support Pioneer Programme involves providers from across the health and social care economy within Kent as partners and stakeholders. The Pioneer Blueprint for our integration plans which the Better Care Fund is based upon was developed with involvement from all stakeholders.

Work on the Health and Social Care Integration Programme took place through HASCIP Steering Groups which are groups of commissioners and providers from health, social care and the voluntary and community sector and has been used to inform this plan.

The Kent HWB undertook a mapping exercise across the care economies to review current activity and priorities across all stakeholders. This included Districts and health and social care providers. A summary of the findings is included in this submission. The findings have helped inform on-going discussions about priority areas and will be used to further evaluate the outcomes of existing programmes of work.

The Integration Pioneer Working Group coordinated the development of the Kent plan and is mixed group of commissioners and lead providers. They have met throughout February, March and August.

As part of the development of the BCF plan engagement events have taken place with providers via our existing Health and Social Care Integration Programme, the Integration Pioneer Steering Group on 13 January and 10 March 2014 and through a facilitated engagement event led by the Health and Wellbeing Board under the Health and Social Care system leadership programme on 16 January 2014.

Presentations on the BCF and how it fits into the context of the CCG Strategic Commissioning Plans have taken place at the West Kent HWB (18 March 2014) and the Kent HWB (26 March 2014).

Discussions on the BCF have also taken place at local Health and Wellbeing Boards, Integrated Commissioning Groups and Whole System Boards across Kent as summarised below:

West Kent

Mapping the Future is a programme of work which has been started in West Kent to describe what the system needs and what a modernised health and care service for West Kent will look like. This programme will deliver the NHS Call to Action within West Kent. During early March discussions around the on-going governance and implementation of the BCF have taken place with both the West Kent Integrated Commissioning Group, and the West Kent Health and Social Care Integration Programme (HASCIP).

North Kent

Kings Fund facilitated workshops have been held on 19th/22nd November 2013 and 6/18th February 2014 involving health and social care commissioners and health providers. A further North Kent workshop took place on 29th January involving all key stakeholders.

East Kent

The local plans are aligned to the East Kent Federation of CCGs vision for integrated care which has been shared and developed at the East Kent Whole Systems Board which includes providers within its membership.

A presentation on the Kent Pioneer Programme and Better Care Fund has been given to the Dover Adult Strategic Partnership and the Shepway Adult Strategic Partnership Meeting which are both liaison events with the voluntary and community sector.

Discussion on the Disabled Facilities Grant has taken place with District authorities, at the Joint Policy and Planning Board, the Kent Private Sector Housing Group and the Kent Housing Executive Board.

Further work will be taking place with providers on the design and implementation of the Better Care Fund schemes through the Integration Pioneer Programme and Whole

System Boards. This has included a number of “summit” events at a care economy level engaging with commissioners, providers and local government representatives. The schedule of these meetings is attached as supplementary information. Although some providers, including the community health trust have aligned their operational plans with the BCF further work will take place in advance of implementation in April 2015 to work with providers on ensuring this.

ii) primary care providers

West Kent

West Kent CCG is made up of 62 GP Member practices that are represented by 12 GP Locality Representatives, elected by the practices to serve a three year term on the Governing Body. Elected GP Locality Representatives are aligned with one of four localities (Invicta; Tonbridge, Tunbridge Wells & the Weald; Sevenoaks; and Maidstone & Malling). Each locality is supported by a Locality Team made up of the Locality Clinical Leads, Practice Nurse Lead, Practice Manager Lead, Locality Manager and Prescribing advisor. Governing Body.

The BCF has been presented to and discussed at Governing Body meetings and the annual plenary meeting alongside the West Kent Strategic Commissioning Plan.

North Kent

Engagement of, and communication with, Primary Care colleagues is acknowledged as pivotal to all of the schemes within the local BCF. Their support and active involvement is crucial to the success of the schemes and as such early plans were put in place to ensure they were included. It was recognised however that there was a need to avoid multiple approaches and inconsistent messages to practices and that all communication in relation to the BCF needed to be branded and presented as part of a coherent, whole programme ‘story’. As such it was agreed that when any project lead attended any GP or primary care event that they would talk about their project but always put it in the wider context of the overall programme of the BCF. Presentations were made to Primary Care colleagues at the Protected Learning Time (PLT) events for both CCG’s in March 2014. .

East Kent

Primary Care providers are represented on Integrated Commissioning Groups and the draft BCF plans have been discussed with primary care providers (as the CCG membership) at various committees and forums. Progress is regularly reported through engagement with Board Members through membership meetings as well as regular communication through local practice visits.

iii) social care and providers from the voluntary and community sector

Regular monthly meetings – via the Adult Transformation Stakeholder Board and the KMCA Board, take place with social care providers at a Kent level, attended by the Director of Commissioning within Adult Social Care. These have included discussions on health and social care integration and delivery of the Better Care Fund and will continue to be used as forums for implementation.

The KCTA are holding a manager’s event in October 2014 on integration, enabling Managers within the Care and Nursing Home and Home Care sector to hear from key speakers in Kent on integration within health and social care.

The voluntary and community sector are an essential component of delivery within the BCF and Kent’s Pioneer Programme. Representatives took part in the facilitated

stakeholder event on 16 January 2014. Further dedicated engagement has taken place through attendance at strategic partnership groups in February and March and via voluntary sector conference held on 27 June 2014.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

It is recognised that the basis of the funding for the Better Care Fund is money that is already committed to health and social care services of many different types. Some services will need to change to support the aims and vision we want to achieve, others will need stability. The schemes we have identified in our plan are about applying targeted investment to transform the system and improve outcomes for citizens and the entire care economy.

In order to achieve the level of cost reduction required there will need to be significant reduction in the level of emergency admissions and A&E attenders in the acute care setting. By the end of 2018 the target level of avoided urgent care admissions ranges across CCGs from up to 5% of the level of today's emergency admissions, with a target end point of 15%. Kent will look to meet the 3.5% national target as a step change to meeting this.

Risk Stratification research by Public Health helps indicate the potential cost savings that can be delivered by a proactive integrated care approach as outlined within the Better Care Fund Plans. The difference in activity attributed to the 'crisis' helps us also to determine realistic benefits of a proactive integrated care approach. The table below shows the potential cost savings, activity reductions for the targeted implementation of systematised integrated care rolled out at pace and scale based on SUS data for 3 financial years (09/10, 10/11 & 11/12)

Impact of preventing the 'crisis year' on acute provider activity, costs and capacity across Kent & Medway			
	Savings in non-elective admissions	Savings in cost	Savings in Bed days
Year 1 Top 0.5%	14,989	£33,437,319	100,917
Year 2 Top 1%	22,058	£49,227,952	148,913
Year 3 Top 2%	29,166	£63,575,702	190,785

Detailed investment and benefit management plans will be designed throughout 2014/15 in line with CCG and Social Care commissioning plans. A summary of the local plans is:

West Kent: Mapping the Future sets out ambitious targets for reducing urgent care costs by £25m by 2018-19. Our plans for the forthcoming operating plan period up until the end of 2015-16 is to secure cost reductions totalling £10m. In order to drive out this level of cost reduction, there will need to be significant reduction in the level of emergency admissions and A&E attenders in the acute care setting. By the end of 2015-16 the target level of avoided urgent care admissions could represent up to 18% of the level of today's emergency admissions.

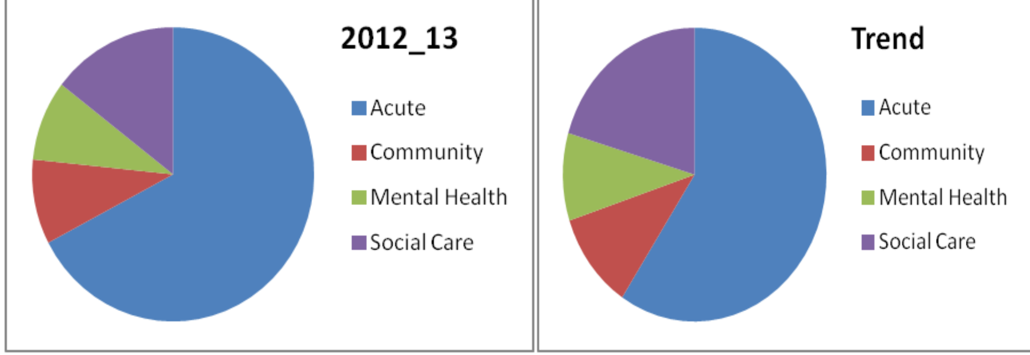
North Kent: The key implication for the Acute sector will be the reduction of non-elective admissions (NEL), based on audit work undertaken across North Kent by The Oak Group and The Kings Fund this ambition is set at 15% over two years:

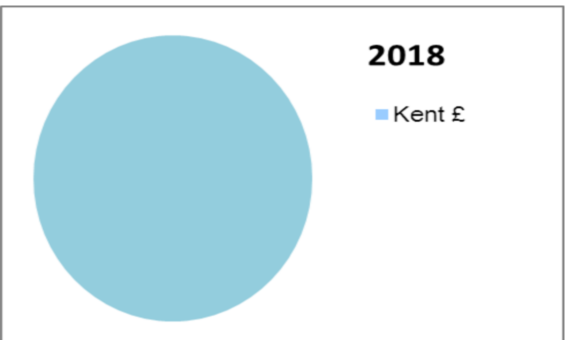
- For DGS CCG this results in reduction in cost of NEL admissions of £8m (4.1m in 2014/15, and 3.9m in 2015/16).
- For Swale CCG this results in reduction in cost of NEL admissions of £2.9m (1.5m in 2014/15, and 1.4m in 2015/16).

Joint agreement was made at the Executive Programme Board / Kings Fund Workshop on February 20th 2014, to reduce emergency admissions by 10% in 14/15.

East Kent: The plans align with the delivery of the CCGs strategy. The majority of the NHS savings will be realised by the reduced emergency attendances and admissions and a reduction in length of stays within the acute setting and therefore there will be a reduced investment in secondary care. The plans will not have a negative impact on the CCGs constitutional targets as set out in the Everyone Counts: Planning for Patients 2014/15-2018/19. The plans should enable the delivery of some of these targets, in particular the A&E waiting times and the proportion of older people at home 91 days after discharge from hospital into Reablement/rehabilitation services.

The Year of Care programme is currently forecasting that a shift in trend of spend across the health and social care system is required to deliver whole system transformation, this distribution based on average cost per patient (£) by Provider type is outlined below. The vision for 2018 is to have developed the Kent £ across the whole system.





Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description – please see CCG plans attached.

Detail of the schemes being delivered within the Better Care Fund is at a CCG level, therefore Annex 1 and the provider commentary has been developed at this level.

Each scheme identified in Section 4d has a detailed scheme description within the relevant CCG area.

ANNEX 2 – Provider commentary – Please see CCG plans attached

Detail of the schemes being delivered within the Better Care Fund is at a CCG level, therefore the provider commentary has been developed at this level. Each scheme identified in Section 4d has a detailed scheme description within the relevant CCG area.