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	**NHS Ashford CCG**
	NHS Canterbury and Coastal CCG
Boundary Differences	**NHS Ashford CCG is co-terminus with Ashford Borough Council** **There are some boundary differences between NHS Canterbury and Coastal CCG and local District authorities.** **Whilst the CCG wholly covers Canterbury City Council's areas, the CCG also covers parts of Swale Borough Council, Dover District Council and Ashford Borough Council.** **There are some inflows and outflows of patients between East and West Kent but this is largely a factor in Swale rather than Ashford and Canterbury.** **In developing the plan discussions with these areas has taken place to ensure consistency of**

	outcomes.
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of BCF pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Ashford CCG and Canterbury and Coastal CCG
By	Simon Perks
Position	Accountable Officer
Date	<date>

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	<Name of council>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

<Insert extra rows for additional Health and Wellbeing Boards as required>

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	**Pioneer Delivery Plan**
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	
Kent HWB Paper 26 March 2014	 140326 BCF HWB report v2.docx
NHS Ashford CGG – Risk Stratification	 Ashford CCG - Risk Stratification.pdf
NHS Canterbury & Coastal CCG – Risk Stratification	 Canterbury and Coastal CCG - Risk St

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

Our vision is to "improve the health and wellbeing of local people by working in partnership with local communities to create a sustainable health care system, integrating hospitals, GPs, social care and community services including the voluntary sector."

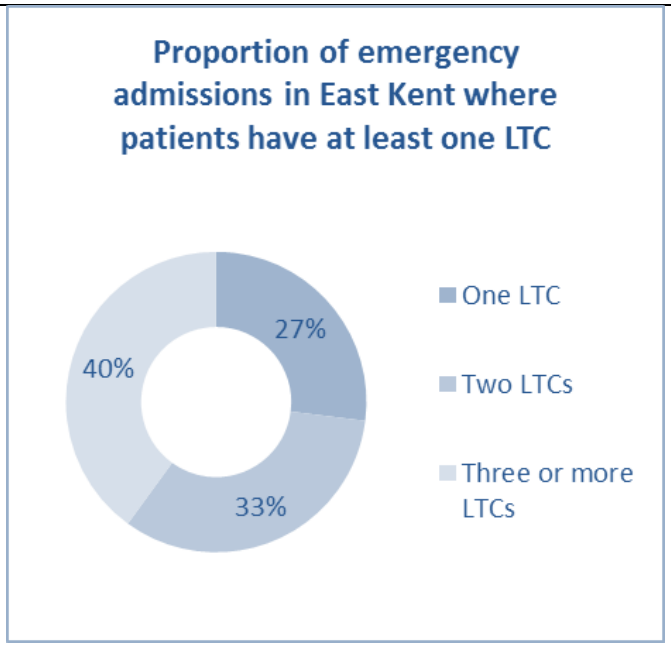
The fundamental, underlying, principle which encompasses across all of the following domains is that the CCG is keen to ensure that care is be delivered as close to where patients live as possible. The consequence of this is that patients will be able to access a variety of services in a number of locations -including their own home, their pharmacy, the optometrist, their GP surgery, community hospitals as well as district hospitals.

For the past two years, the health and social care community has been working collectively towards creating an integrated system of care that seeks to wrap care and support around the needs of the individual, their family and carers and helps to deliver on this wider vision. We recognise that collectively planning improved care and support services requires significant transformation of existing methods of service delivery. Through integrated working with partners we can deliver services which are fully integrated and support the following:

- Reduction of duplication process and delivery
- Supports parity of esteem across the population
- Reduces unnecessary activity within secondary care
- Reduce unnecessary activity within social care
- Has patient safety at the heart of all we commission
- Delivers 7 day working across health and social care
- incorporates innovation across service delivery
- Demonstrates value for money

Health Profile
Nationally recognised evidence, regarding long term health needs, leads us to three main conclusions:

- Older patients tend to have longer hospital spells and are readmitted more frequently after a first hospital spell
- Ageing is a fundamental factor, as the prevalence of Long Term Conditions is up to 6 times higher in over 65s than in under 65s
- Patients with LTCs have been recently estimated to account for 70% of the total health and care spend in England



NHS Ashford CCG

Ashford's population is ageing due to lower birth rates and higher life expectancy over the past few decades. This is a universal problem that many developed countries currently face. The implications for health services are: increasing need for health and social care for elderly people at home or in care homes, requiring more staff and more funding. The population in Ashford is expected to grow rapidly over the next few years as a number of new developments are in the planning stage.

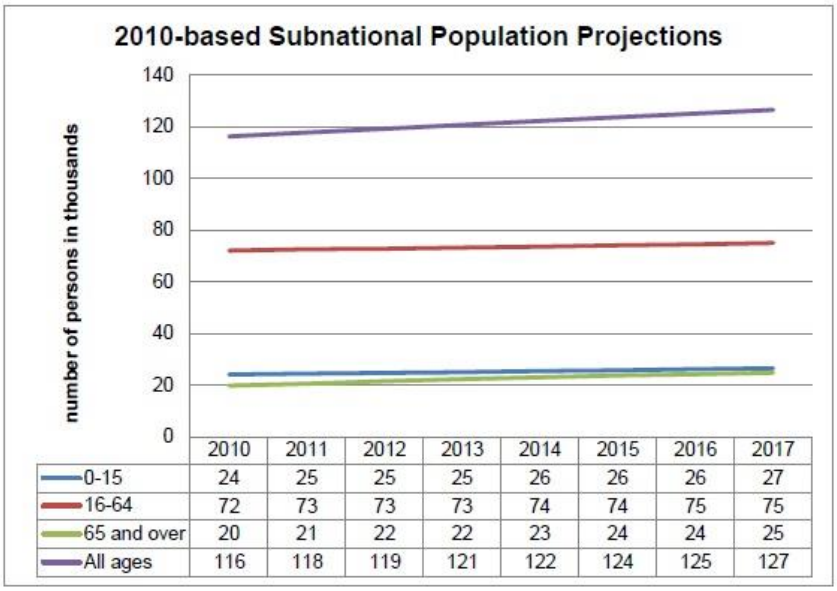
Emergency admissions in Ashford are comparatively lower than in the rest of Kent. It is important that commissioners are aware of what types of admissions are avoidable and how to prevent them. Encouraging self-management of people with Long Term Conditions and good access to primary care including out-of-hours are important.

Long Term Conditions are expected to increase as the population structure gets increasingly older. There are large variations in prevalence by GP practice suggesting a risk of under diagnosis in some population groups. Case finding is important in order to target prevention programmes to the appropriate population groups. The focus for people with long term conditions should be on self-care but with appropriate services and equipment available to support patients and their carers.

The 15 GP practices within the Ashford CCG serve a population of 120,116 (ONS, mid-year estimates 2012). The population pyramid shows graphically the distribution of age groups in a population. The distribution of the Ashford CCG population can be classified as a "constrictive" pyramid, meaning that there are lower numbers of young people and larger numbers in the age ranges between 40 and 69. This type of age structure is often referred to as the "ageing population time bomb". The shift in age structure towards older people with a simultaneous reduction in working-aged adults has implications on future pensions, provision of health and social care and economic growth.

In comparison to England, Ashford has a considerably smaller proportion of 20 to 34 year olds and a larger proportion of 40-49 and 60+ year olds.

The population in Ashford is predicted to increase over the next few years with the largest percentage increase expected in the 65+ year age group (20,000 in 2010 to 25,000 in 2O17 = 25%).



	2010	2011	2012	2013	2014	2015	2016	2017
0-15	24	25	25	25	26	26	26	27
16-64	72	73	73	73	74	74	75	75
65 and over	20	21	22	22	23	24	24	25
All ages	116	118	119	121	122	124	125	127

Ashford has an "ageing" population structure and population projections predict further population increases disproportionately in older age groups over the next few years. This has an implication on the provision of health care and social care at home or in care homes with increasing needs for staff and funding in the future. Plans need to be in place on how the demand will be met.

The main cause of death in Ashford is from circulatory disease, followed by cancer and respiratory disease. Mortality from circulatory disease and from cancer has been decreasing since 1996. This is an encouraging observation and the aim should be to maintain this trend of reducing avoidable deaths.

NHS Canterbury and Coastal CCG

There are22 practices in C4G, 14of which are located in Canterbury City Council area. Four practices are located in Faversham within Swale Borough Council area and the other three practices are located in the Dover District Council area. There is also a branch practice located in Chilham which is in the Ashford Borough Council area.

- 209,868 people are registered with practices within C4G this is L4% of the total registered practice population for Kent.
- The population age and sex structure differs from that for Kent and Medway. Canterbury is a university city and has a larger proportion of people aged between 15 and 29 because of its student population.
- Based on data for Canterbury City Council area, the population is projected to increase by 5.32% over the next five years and 9.2% over the next 10 years. Population growth over the next five years in the 65+ group ts L4.L% and in the 85+ group is9.2%.

Compared to the rest of Kent and Medway, Canterbury and Coastal has a higher than average student and elderly population. For the elderly population this means that there may be a higher than average demand for services pertaining to long term conditions (including dementia), life expectancy is higher than the average but not as high as our neighbouring CCG, Ashford.

Emergency hospital admissions can be an indicator of how well patients are being managed within primary care.

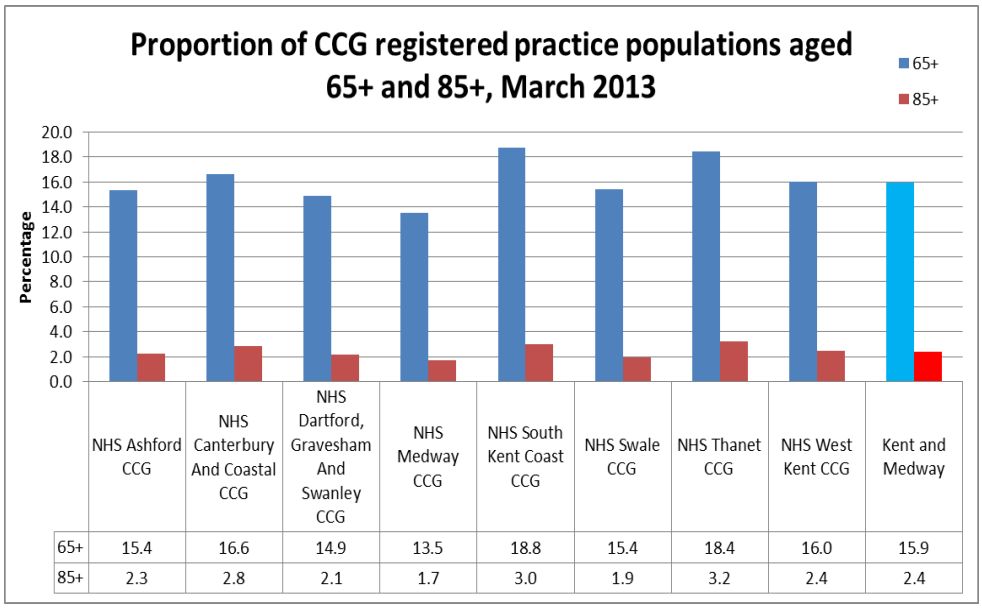
The CCG records higher emergency admission rates for CHD and COPD. The trend for each of these conditions is increasing; however the was a decrease last year in CHD emergency admission rates.

Dementia and cancer emergency admissions rates are lower than Kent and Medway and continue to decline; however cancer emergency admission rates have risen slightly since 2010/11.

71.9% of all deaths in 2012 are attributable to three main diseases: Circulatory disease (32.8%), Cancer (26.0%) and respiratory disease (13.1%). Mortality rates from Circulatory disease

(Coronary Heart disease and Stroke) and Cancer have been steadily declining since 1995, and the rate of premature mortality is lower than that of England.

19% of the CCG population is in the over 65 age bands. This is slightly higher than the Kent average (15.9% 65+ and 2.4% 85+).



	NHS Ashford CCG	NHS Canterbury And Coastal CCG	NHS Dartford, Gravesham And Swanley CCG	NHS Medway CCG	NHS South Kent Coast CCG	NHS Swale CCG	NHS Thanet CCG	NHS West Kent CCG	Kent and Medway
65+	15.4	16.6	14.9	13.5	18.8	15.4	18.4	16.0	15.9
85+	2.3	2.8	2.1	1.7	3.0	1.9	3.2	2.4	2.4

The high emergency admissions for older people tend to take place where many older people live in but in areas of deprivation where the life expectancy (at aged 65) is relatively low. The concentration of emergency admissions for people over 65 appears to map to the location of care homes. Better interagency care and support services in the areas where current domiciliary and residential care is provided should reduce the urgent and unplanned admissions for older people.

The very old in any population group will make the highest demands on health services. Nevertheless the biggest challenge for any CCG is to engage the 65+ age group in their health to prevent premature onset of chronic disease with the risk of related complications necessitating increased demand for secondary care based treatment. Where diagnoses of chronic diseases are made, it is essential that these conditions are identified early so that they can be managed effectively long term in primary and community care settings.

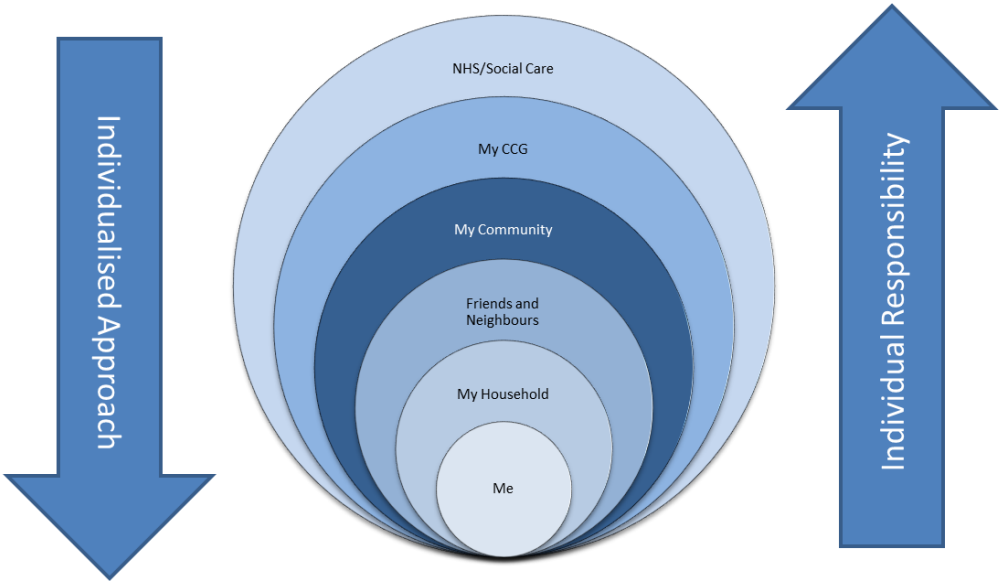
Our Approach

Our approach recognises that whilst services are currently delivered by different organisations, organisational boundaries in the future will continue to be more permeable and flexible with staff working to support and care for people as part of interdisciplinary endeavour. Services must be based around the needs of people, not around organisations. Our ambition over the next five years is that through continuous evaluation and learning from elsewhere, our residents will be able to access further community facilities of this nature.

We also recognise that developing a broader range of community-based services will require the collective pooling of resources to effect the movement of funding from acute and long term care models to those new community based services. All BCF stakeholders will continue to experience considerable financial challenges and therefore our transformation programme is designed to generate significant efficiencies within the whole system of care to ensure that the health and

care system remains sustainable and of high quality.

Our vision is to be providing person centred care with easy to access, 24/7 accessible services wrapped around them that cross 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.



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. Building on a long history of joint commissioning of services, the BCF provides further opportunity to commission services together. Our ultimate ambition remains the pooling of all current resources committed to the commissioning of health and social care services as we endeavour to spend the "Kent £" wisely.

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

We will use the Better Care Fund to:

- Deliver the 'right care, in the right place at the right time by the right person' to the individual and their carers that need it. Reducing the pressure on the acute hospitals by ensuring the right services are available and accessible for people when they are required.
- Support people to stay well in their own homes and communities, wherever possible – avoiding both avoidable and where appropriate some currently unavoidable admissions by developing "hospitals without walls".
- Enable people to take more responsibility for their own health and wellbeing.

- Get the best possible outcomes within the resources we have available.
- Take the transitional steps that achieve transformation of health and social care – delivering the 'right care, in the right place at the right time by the right person' to the individual and their carers that need it.
- Reduce unnecessary activity within secondary care by ensuring the right services are available and accessible, within the community, for people when required.
- Get the best possible outcomes within the resources we have available.

What we want to achieve in 5 years (as outlined in Kent's Integrated Care and Support Pioneer Programme):

<u>Integrated Commissioning:</u>

- Together we will design and commission new systems and 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 achieving 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.

<u>Integrated Provision:</u>

- 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. We will also need to ensure that we link in with our partners within education
- 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-care/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.

As a Pioneer Kent will be undertaking a baseline assessment and delivering against the performance measures set out by the Programme. These will be combined with the metrics as outlined in the Better Care Fund plan and those required through Year of Care to produce a robust performance and outcomes framework that is monitored and managed via a dashboard

at the Health and Wellbeing Board.

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?

Across Kent new Secondary Care models will seek 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 and fully supporting 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.

"Community Networks" is the title given to a number of projects leading towards an overall strategic aim.

The component projects, forming part of the Better Care Fund initiative are detailed individually below**:**

Scheme Name
1. Integrated Urgent Care Centre Extending Scheme 1 is the integration of urgent care services to ensure that patients receive the same standards of care, entering the same pathways, regardless of which point they access the Urgent Care system. It will achieve this by providing rapid access to key health economy services which include: • General Practitioners • Community Support Services • Social Services • Psychiatric Services • Secondary Care Consultants (including Geriatricians) The smooth flow of patients through the health and social care system is fundamental to meeting patients' expectations of urgent care services. It is apparent that a significant proportion of urgent and emergency demand could more appropriately be classified as "primary care related" and undertaken by GPs or practice and community nursing.

2. Mental Health Services

We recognise that like physical health related long term conditions, mental illness has a huge impact on the quality of life for the patients and their carer. The CCG will work with all partners to deliver improved mental health services for all age ranges to support:

- Increased schemes to support health minds and early interventions
- Crisis support within all pathway
- Integrated models for all pathways to support patients within range of pathway
- Systematised self-care/self-management through assistive technologies
- Improved care navigation
- The development of Dementia Friendly Communities and,
- To facilitate access to other support provided by the voluntary sector.

3. Support for Care Homes

This model supports older people with a range of needs including physical disabilities and dementia will align specialists across multiple teams, including secondary care, to ensure patients in care homes have anticipatory care plans in place and those that are admitted to hospital have robust discharge plans in place before they are discharged in order to prevent re-admissions.

4. Health and Social Housing

To improve the utilisation and appropriate use of existing housing options and increase the range if housing options available to people and to ensure it's used flexibly and enables more people to live independently in the community with the right level of support. This will also require responsive adaptations to enable people to manage their disability in a safe home environment.

5. Falls Prevention and Management

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 political will to develop an integrated pathway of care, starting from when an ambulance is called out to elderly faller, all the way to a person being assessed and referred for community based exercise programmes to prevent falls.

An integrated intelligence approach will help us not only 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.

6. Integrated Health and Social Care Team

We will continue to develop our integrated health and social care team to ensure that they will be available 24 hours a day seven days a week and will be contactable through a single access points. The team will be focussed on both ends of the patient journey, through supporting patients, carers, social services and clinicians to avoid the need for patients to be admitted to hospitals, however where this is necessary the team will mobilise to ensure timely discharge of the patient.

These teams will ensure wider integration with other community and primary care based services, including voluntary sector provided services, as well as hospital specialists working out in the community. The ultimate aim is to enable people to be cared for in their own homes or within their own community. The aim of team is to support people to self-manage and to be independent in their own homes.

Impact on service configuration

Part of our five year ambition is to ensure that we have specific, appropriate service configuration that allow us free patients to be able to self-manage their condition, with NHS and Social Care support, whilst also offering service capable of intervening quickly an appropriately to meet patient needs. BCF is designed to form a major part of this new approach.

Although contract management may be seen as operational rather than strategic – the impact it has had on our strategic outcomes means that this is an additional key enabler for us in delivering the outcomes set out in our five year plan. As we move towards new service and contract mechanisms, we have laid the foundations for both risk and benefit sharing with our main providers.

Acute Care

A number of challenges will emerge over the longer term, and it is within this context that our main provider, East Kent Hospitals NHS University Foundation Trust (EKHUFT) commenced the development of an outline 5-10 year strategy 'Looking to Our Future', identifying key levers, drivers and their interrelationships, with a set of strategic options that illustrate the potential impact of those options on activity and the financial position of the organisation.

With the implications of our five year strategy, outline in this plan, it is clear that activity levels across the acute sector will reduce and therefore this will have an impact on how services are configured across EKHUFT's estate. Some of the activity reductions may create capacity for EKHUFT to respond to the CCG desire to repatriate services from London centres.

Community Services

Kent Community Health NHS Trust (KCHT) are transforming their services so that they meet the future health and financial challenges. This programme of work, known as "The Human Touch", is will lead to an improvement of services in five major ways:

- Transforming models of care – to be more integrated and patient focused. Helping people to remain living at home at times of vulnerability, rather than see an unwanted, costly

and unnecessary hospital admission.

- Transforming the times and places where care is provided – moving away from traditional health care settings to offer more services either within people's own homes or close by in friendly, community venues, making good health part of everyday life.

- Transforming the workforce - developing generic roles across directorates and functions, for example combining elements of the health care assistant role and the health trainer role to support the long-term conditions pathway.

- Transforming clinical support systems – offering better access for patients and more efficient ways of working for through technology.

- Transforming partnerships – alongside the CCG community networks, integrating health and social care teams, developing innovative joint solutions to support wider health and social care system transformation.

Mental Health

Kent and Medway NHS and Social Care Partnership Trust has embarked upon the implementation of a significant transformation programme which will support the delivery of excellence in all that the Trust does. This includes:

- Improved recovery through the implementation of community wellbeing centres and primary mental health care workers delivered in partnership with community networks thereby delivering a more seamless pathway of care and a more holistic approach to recovery.

- Clinical Strategy which aims to provide excellent community services close to home reducing the number of people who need inpatient care.

- Organisational Development Strategy which aims to ensure that we are not only an employer of choice but that we support the continued growth and development of all of our workforce to ensure that they have the skills to deliver excellence in all that they do.

- Service User and Carer Engagement Strategy which aims to ensure that we have a comprehensive range of approaches to engaging with service users and carers

- Estates Strategy which aims to ensure that all of our facilities provide a high quality therapeutic environment for service users and carers.

- Information Communications and Technology [ICT] Strategy which aims to promote the delivery of services through mobile technology.

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.

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).

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 related to 3 programme areas that affect the complex frail elderly – falls and fractures, dementia and end of life.

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 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 Kent whole population dataset http://www.nhsiq.nhs.uk/resource-search/publications/population-level-commissioning-for-the-future.aspx . It only not 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
- Multi-morbidity appears to be more strongly related than age to total health and social care costs
- Acute non-elective costs contribute most to the increased cost for people with multimorbidity.
- 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
- 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.

Risk Band	No. of patients as at 4.4.2011	% popn	Deaths during 2011/12	Proportion
1	476	0.4%	88	18.5%
2	5300	4.4%	266	5.0%
3	15214	12.5%	270	1.8%
4	100465	82.7%	263	0.3%
Totals	**121455**	**100%**	**887**	**0.7%**

Ashford CCG – Risk Stratification Bands

Risk Band	No. of patients as at 4.4.2011	% popn	Deaths during 2011/12	Proportion
1	1114	0.5%	201	18.0%
2	10393	4.9%	713	6.9%
3	27267	13.0%	568	2.1%
4	171371	81.5%	564	0.3%
Totals	**210145**	**100%**	**2046**	**1.0%**

Canterbury and Coastal CCG – Risk Stratification Bands

When looking at the profile of the two CCGs, it is clear that those patients in Band 2 and 3 use the greatest proportion of the health budget but also offer the largest opportunity for community based services to avoid hospital admissions.

The full reports are attached (front page) for information.

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 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), of which the CCGs are partners, as well as Ashford and Canterbury & Coastal CCGs' strategic vision for Community Networks.

Pioneer Programme

The Pioneer programme has been developed as a phased approach across 3 overlapping waves, which take the whole system to the integrated commissioning of integrated health and social care provision. 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		

Better Care Fund

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.

Discussions have taken place across CCG areas with providers on the impact of implementing the schemes within the Better Care Fund plan as detailed above.

Community Networks

The CCGs vision is a grass roots upward approach to co-designing local services attempting to re-balance the system – based upon known pressures – including financial, workforce, population epidemiology. The focus is on reducing the need for acute hospital services through a focus on prevention (including supported patient self-care), raising the quality of general practice with the interface to community based services delivered via integrated health and social care teams whom act as a the single point of access for signposting patients & carers to local services (voluntary sector and other services). Part of this approach will require a redesign and modernisation of community services, including general practice, to enable greater in-reach to patients at home and pro-actively pulling people out of hospital.

This is a three year programme with annual reviews of progress and assessment of ongoing actions to allow for changes in national, and local, objectives and performance. The outline project plan is attached:

Community Networks Project Plan

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

Kent Wide

The Kent Health and Wellbeing Board 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 Sept 2014 to support development of the pooled fund and area section 75 agreements. It is recommended that this group retain responsibility for regularly reviewing progress on the BCF and making recommendations to the Kent HWB as appropriate.

Community Networks Project

Within the CCGs, a working group has been established to undertake the technical, operational, tasks required during the implementation phase. This group is responsible for the "value for money" review of existing services and post implementation of new services.

This working group comprises purely officers of the CCG, but maintains links with the clinical sponsors of the project to ensure that we maintain clinical oversight in line with the "Clinical Commissioning" remit of the CCGs. This is to ensure best use of clinical input, given that the task of this working group will predominantly be technical rather than clinical.

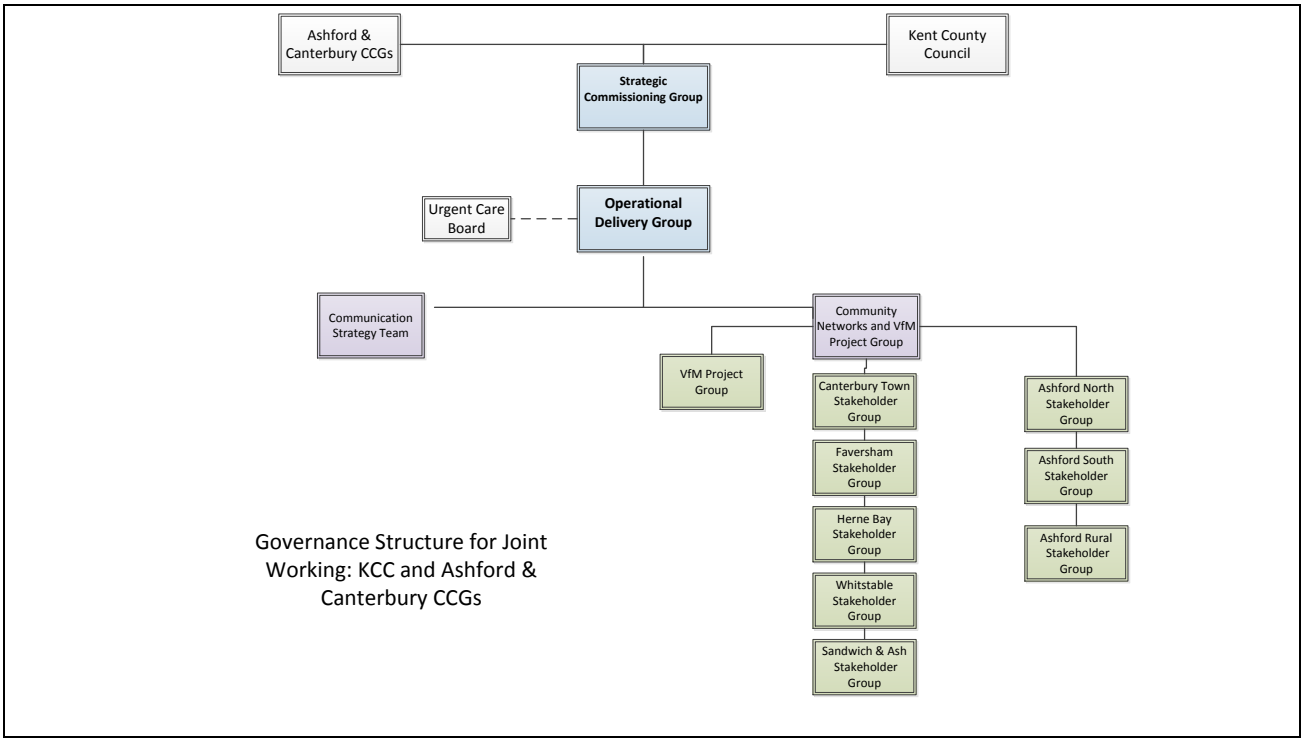
The working group has established three task/finish groups, these will be focussed on:

- Activity and Financial Modelling
- Review of Commissioned Service, working directly with relevant commissioner and clinical lead
- Review of services with providers, to ensure provider input in establishing VFM.

The working group reports to both the Joint KCC/CCG Community Networks Project Board and the CCG Clinical Strategy and Investment Committee, who will both provide strategic oversight.

Throughout the implementation process, the working group will ensure ongoing community engagement in the co-production of the community networks through local engagement events and meetings. The process of co-production has already commenced with a series of engagement events.

The overall governance arrangement is described in the organogram below:

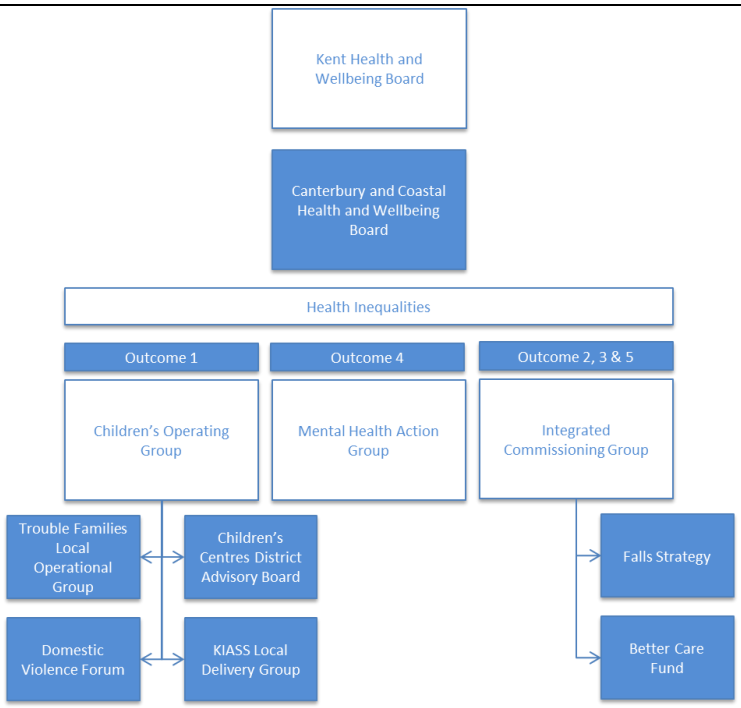


c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

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 Sept 2014 to support development of the pooled fund and area section 75 agreements. It is recommended that this group retain responsibility for regularly reviewing progress on the BCF and making recommendations to the Kent HWB as appropriate.

Further to this, local strategic oversight is provided through the local Health and Wellbeing Board, with the working groups taking responsibility for delivery. This is best described in the organogram below, using Canterbury as an example:



The local HWB Board reviews spending plans and priorities of the constituent partners e.g. public health, district and county council and CCG and their contribution to health and wellbeing and informs priority setting, commissioning decisions and the planning process .

In order to discharge its responsibilities, the board has identified three working groups to deliver against the domains of the Kent Health and Wellbeing Strategy. The Integrated Commissioning Group has responsibility for ensuring that the Better Care Fund is closely linked to the priorities of the health and Wellbeing strategy.

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.

Ref no.	Scheme
1	Integrated Health and Social Care Team
2	Integrated Urgent Care Centre
3	Mental Health Services
4	Support for Care Homes
5	Health and Social Housing
6	Falls Prevention and Management

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**
Shifting of resources will destabilise existing providers, particularly in the acute sector	2	5	10	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.
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 1

				and 2 also targeting this risk.
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.
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.
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.
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.
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.
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
Ability to deliver programme in line with KCC timelines may result in fragmentation	3	3	9	Working with KCC lead to align programmes

Ability to implement networks whilst ensuring financial stability	3	3	9	Locality business plans to include expected savings to support reinvestment
Ability to develop comprehensive business cases within required timescales at locality level	3	3	9	Stakeholder events to determine core services and supporting locality teams to develop cases with IPM/Finance
Delivery of consistent service standards across all networks	3	3	9	Specification for core services to contain consistent KPIs
Locality plans to support actual local need	3	3	9	Development plan to include services to address local needs documented within JSNA Plan will not be signed off unless it documents clear actions to address needs
Lack of patient engagement across all patients groups	3	3	9	Stakeholder groups to include representation from all patient groups Team to meet individual groups as required
Support of members and patients at locality level to deliver project against competing demands for time	3	3	9	Project team to support members through existing town team structure Clinicians time to be focused on development of pathway
Vacancy levels within commissioning teams may have impact on ability to deliver projects	3	3	9	Potential to transfer staff from another work programme. Needs agreement from OLT
Ability of providers to respond to service changes within timescales	4	3	12	Providers to be included within locality network development project timescales to be include within contract round
Urgent care programme timescales need to be built into programme to support whole systems transformation	3	3	9	Project plan to be tabled at UCB Programme heads to meet fortnightly to progress integrated delivery
Provider strategy may not be in line with focus of project	3	3	9	OLT discussions with provider executive teams in place Providers to be included as part of project team

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

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.

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.

The financial risk between commissioners and providers in East Kent will be part of the contract with East Kent Hospitals Foundation Trust and the agreement with them that we have scheduled to make prior to October 2014. The current contractual arrangement puts a total cap on the levels of risk incurred by the CCG and has a gain share element for underperformance.

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.

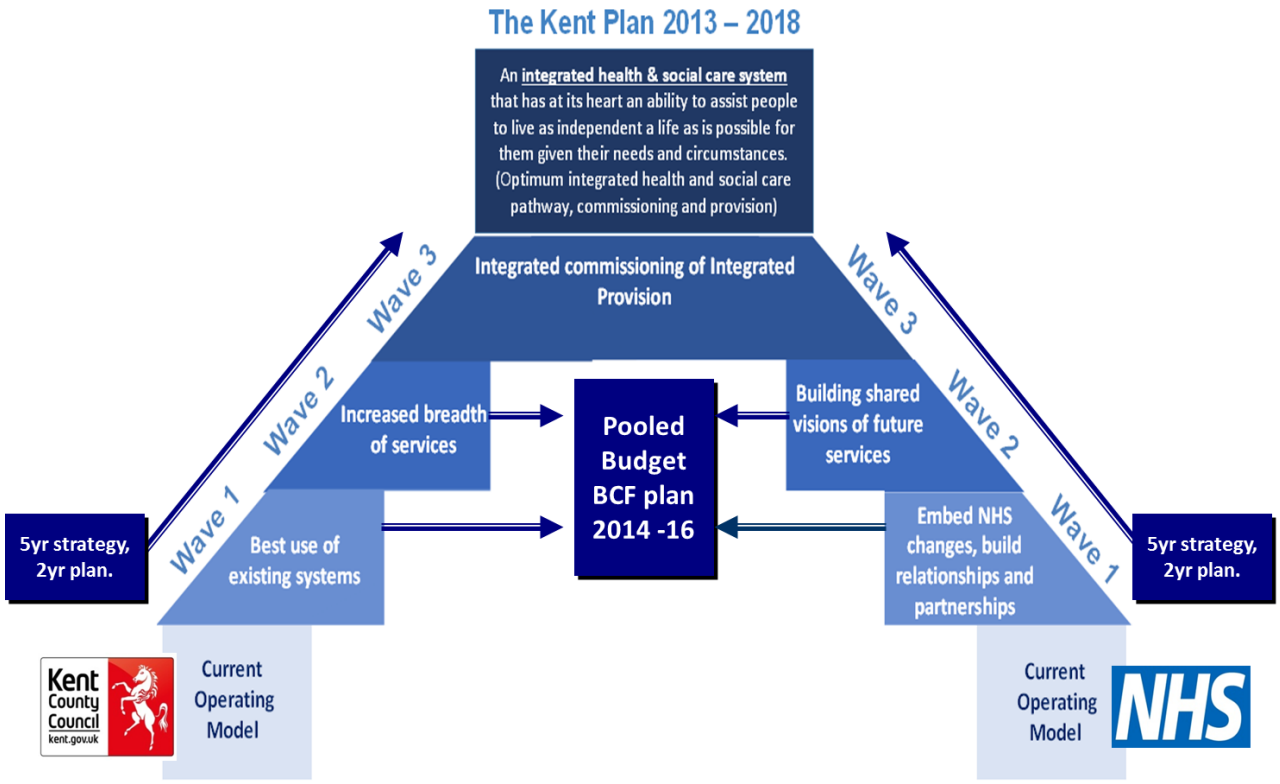
It also enables the plans to link to other existing care and support initiatives taking place as part of Kent's Pioneer such as Year of Care and Going Further Faster.

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 and SRO for the Better Care Fund who will be able to oversee sharing of good practice across Kent.

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

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 implantation of the Better Care Fund.



Further details on how the BCF aligns with CCG plans is:

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.

The development of community networks, which form the foundation of the CCGs five-year plans, will require some services to change to support the aims and vision we want to achieve, others will need stability.

All of our local partners will continue to experience considerable financial challenges and therefore our transformation programme is designed to generate significant efficiencies within the whole system of care to ensure that the health and care system remains sustainable and of high quality.

Our ultimate ambition remains the pooling of all current resources committed to the commissioning of health and social care services as we spend the taxpayers' funding wisely. 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.

Building on a long history of joint commissioning of services, the Better Care Fund provides further opportunity to commission services together. Through the two approaches, of integrated commissioning and integrated provision, we will deliver the transformation of health and social care – delivering the 'right care, in the right place at the right time by the right person' to the individual and their carers that need it.

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.

The BCF is integral to the CCGs in Canterbury and Ashford's co-commissioning plans. We 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 (as referred to in our plans above) will be crucial to the delivery of better care for our patients.

We want our patients to recognise that the local NHS is sited within their own community and not around specific estate or hospitals. We want these networks to offer the largest possible range of services meeting the largest possible range of needs and that most aspects of any patient journey, through the health and social care system, is local to them.

One of the attractions of this approach would be to liberate local communities enabling them to

innovate in how care is delivered in order to meet local need allowing scope for different approaches to be developed in different areas. For the public and patients, community networks have the potential to offer accessible and responsive services that extend well beyond what is currently available in general practices. These services would have general practice at their core, with practices working hand-in-hand with a range of other services that people need to access from time to time. GPs would help people navigate through these services and would retain a key role in co-ordinating care in different settings.

General practice has a central role within our vision for the next five years, providing care alongside other NHS staff working in the community, voluntary sector organisations and colleagues in social care. General practice delivers significantly more services than ten years ago and this trend will continue with a proportion of this additional work transferred from traditional community or hospital bases.

In order for this is be possible a number of changes in the way which general practice operates will need to occur. This may require moving away from the current model of small, independently minded practices towards new forms of organisation that enable practices to work together and with other providers to put in place the networks of care that are required

Ultimately we anticipate that the outcome of this longer term approach will mean larger or federated practices offering more services, including Social Care, acting as the central hub for a wider variety of services and with improved access for traditional GP services.

The intention is for the CCGs to take on a joint commissioning arrangement with NHS England with effect from April 2015. In anticipation of this, the CCGs are working with our membership on developing a five year strategic plan for transformation of local GP services. We have highlighted eight ambitions for improvement, specifically these are:

- Improved Patient Access
- Increased Public Involvement
- Primary Care Workforce
- Premises
- Quality and Outcomes
- Integration
- Use of Technology
- Payments and Investments

As part of this approach we are looking at a new model for primary care, currently referred to as GP *Plus*, this would not affect existing GMS contracts but would instead be an enhancement to the nationally agreed contract. The intention is that we retain the best aspects, valued by our patients, of the existing model specifically; retain the registered list approach and continuity of care. However the enhancements will allow, as examples, for extended appointments for those in greater need, and the use of Skype style appointments.

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)

At a time when we are planning to make significant investments in community-based, person-centred health and care services, we are seeing rising demand on our health and care services, as we get better at keeping people alive longer and see our population age. Against this backdrop, local authority social care budgets are facing a prolonged period of real-term reduction, increasing the risk that individual care needs will not be met.

Our BCF plan is about applying targeted investments to convert this potentially negative cycle into a positive one, driven by improved outcomes for individuals, communities and the health and social care system as a whole. We recognize that the BCF alone will not resolve the financial challenges faced by Social Care, but we are confident that as part of our overarching transformation plans, these will be met.

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.

Our primary focus is on continuing to develop new forms of joined up care which help to ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and the local health and social care economy as a whole. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focusing on the supply of services. 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.

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.

The Better Care Fund also identifies the social care support required for the implementation of the Care Bill.

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.)

Through Section 256 agreements, the CCG will continue to offer funding to assist the protection of adult social care service as part of the Better Care Fund. In 2015/16, for example, this funding is £2.4m (Ashford) and £3.7m (Canterbury).

In addition, funding of £776k has been identified for our commitments to the £135m fund for implementing our Care Act duties.

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

Specifically the CCGs have set aside £605k (Ashford) and £923k (Canterbury) which is specifically related to carer support. However, this doesn't negate the investments across a number of different schemes which are designed to offer respite and support for carers in the everyday pressures of their role. This will be delivered through the whole project, which will lead to more streamlined and responsive service thus easing the pressure (in both time and complexity) for carers and their charges.

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 would require Adult Social Care to begin to slow down other commitments to stay on course to meet its requirements for Transformation to 2016.

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.

In addition the above schemes will support admission avoidance and timely discharge

Moving health and social care services from five to seven days is a key commitment across the Health and Social Care system. The day of the week on which a person becomes ill (or recovers from illness) should not be the determinant of the services that someone can receive, or the speed with which they can access services or return home.

Simply having services available seven days a week isn't enough. Services across primary, secondary, community and social care also need to be co-ordinated. We already have several well established seven day established community services, for example, district nursing and joint care managers, and have begun to further enhance other service availability.

A detailed plan for a 7 day service will be developed during 2014/15 as part of our 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.

Additionally, the CCGs have funded a trial for 7-day GP services. These pilots have been launched in Faversham, Whitstable and Herne Bay in November and the 7 day trial at Tenterden has been extended

Early indicators are being uploaded to LUCI – an analysis of trends developed for Ashford suggests a trend towards admission avoidance for older patients in the Ashford area, however the trial is in its early stages. A full review of all practices will be undertaken in mid-December.

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).

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.

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 CCG 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.

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.

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.

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.

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

We have a well-established system of risk stratification already in place to identify patients at high risk of hospital admission. The system supports accountable lead professionals to work in a more proactive and preventative way, identifying patients before they become unwell and ensuring they have a tailored care plan in place.

The introduction of new arrangements for GP contracting next year provides an opportunity to adapt the way in which the tool is used. The tool will need to be used to identify the top 2% high risk patients from each practice and from that will also need to include the development of a care plan. The plan will identify a named accountable GP within the practice who has responsibility for the creation of each patient's personalised care plan. In addition, the plan will also specify a care co-coordinator, who will be the most appropriate person within the multi-disciplinary team to be the main point of contact for the patient or their carer to discuss or amend their plan. This could be the GP or it could be another member of the integrated neighbourhood team. This process will ensure MDT input into care, coupled with professional accountability.

Kent's whole system analysis 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.

To support risk stratification and motive further joint working, a complimentary CQUIN will come into effect in April 2014. The CQUIN will incentivise community health services to work in a more multi-disciplinary way with primary care, to deliver improved proactive care management.

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

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 patient and the relatives where appropriate. This scheme for Canterbury is already counted under QIPP.

- Patients and health and social care professionals to have access real time to agreed health and social care information.
- Consultants (in long term conditions) to increasingly no longer have caseload but outreach to support primary care to deliver high quality complex care.

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

GP Practices through the Risk Stratification tool are identifying around 2% of the population. Work is on-going to develop individual care plans.

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 is assisting in outlining the evaluation of objectives and outcomes against I Statements.

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. As part of the operational integration programme regular surveys on integrated are undertaken with patients by providers and the CCG.

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.

Patients, service users and the public have played, and will continue to play, a key role in the development of sustainable plans for health and social care across the CCG. We will seek to further engage the public on the contents of the plan throughout February and March, and into the new financial year, via local networks. The CCG has existing forums for engagement with patients, care homes and volunteer agencies which will support the projects

Patients and service users are already involved in designing services and shaping change through patient advisory and liaison groups and representation on boards and steering groups. We have a strong relationship with our local HealthWatch organisation, represented on the district Health and Wellbeing Board. This means that commissioner plans involve patients and service users, who offer challenge and a unique perspective before implementation of service change.

On a practical level, the key mechanism for us to deliver greater integration and the Better care Fund will be through the development of a series of community networks. There will be eight networks in total based around the main centres of population in our area.

Through the community networks which we have begun to establish with Kent County Council (KCC), we will work with patients, GPs, providers, the voluntary sector and other stakeholders to tailor local out-of-hospital services to local communities.

Launch events took place in early September 2014 to begin the co-design process. The workshops mark the start of a journey that will enable us to find out which health and social care services patients, voluntary organisations and service providers believe need to be available within their community.

Feedback from the launch events is being used to help us begin co-designing the new community networks. The next stage will involve setting up local stakeholder forums to support communities in developing their individual network.

Finally, the NHS Call to Action has provided us with 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.

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

Over the past year, the CCGs have helped to establish the Whole Systems Board in east Kent. Membership of the board includes leaders from NHS Trusts and Foundation Trusts working alongside commissioners, social care, and primary care.

Part of the board's work involves developing a robust communications, information and engagement plan to provide stakeholder organisations, and their clinical staff and GP members with a coherent story that they have shaped together, and feel confident to share with the patients and public.

This shared approach includes forming the case for change: covering the scale of the challenge faced across the whole health and social care system, and the way that individually and collectively the commissioners and providers are working together to facilitate and agree a whole system solution(s). The prime aim is for the whole system to collaborate on an overarching strategy based on what is best for the patients, and what is best for the sustainability of the system.

A five year strategic commissioning plan has been developed for the east Kent Whole System Board. It sets out the level of challenge being faced due to changes in demographics, growth in demand - especially around long term conditions, shifts in policy and service innovations; and the need for the whole system to change and work together in a more integrated way, as both commissioners and providers, to ensure that patient services continue to be of a high quality.

Having a co-ordinated approach and an overarching narrative and evidence base would give all these separate but linked activities a coherence, and would provide reassurance to both local staff stakeholders and patients as well as national policy leads.

This is intended to be a two-way process where staff, stakeholders and the public feel they have influence then there must be opportunities to share the problems and work together on agreeing the solutions. The fact that many of the problems are fundamentally complex means there may not be a single right answer. What is important is having the stakeholders take part in defining the solutions that emerge.

EKHUFT have stated that they recognise and fully support the vision for health and care services and have been engaged with the CCGs about the schemes detailed in the submission and are working in partnership with them on many of these. The schemes emphasise the importance of integration and community based care to prevent/reduce A/E attendances and emergency admissions. The strategic direction of EKHUFT is aligned with priorities in this submission, specifically to:

- Reduce non –elective activity
- To design a health-care system less reliant on in-patient beds
- Focus on long term conditions and the aging population
- Ensure local services for local people wherever possible
- To deliver integrated service provision.

ii) primary care providers

Our member GP practices have played, and will continue to play, a key role in the development of sustainable plans for health and social care across the CCG. We will seek to further engage the public on the contents of the plan, and into the new financial year, via local networks. The CCG has existing forums for engagement with our members which will support the projects

Practices are already involved in designing, and delivering, services and shaping change through membership meetings and representation on boards and steering groups. We have a strong relationship with our local town teams, who offer challenge and a unique perspective before implementation of service change.

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.

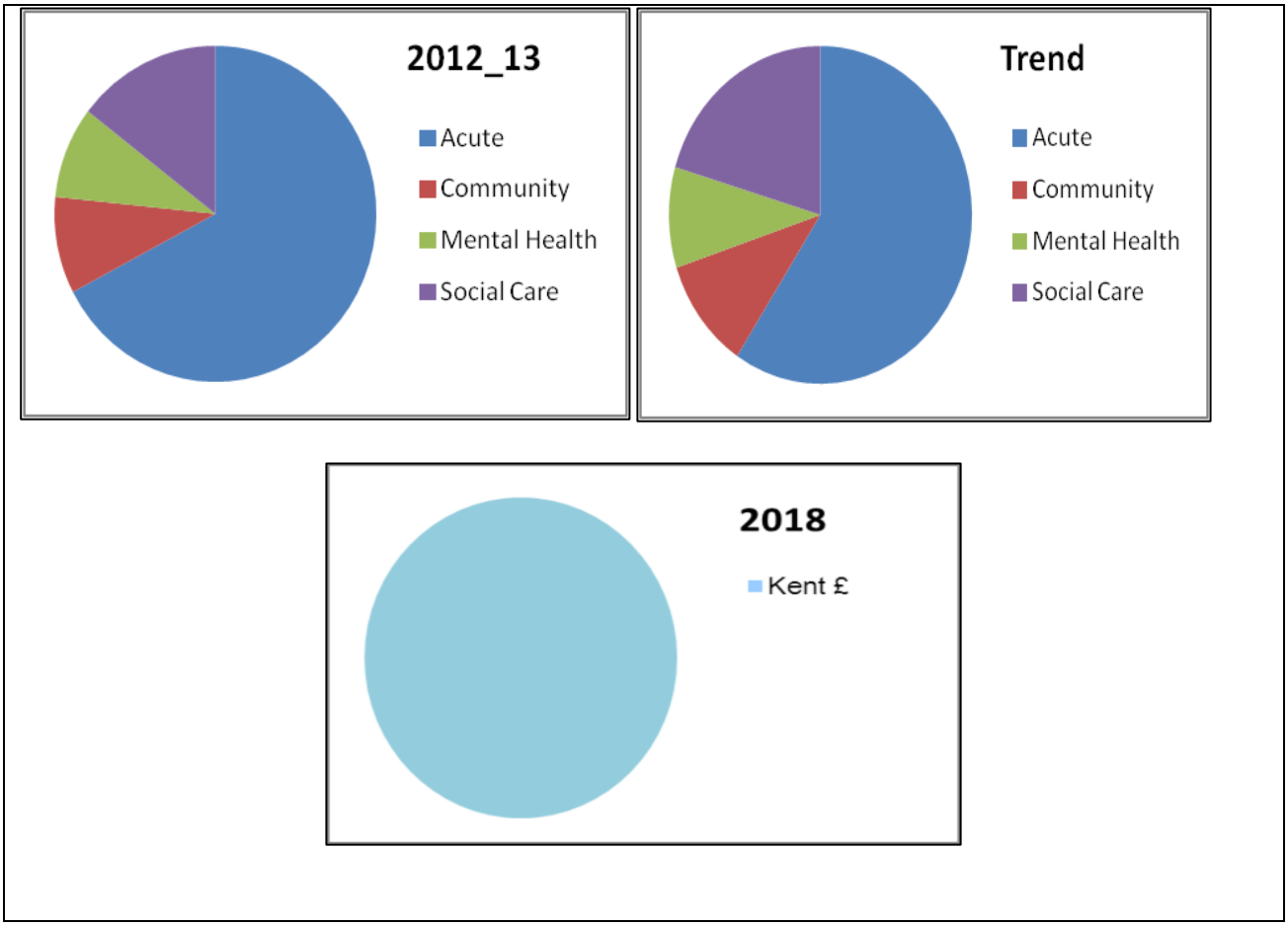
Risk Stratification research by Public Health helps indicate the potential cost savings that can be delivered by a proactive integrated care approach as outlined within the Better Care Fund Plans. The difference in activity attributed to the 'crisis' helps us also to determine realistic benefits of a 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.

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.

YOC 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

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Community Networks
What is the strategic objective of this scheme?
The fundamental, underlying, principle which reaches across our strategic direction is that the CCG are keen to ensure that care is be delivered as close to where patients live as possible. The consequence of this is that patients will be able to access a variety of services in a number of locations –including their own home, their pharmacy, the optometrist, their GP surgery, community hospitals as well as district hospitals. Ultimately we anticipate that the outcome of this longer term approach will mean larger practices offering more services, including Social Care, and acting as the central hub for a wider variety of services and with improved access for traditional GP services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
"Community Networks" is the title given to a number of projects leading towards an overall strategic aim. The component projects, forming part of the Better Care Fund initiative are detailed individually below
The delivery chain
Kent Adult Social Care The CCG Provider Organisations including Voluntary Sector
The evidence base
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme The schemes will ensure that residents received both health and social care using pathways that address all of the issues. Through a coordinated approach this will support the dependence upon health services

SCHEME REQUIREMENTS:

- Core set of community based health **and** social care services, with tailored community based services
- General Practice as the most frequent point of contact for patients and carers;
- Improved GP access - in terms of time waiting for an appointment and telephone access
- More services provided locally, within a community setting e.g. at or via the GP surgery
- More locally based day services for carers and patients
- Improved communication with patients and carers. This could reduce patients' and carers' concerns regarding treatment and disputes regarding decisions about health care provision and support
- Improved communication between health care professionals and across health and social care
- Better information, whether it is about services that are available (accessibility, timings, contacts) in different formats including easy read
- Reduced cost of void space to the CCGs in future
- Improved community bed utilisation
- Voluntary and social services integrated into community-based contracts
- Integrated contracts for defined geographical locations
- Increased emphasis on early interventions and health and wellbeing

Feedback loop

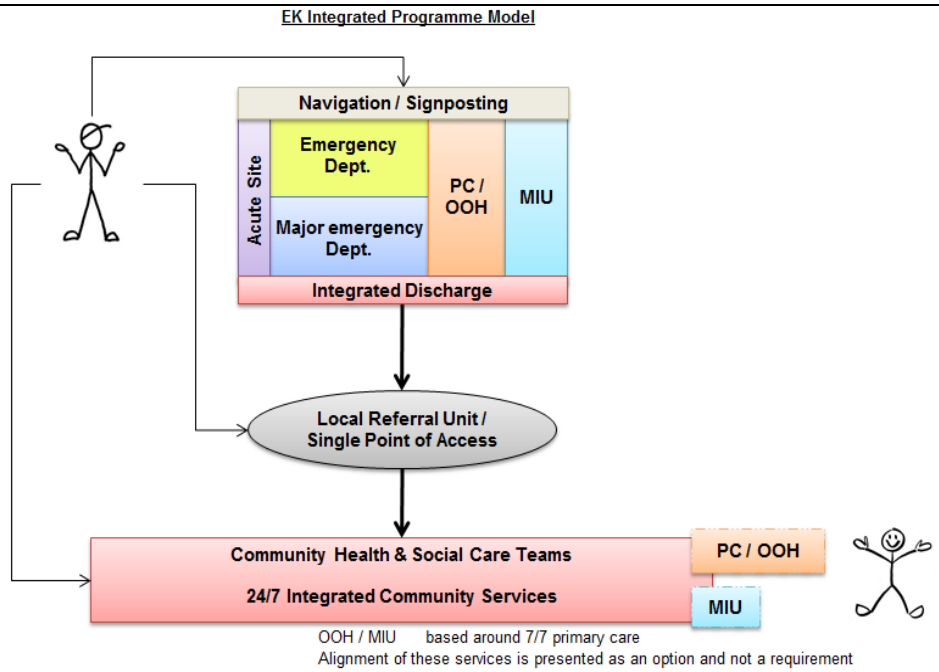
What are the key success factors for implementation of this scheme?

- Reduced emergency admissions;
- Reduced A&E attendances;
- Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia;
- Improve patient, carers' and relatives' experience;
- Improve health and social outcomes;
- Reduced length of stay across the health and social care economy;
- Improved transfers of care across health and social care;
- Reduced long term placements in residential and nursing home beds;
- Reduced need for long term supported care packages;
- Increase patients returning to previous level of functionality in usual environment
- Improving patients ability to self-manage

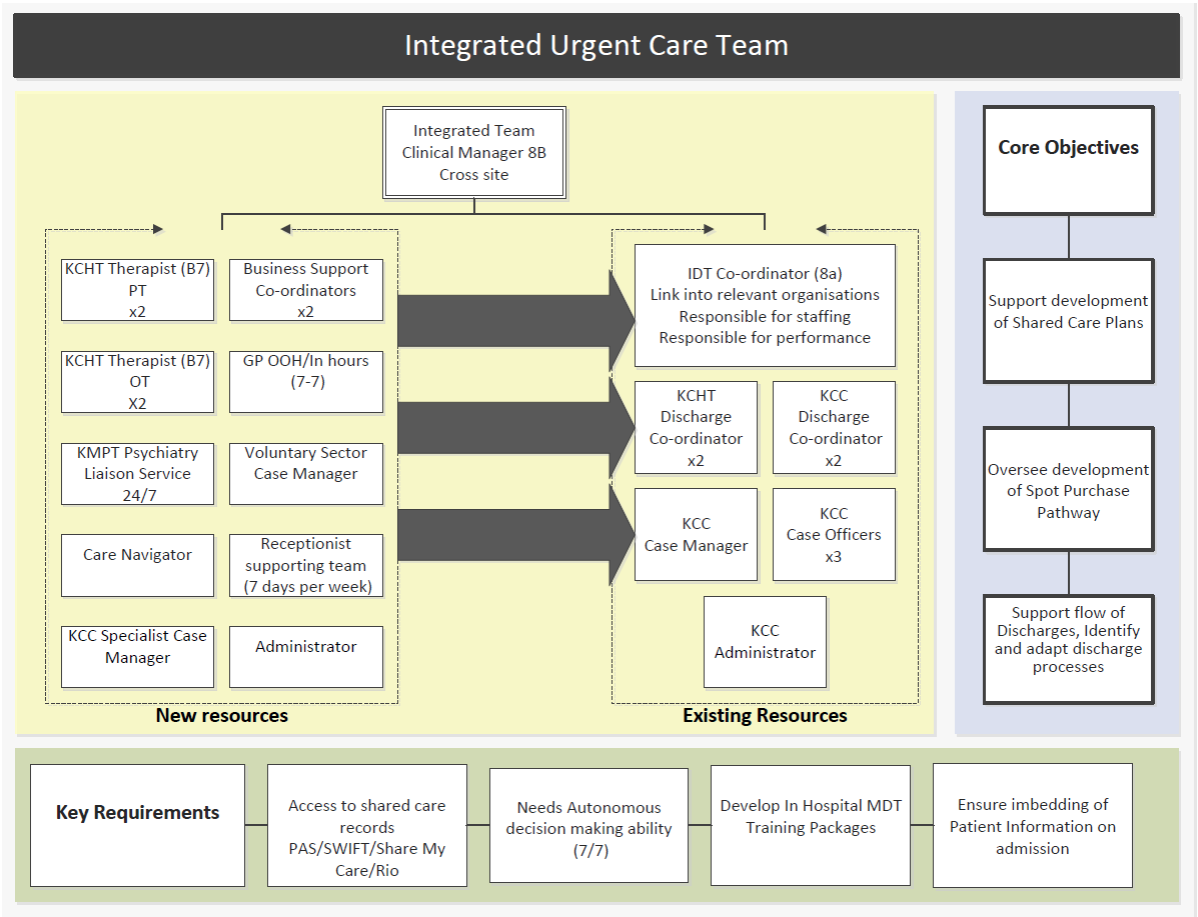
ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Integrated Urgent Care Centre (IUCC)
What is the strategic objective of this scheme?
This initiative will improve the effectiveness of multi-disciplinary agencies for the following benefits: • Enhanced Patient Experience • Reduced Admissions • Improved flow of discharges over 7 days a week • Reduced Acute Hospital Length of Stay
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The IUCC is an initiative which will bring together providers across health and social care settings under one management structure. It aims to reduce administrative burdens and to enhance productivity by creating a team of senior decision makers working towards shared objectives with shared governance arrangements. The team will be responsible for working both within the Acute aspects of Hospitals (A&E, Clinical Decision Unit and Surgical Assessment Unit) and also the speciality inpatient wards, covering a 7 day per week service provision. The model is described below



The Team Structure is outlined below:



The delivery chain

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

Commissioners

Ashford CCG

Canterbury and Coastal CCG

South Kent Coast CCG

Thanet CCG

Providers

Kent County Council

East Kent Hospitals University Foundation Trust

Kent Community Healthcare Trust

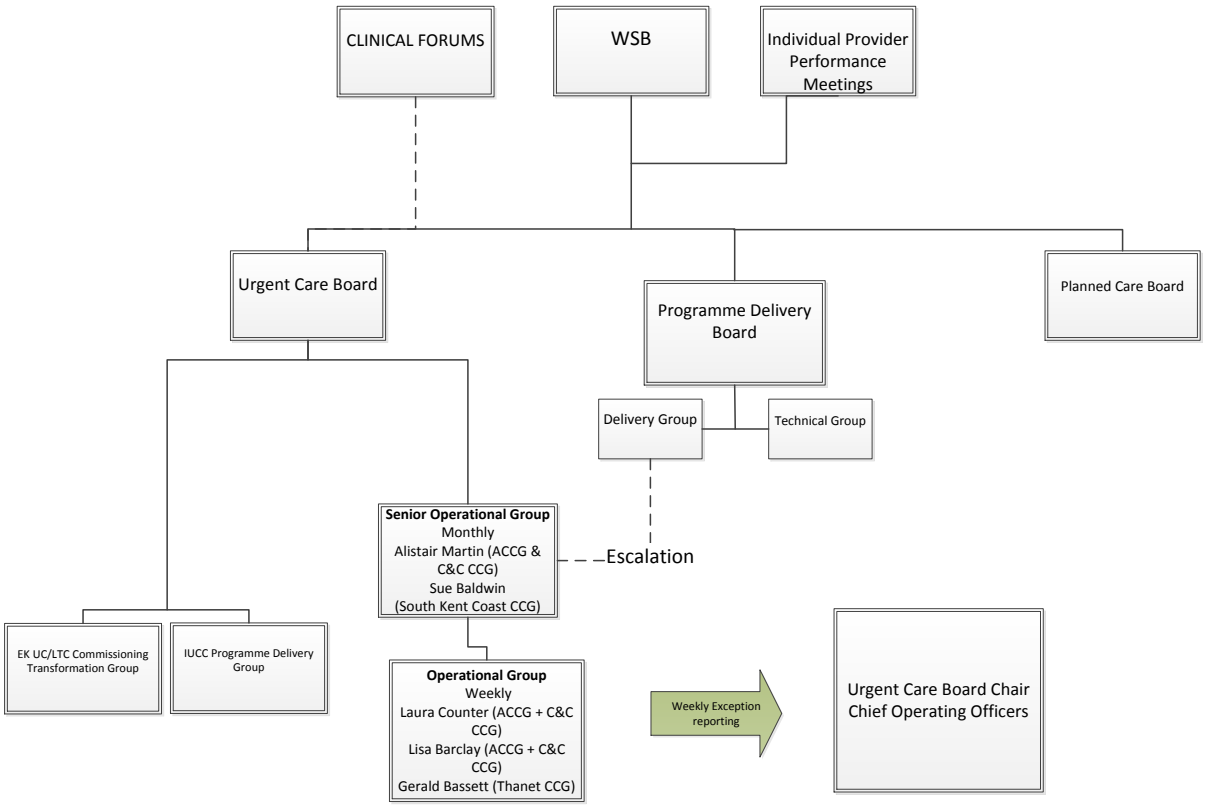
Kent & Medway Partnership Trust

South East Coast Ambulance Service

Intermediate Care 24 Ltd

Invicta Health

Delivery Structure:



The evidence base

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

Transforming Urgent and Emergency Care services in England (Sir Bruce Keogh, 2013)

Urgent and Unplanned Care: Operational Resilience and Capacity Planning for 2014/15 (NHS England, 2014)

Costing 7 day Services: The Financial Implications of seven day services for acute and urgent services and supporting diagnostics (Healthcare Financial Management Association (HFMA), 2013)

The Diseconomies of Queue Pooling: An Empirical Investigation of Emergency Department Length of Stay (Harvard Business School, 2014)

East Kent Integrated Urgent Care Centre Strategy (East Kent Hospitals University Foundation Trust, 2013)

Investment requirements

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

Impact of scheme

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

Key deliverables:

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

Enabling KPI

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

Feedback loop

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

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

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

• Reduced A&E attendances; • Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia; • Improve patient, carers' and relatives' experience; • Reduced spend on medication; • Reduced duplications across the health and social care system; • Reduce delays in provision of care • Reduce long term admissions to care homes • Reduction in A&E waiting times • Reduction in Ambulance Conveyances to Hospital • Improvement of Emergency Access Standard • Reduction in Acute Hospital Length of Stay • Reduction in 0-7 day Acute Hospital re-attendances

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Support for Care Homes
What is the strategic objective of this scheme?
To support the reduction in A&E attendances and unplanned admissions for care home residents (nursing and residential).
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The services provide specialist assessment, advice and treatment to older people in care homes (nursing and residential). The models differ slightly in each locality, an overview of each is provided below; **Ashford:** Funding supports the employment of a Community Matron, available 8am-8pm 7 days a week and 8pm-8am 7 days a week via an on call bleep for advice only, and a Community Geriatrician available in office hours (9am-5pm Monday to Friday). The Geriatrician job plan includes the provision of a Community Geriatric Assessment clinic. New care home admissions, residents who have been discharged from hospital, and those with perceived high risk of unplanned emergency attendance will be identified and referred to the Community Matron Team to arrange a visit, commence assessment and future planning. The Community Geriatrician and Matron Team work together to ensure individuals are assessed in their care home or own home, with a view to assessing their health and care needs and where appropriate initiate anticipatory care plans with clients and relatives. By working with care home staff, it is anticipated that this will continue to improve confidence in managing frail older people in the community. Fixed, daily sessions of Consultant Geriatrician time will be provided for domiciliary assessments of care home residents Weekly outpatient clinics will be provided enabling the removal of secondary care outpatient activity into the community. The clinics will be accessible by care home residents and GP referred complex elderly patients living within their own homes providing care closer to home.

Canterbury:

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

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

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

The delivery chain

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

Commissioners:

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

Providers:

- GPs
- East Kent Hospitals University Foundation Trust (EKHUFT)
- Kent Community Health NHS Trust (KCHT)
- South East Coast Ambulance Service (SECAmb)
- Local Care Homes

The evidence base

Please reference the evidence base which you have drawn on

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

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

Analysis of activity data in relation to care homes in 2012 demonstrated that over 40% of

patients who were transferred to Accident and Emergency for urgent review were discharged back to the care setting for continuation of their current care package. In addition the majority of transfers occurred out of hours.

The initial investigation highlighted that care homes felt that they had no alternative option due to lack of anticipatory care planning, lack of advice out of hours and whilst GPs were assigned to undertake medical services within the care home they do not necessarily have the depth of knowledge in relation to care of the elderly patients. The community matron did have responsibility for the care homes but did not work beyond 5pm.

There was also evidence that the readmission rate for care home patients was above 20% due to lack of robust care plans.

Investment requirements

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

Total expenditure:

Canterbury and Coastal CCG - £135,000

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

Impact of scheme

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

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

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

Feedback loop

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

A&E and admission data will be reviewed on a monthly basis to identify admission avoidance against pre agreed criteria.

The project reports into the joint CCG and KCC Health and Social Care Operational Group for Care Providers (Adults), this feeds into the Integrated Commissioning Group, a sub-group of the Health and Wellbeing Board.

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

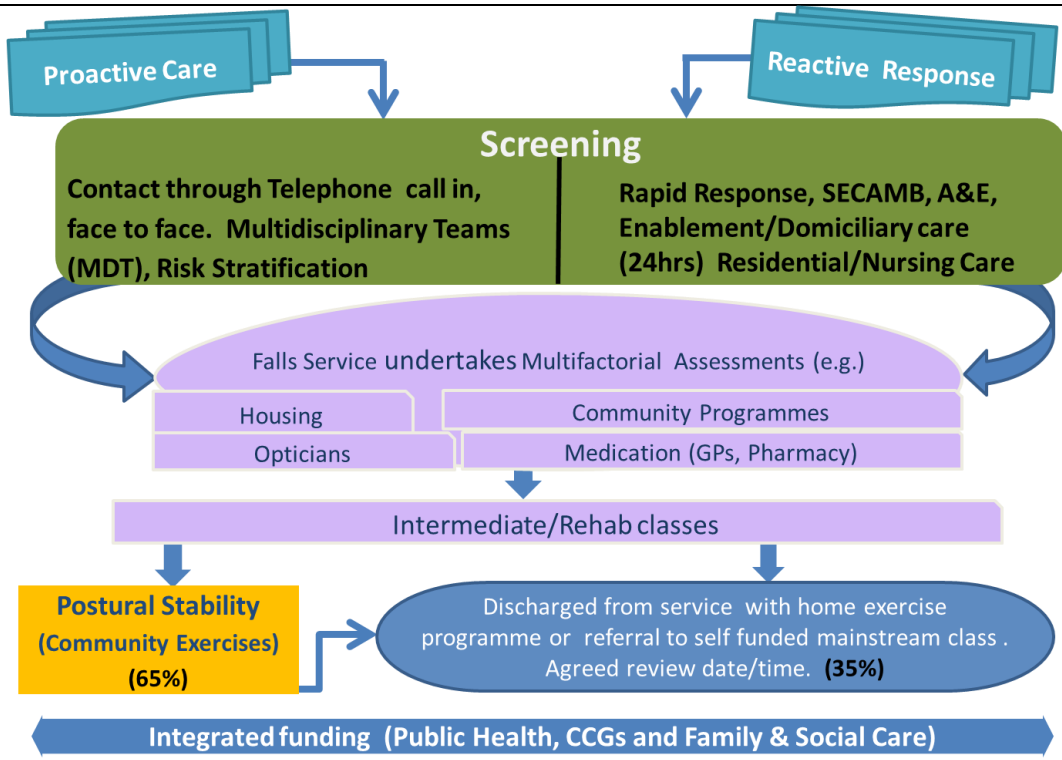
- Reduced A&E attendances;

- Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia;
- Improve patient, carers' and relatives' experience;
- Reduced duplications across the health and social care system;
- Reduce unnecessary prescribing;
- Improve patient satisfaction through personalised care planning.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Falls Prevention and Management
What is the strategic objective of this scheme?
The Kent Health and Wellbeing Board have agreed a framework which promotes an integrated multi-agency, multidisciplinary service for the secondary prevention of falls and fractures and is based on a recommendation made by the Department of Health (DH 2009) for developing an Integrated Falls Service. The overall aim of the proposed 'framework' is to focus on objectives 2 and 3, and improve the quality of life for local residents (particularly over 65yrs of age): • Objective 2 - respond to a first fracture and prevent the second – through fracture liaison services in acute and primary care settings • Objective 3 - early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The intention is to work with partners to develop an integrated multi-agency, multi-disciplinary falls service across Ashford and Canterbury. This will focus predominantly on those aged over 65 years. The Kent Health and Wellbeing Board have agreed a framework which promotes an integrated multi-agency, multidisciplinary service for the secondary prevention of falls and fractures and is based on a recommendation made by the Department of Health (DH 2009) for developing an Integrated Falls Service.



The 'framework' covers the entire spectrum across a range of stakeholders including acute trusts, community health trusts, CCGs, adult social services, district authorities and voluntary organisations.

Considering the guidance from NICE and the National Service Framework, the framework recommends following interventions, which if undertaken in a systematic way will prove beneficial at a population level. These include:

1. Screening of adults who are at a higher risk of falls

2. Integrated multi-disciplinary assessment for the secondary prevention of falls and fractures

3. Use of standardised Multifactorial Falls Assessment and Evaluation tool

4. Availability of community based postural stability exercise classes

5. Follow on community support for on-going maintenance closer to home

These interventions should be available as a "core offer" for the population if we are to see a reduction in the number of falls related hospital admissions and reductions in numbers of older people living in residential care as a result of falls.

A scoping exercise has been undertaken to review the existing pathways (re-active and pro-active) and services identifying what works well, what requires further development and gaps in existing provision. The outputs of this will be reviewed by the falls task and finish group to support the move to an integrated service.

The delivery chain

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

and providers involved

Commissioners:

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

Providers:

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

The evidence base

Please reference the evidence base which you have drawn on

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

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

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

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

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

Both NICE and National Service Framework (NSF) for older people recommend the prompt delivery of multifactorial assessment and interventions to be delivered by a specialist falls

and fracture prevention service working closely with primary care and social care professionals.

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

Investment requirements

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

Impact of scheme

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

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

The outcomes of this service will be to;

- Minimise duplication of existing services, to maximise the use of existing resources
- Ensure service delivery is in line with National Guidance and is evidence based
- Ensure equity of provision
- Improve access to services
- Reduce hospital admissions related to falls by preventing the patient from having a second fall
- To reduce the number of health and social care activity related to falls and fracture in older people
- Improve patient experience of services
- Improve outcomes for patients

Feedback loop

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

Outcome measures will be identified in conjunction with the development of the pathway and supporting business case.

The project reports into, and is monitored by, the Integrated Commissioning Group a sub-group of the Health and Wellbeing Board

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

- Reduction in hospital admissions related to falls by preventing the patient from having a second fall

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

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Mental Health
What is the strategic objective of this scheme?
Through provision of integrated services patients will be able to access coordinated mental health service provision ensuing that the pathway is designed to have maximum input from prevention to treatment.
Overview of the scheme
We recognise that like physical health related long term conditions, mental illness has a huge impact on the quality of life for the patients and their carer. The CCG will work with all partners to deliver improved mental health services for all age ranges to support: • Increased schemes to support health minds and early interventions • Crisis support within all pathway • Integrated models for all pathways to support patients within range of pathway • Systematised self-care/self-management through assistive technologies • Improved care navigation • The development of Dementia Friendly Communities and, • To facilitate access to other support provided by the voluntary sector. **SCHEME REQUIREMENTS:** • Street triage services, aligned with Kent Police to ensure earlier assessment of a patient in crisis, thus avoiding the need for hospital admission • Develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by General Practice • We will ensure that patients are supported outside of the hospital environment through "Befriending Services" to address and support the needs of vulnerable people. • Improved support for carers during periods of "crisis", including short breaks for carers. • Improvements to Psychiatric liaison service provided within urgent care facilities • We will promote the use of integrated personal health budgets for patients with long term conditions and mental health needs to increase patient choice and control to meet their health and social care needs in different ways; • Pathways which are integrated across health and social care • Primary care and the integrated team will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the community; • Improved signposting and education will be available to patients through care coordinators and Health Trainers to ensure patients are given information about other opportunities to support them in the community, including the voluntary sector, and community pharmacies; • Develop a Health and Social Care information advice and guidance strategy to enable people to access services without support from the public sector if they choose to. • Introduction of an "all-age" earlier identification and intervention for problematic eating behaviours • Improved discharge pathways for patients with mental health related conditions

The delivery chain
Sue Scammel Mental Health Commissioner KCC Jacqui Davies Mental Health Commissioner Kent & Medway Commissioning Support Unit Ian Reason Commissioning Project Manager Ashford CCG Kent Police Kent and Medway Partnership NHS Trust East Kent Hospitals University Foundation Trust
The evidence base
Closing the Gap DOH 2014 Kings Fund Making the Case for Family Networks 2014 Kings Fund Lesson from Mental Health 2014 Kent Health and Wellbeing Strategy
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme
The delivery of mental health pathways will incorporate integrated service delivery to manage the full range of the patient's pathway from prevention to medical intervention. This will support patients with their needs across their support network and social needs
Feedback loop
The projects will report into the Integrated Commissioning Group which is a sub group of the Health and Wellbeing Board
What are the key success factors for implementation of this scheme?
• Reduced emergency admissions; • Reduced A&E attendances; • Improve patient satisfaction and well-being; • Increase levels of patient self management of long term conditions; • Increase levels of patients with personal health budgets and integrated budgets; • Improve health outcomes by better use of prevention services. • Increase in number of patients returning to their normal daily activities

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Health and Social Care Housing
What is the strategic objective of this scheme?
To ensure that development of Health and Social Care Housing schemes are developed in partnership across the health and social care economy. This will facilitate the ability to maximise the benefits of the facility through access to focused health provision
Overview of the scheme
To improve the utilisation and appropriate use of existing housing options and increase the range if housing options available to people and to ensure it's used flexibly and enables more people to live independently in the community with the right level of support. This will also require responsive adaptations to enable people to manage their disability in a safe home environment. There are several housing projects in various stages of development. The largest of these are focused on elderly and homeless patients. It is proposed that the facility for elderly patients will support the ability to provide site based health delivery to include the primary care, consultant geriatrician and the wider integrated team. The homeless facility will be supported by the integrated team and will include primary care, social services, mental health and voluntary agencies. The team will ensure that all residents are fully assessed and where required implement a plan to manage the complex care needs of this patient group **SCHEME REQUIREMENTS:** • An integrated approach to local housing and accommodation provision, supported by a joint Health and Social care Accommodation Strategy, to enable more people to live safely in a home environment and other environments. • Responsive timely adaptations to housing; • Preventative pathways to enable patients and service users to remain in their homes safely; • Flexible housing schemes locally; • Increased provision of extra care housing locally; • More supported accommodation for those with learning disabilities and mental health needs
The delivery chain
Paula Parker Commissioner KCC

Sue Luff Clinical Commissioning Group

Ashford Borough Council

Canterbury City Council

The evidence base

District Council Housing Strategy documents the importance of ensuring that new developments incorporate services to meet the needs of the residents.

Kent Health and Wellbeing Strategy

Investment requirements

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

Impact of scheme

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

Feedback loop

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

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

Delivery of services at point of facility opening.

- Reduced A&E attendances;
- Reduced hospital admissions and re-admissions;
- Improve patient, carers' and relatives' experience;
- Reduced duplications across the health and social care system;
- Reduce unnecessary prescribing;
- Improve patient satisfaction through personalised care planning.
- Reduced residential care admissions;
- Reduced care packages

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Integrated Health and Social Care Teams
What is the strategic objective of this scheme?
To implement new ways of working which will ensure that the service delivery is a joint service across health and social care thereby facilitating the ability to shift care from secondary to community.
Overview of the scheme
Through reducing the current division across health and social care this will support the ability to implement services which are delivered by one team sharing their skills and competencies to reduce duplication and unnecessary interventions from multiple agencies. The impact of this is that patients will be supported within their own care environment as the norm • Aligned to geographical areas the support will be accessible 24 hours a day seven days a week and will coordinate integrated management of patients through a multi-disciplinary approach with patient involvement at every stage of the process including the development and access of anticipatory care planning to ensure patient centred care and shared decision making; • Each Team will include input from the wider community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, and Social Case Managers as part of the multi-disciplinary approach; • The teams will support patients with complex needs to better manage their health to live independent lives in the community, including supporting and educating patients with their disease management by using technology, for as long as possible empowering them to take overall responsibility for managing their own health; • The integrated teams will provide continuity of care for patients who have been referred for support and care in the community, including within care homes. • To ensure continuity for patients with long term needs, the team will provide seamless coordination and delivery of End of Life care; • There will be a single point of access, the Health and Social Care Co-Ordinator, and single assessment to ensure responsive onward referral to either rapid response services or intermediate care services ensuring transfer to most appropriate care setting (including patients own home); • Specialist dementia nursing support, through the Admiral Nurses, will be integrated into the teams as part of an approach to maximising the knowledge of the team through the inclusion of specialists. • Each patient, identified through risk stratification, or as resident of a care home, will have a comprehensive anticipatory care plan to identify their individual needs and to identify possible pressure points so that approaches to the patients care can be identified in advance of the need arising. • We will ensure that patients are supported outside of the hospital environment through “Befriending Services” to address and support the needs of vulnerable people. • Improved support for carers during periods of “crisis”, including short breaks for carers. • Sharing of practice across professionals will improve the quality of care provided to patients and carers

- We will implement a shared IT solution to allow health and social care professionals to access the shared care plan.
- The aspiration is that, where possible, the team will be co-located. We suspect that this may prove to be the optimum model.
- The voluntary sector is seen as having an important role in the delivery of this scheme.

The delivery chain

Paula Parker Commissioner KCC

Sue Luff/ Lisa Barclay Commissioner Clinical Commissioning

The evidence base

Kent Health and Wellbeing Strategy

A New Settlement for Health and Social Care, Kings Fund 2014

Community Services – How they can transform care, Kings Fund 2014

Investment requirements

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

Impact of scheme

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

Feedback loop

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

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

- Reduced emergency admissions;
- Reduced A&E attendances;
- Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia;
- Improve patient, carers' and relatives' experience;
- Improve health and social outcomes;
- Reduced length of stay across the health and social care economy;
- Improved transfers of care across health and social care;
- Reduced long term placements in residential and nursing home beds;
- Reduced need for long term supported care packages;
- Increase patients returning to previous level of functionality in usual environment

- Improving patients ability to self-manage

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Kent and Medway
Name of Provider organisation	East Kent Hospitals University NHS Foundation Trust
Name of Provider CEO	Stuart Bain
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	31,057
	2014/15 Plan	31,068
	2015/16 Plan	30,437
	14/15 Change compared to 13/14 outturn	+11
	15/16 Change compared to planned 14/15 outturn	-620
	How many non-elective admissions is the BCF planned to prevent in 14-15?	-1,087
	How many non-elective admissions is the BCF planned to prevent in 15-16?	-1,087

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	We support the plans to reduce non-elective admissions in 15/16 compared to the planned 14/15 out turn. We recognise the schemes identified recognise the importance of integration and community based resources to reduce and/or prevent attendances/admissions at A/E. They also reflect the need for consistent service provision 7 days per week.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	We can confirm that we have considered the resultant implications for our services and indeed require the transformational changes described to be successfully implemented to support the sustainable delivery of high quality care.