Updated July 2014

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Kent County Council
Clinical Commissioning Groups	West Kent CCG
Boundary Differences	There are some boundary differences between West Kent CCG and Sevenoaks District Council affecting the Swanley area. In developing this plan discussions planned to take place to ensure consistency of outcomes.
Date agreed at Kent Health and Well-Being Board:	17 September 2014
Date submitted:	19 September 2014
Minimum required value of BCF pooled budget: 2014/15	£5,136,000 Kent Wide contribution
2015/16	£26,394m CCG contribution only
Total agreed value of pooled budget: 2014/15	£5,136,000 Kent Wide contribution
2015/16	£101,404m Kent Wide contribution

b) Authorisation and signoff

Signed on behalf of the West Kent Clinical Commissioning Group	
By	Ian Ayres
Position	Accountable Officer
Date	19 September 2014

Signed on behalf of the High Weald Lewes Haven Clinical Commissioning Group	
By	Frank Sims
Position	Accountable Officer
Date	19 September 2014

Signed on behalf of the Maidstone Borough Council	
By	Alison Broom
Position	Chief Executive
Date	19 September 2014

Signed on behalf of Sevenoaks District Council	
By	Pav Ramewal
Position	Chief Executive
Date	19 September 2014

Signed on behalf of Tonbridge & Malling Borough Council	
By	Julie Beilby
Position	Chief Executive
Date	19 September 2014

Signed on behalf of Tunbridge Wells Borough Council	
By	William Benson
Position	Chief Executive
Date	19 September 2014

Signed on behalf of the Kent County Council	
By	Andrew Ireland
Position	Director
Date	19 September 2014

Signed on behalf of the Health and Wellbeing Board	West Kent
By Chair of Health and Wellbeing Board	Dr Bob Bowes
Date	19 September 2014

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

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

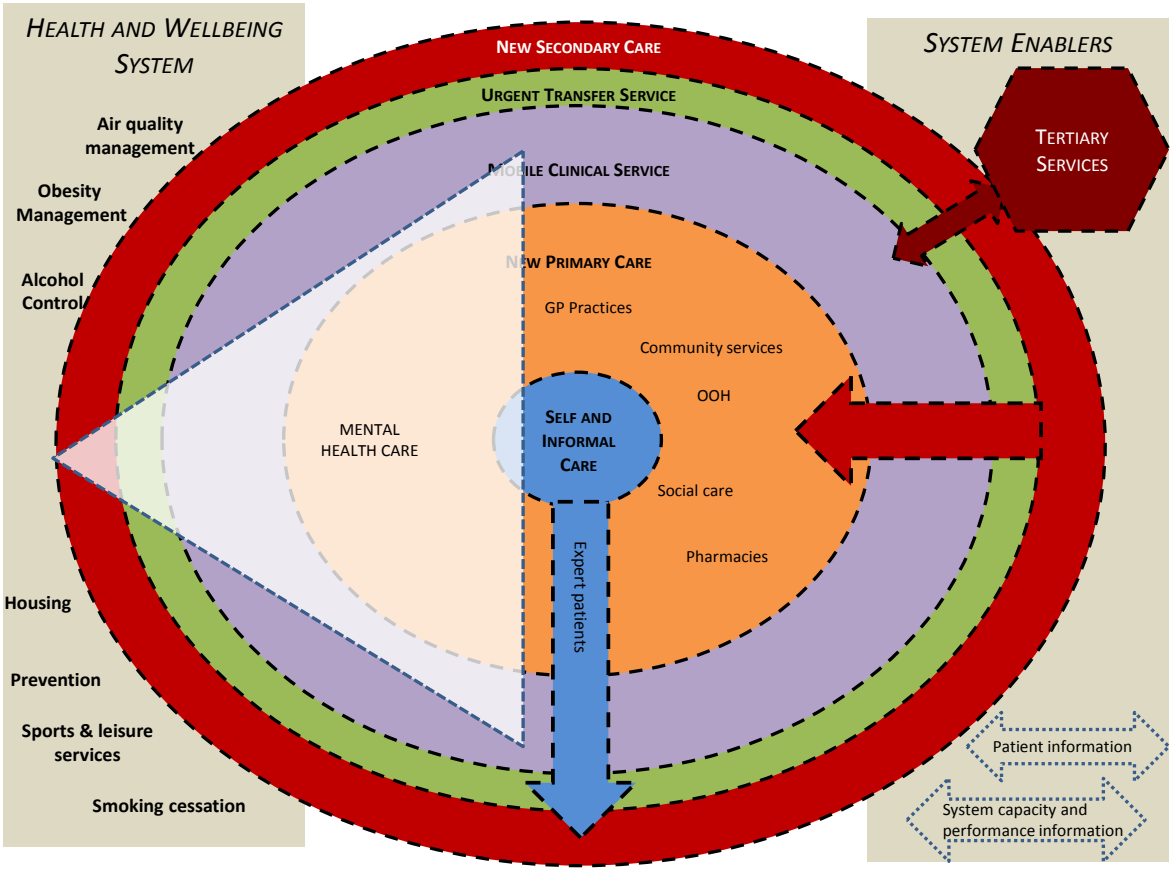
Document or information title	Synopsis and links
Joint Strategic Needs Assessment	http://www.kmpho.nhs.uk/jsna/
Kent Health and Wellbeing Strategy	**http://www.kent.gov.uk/about-the-council/strategies-and-policies/health-and-public-health-policies/joint-health-and-wellbeing-strategy**
Kent Integrated Care and Support Programme Plan	**http://www.kent.gov.uk/social-care-and-health/health/health-and-public-health-policies/kent-integration-pioneer**
HWB Assurance Framework	**https://democracy.kent.gov.uk/documents/s45113/Item%206%20Assurance%20Framework%20mv%202.pdf**
Kent HWB Paper 26 March 2014	**https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=790&MId=5465&Ver=4**
Mapping the Future	**http://www.westkentccg.nhs.uk/about-us/mapping-the-future/**
WKCCG 5 year Commissioning Plan	**http://www.westkentccg.nhs.uk/about-us/our-plans-reports-and-strategies/**

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

By 2018 we want to achieve a care economy that is sustainable for the future with improved outcomes for people. Our vision is to be providing care that crosses the boundaries between primary, community, hospital and social care with services working together, along with voluntary organisations and other independent sector organisations, to forge common goals for improving the health and wellbeing of local people and communities. The *Mapping the Future* blueprint will help local health care providers develop more coherent plans, provide more joined-up services and reduce unnecessary spend. It will seek to:

- Lead to the creation of a five-year healthcare plan for West Kent
- Provide the opportunity for local people to become involved in decisions about what should happen
- Enable commissioners and service providers – hospital trusts, community services, the mental health trust, ambulance services and social care providers – to plan more effectively
- Put patients at the heart of the process so that services are planned, commissioned and delivered in their very best interests
- Make it easier to coordinate care, especially for people with multiple health and/or social care needs
- Ensure resources are used wisely.

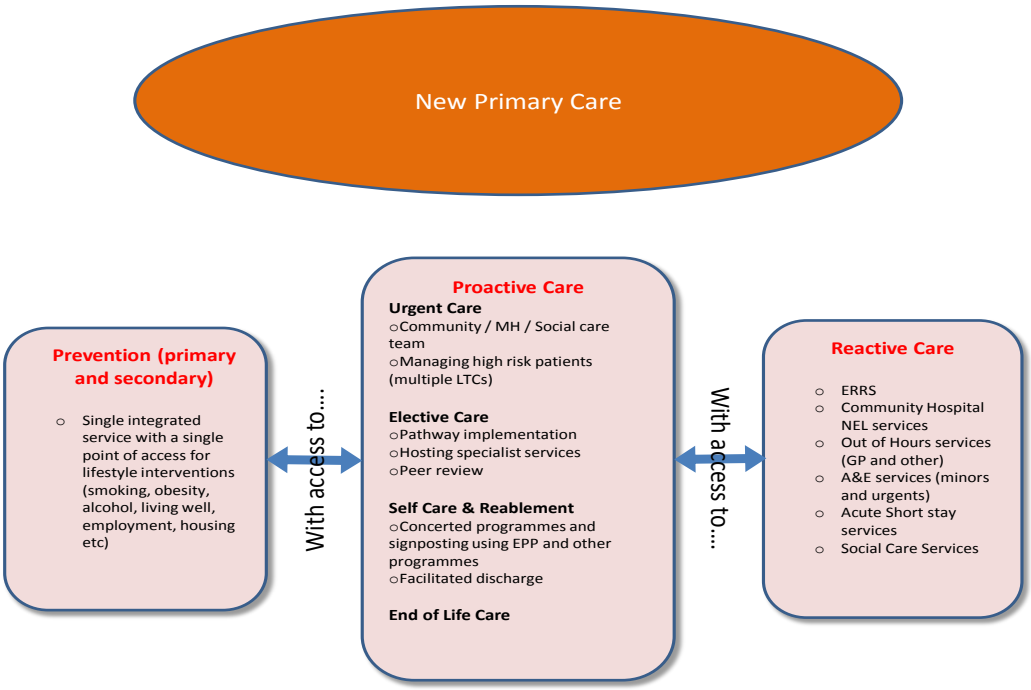


Mapping the Future sets out a whole system approach for West Kent where all *health and well-being system* partners use their individual and collective efforts to tackle the root causes of health and well-being problems where people are encouraged and supported to take greater responsibility for their health and healthy choices (the Blueprint). This blueprint places self and informal care at the centre, enhancing the capacity of communities and individuals to support themselves and each other. People are fully informed and take part in planning their care helping are supported to stay at home and independent longer.
It introduces a *new model of Primary Care* focusing on three distinct but interlinked areas of care (prevention, proactive and reactive) creating larger scale GP led multi-disciplinary teams which are wrapped around a suitably sized group of practices.

It supports the provision of more capable and cost effective out of hospital proactive care and brings together elements of urgent care, elective care, self-care, reablement services and end of life care.

The teams will include clinically-led professionals that take a care management and coordination role for patients who are elderly and those with the most complex needs. They will operate within a framework of clear clinical pathways spanning the health and care system and will have access to consultant opinion to enable them to support patients, most often without the need to send them to hospital.

The focus will always be to support citizens to manage and coordinate their own care whenever possible.



Community based support and prevention will be available to residents of West Kent. A core offer will be developed and commissioned which will ensure a comprehensive range of universal support services are available to people. Some will be targeted services for particular populations e.g. smoking cessation, weight management, and employment support. Other

support services commissioned via voluntary sector organisations will help reduce demand on more specialist health and social care services through preventative activities. Some will be linked to care pathways, for example, falls prevention classes, while others will offer universal access e.g. carer support, or dementia support.

NHS 111 will continue to provide advice online and by phone to patients and carers supported by GPs. This will be complemented by an integrated Information, Advice and Guidance service which will enable residents to access information and will enable those working within health, social care and housing services to signpost people to other support available within local communities.

Self and informal care will be an important part of the new system, with more people and their families being supported to manage their own care and long term conditions through the use of smart technology and the development of a self-care/self-management model. Integrated telecare / telehealth solutions will be backed up, where necessary, by trained staff working in an integrated telecare / telehealth monitoring centre, who will be pro-actively monitoring changes in activity and health condition, alerting integrated community teams where further intervention to prevent increases in care needs.

Mobile clinical services (MCS) will provide direct care to people at the point it is needed by taking care to the patient wherever possible and clinically appropriate to do so. The MCS will work as a complementary workforce to the new Primary Care System using similar pathways, protocols and medical records.

MCS will be supported to help people remain at home, through the development of a new integrated (health and social care) intermediate care/ reablement service with a workforce trained to deliver comprehensive care that supports independence, recovery, maintenance of existing situation or for some people, quality end of life care. The breadth of these services will be enhanced to include best practice use of assistive technologies to complement hands on care and where appropriate clear referral pathways to non-clinical partners.

Community based integrated care teams will be established to provide targeted, proactive co-ordinated care and support to those people identified as being of highest risk of hospital attendance or increasing use of care services.

New Secondary Care will seek to manage urgent and planned care as separate entities for optimum efficiency with some highly specialised services concentrated in larger centres. Hospital based urgent care will work as part of the total system connected with primary and community services and mobile clinical services. Together they will optimise patient flows to deliver the most cost effective service with coordinated care around people with complex needs. It is anticipated that this will allow secondary care services to be provided with a more community base model that reduces dependency on beds and buildings.

To enable mapping the future to be delivered we will look to develop our approach to risk management to ensure that financial and contractual levers are aligned and promote access to shared information management systems

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

Mapping the Future has identified that in the West Kent health system a significant reduction is required over the next 5 years in the level of activity which is currently delivered as non-elective care in hospitals. This is required

- to ensure that the urgent care elements of the local health system can function safely and efficiently,
- to ensure that those patients requiring planned care do not experience unexpected delays due to emergency pressures
- to enable the system to operate at optimum capacity which allows it to cope with peaks in demand when necessary
- to allow as much of a patient's diagnosis and care delivery to take place in a planned and therefore well managed way
- to allow people with health and social care needs to be in greater control of their health and social care support and are enabled to keep themselves well through access to self-care services
- to allow a reduction in the level of funding spent on care provided in hospitals and residential care and use this more effectively to provide care in a planned way and outside of the hospital or care home setting
- to meet the challenges presented as a result of demographic demand pressures

The patient and service user outcomes we are aiming for:

- Consistent, high quality health and social care services that are interconnected and available round the clock
- A system that offers the most effective and efficient care so that people get the right care in the right place by professionals with right skills the first time
- Proactive care which aims to prevent people from developing illnesses and limiting the severity of their conditions
- Individuals and carers are active partners in their care, receiving personalised and coordinated services and support
- Helping individuals to lead fulfilling healthy, active and independent lives in their homes wherever possible.
- Care is organised in a way that enables people to be as independent as possible and to only visit hospital when it is absolutely essential
- Health and care services that are efficient in the way they use resources

West Kent CCG and Kent County Council are committed to commissioning care for people to ensure these commitments are honoured.

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.

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?

We will use the BCF to:

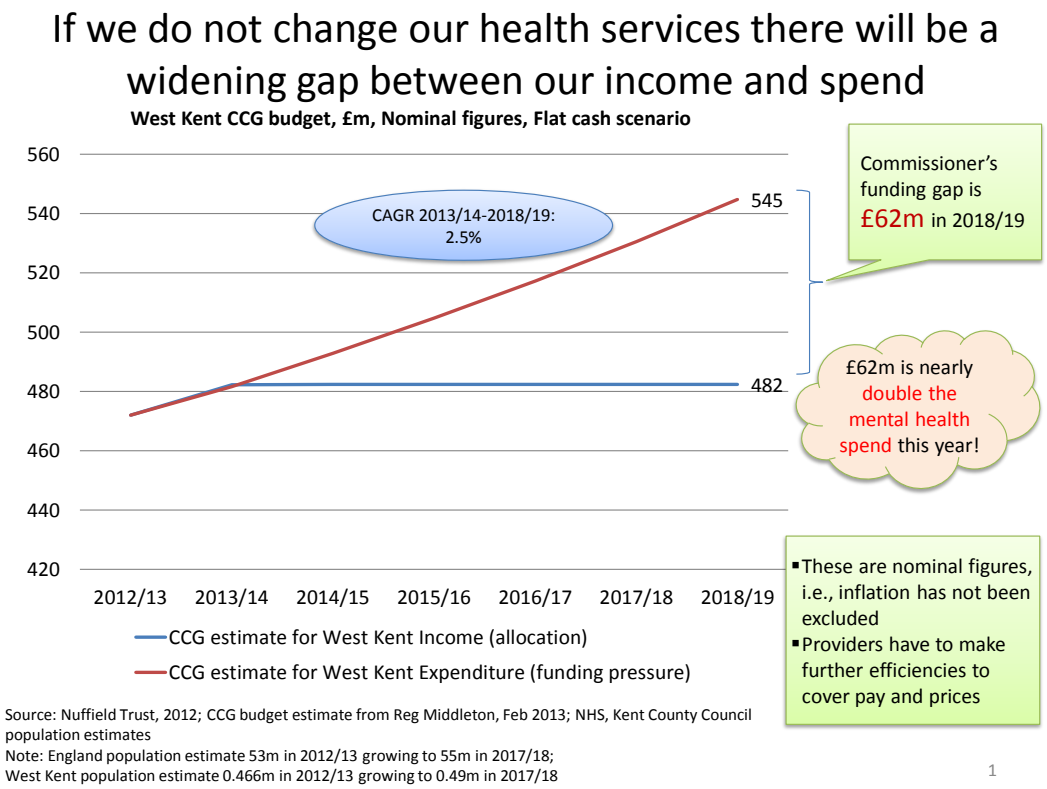
- buy more provision of reablement and 7 day access to services to keep people independent in their own homes
- Invest in falls prevention services to prevent falls and fractures in the first place (a major cause of health and social care spend)
- rapidly develop integrated care through bringing together inreach/outreach services, community hospital provision, and GP out of Hours as part of a network of integrated multi-disciplinary teams. All of this will be delivered with strong medical/clinical leadership and joint assessment processes.
- minimise use of physical resources i.e. hospital buildings and maximise use of human resources i.e. skilled workforce with a multi-disciplinary health and social care approach
- support the principle of unequal investment to close the health inequality gap by addressing specific needs in specific areas to improve health outcomes

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.

At present different organisations and individual services make their own plans. This creates a disjointed and inconsistent service for people who need health and care services. *Mapping the Future* is a programme of work which has been started in West Kent to describe what the system needs and what a modernised health and care service for the 463,956 people who live in West Kent will look like. The programme will produce a future picture of the modern, efficient health and care services that we will need to provide in order to meet the changing needs of people in West Kent over the next 5 years. This programme will deliver the NHS Call to Action within West Kent.

West Kent's health and care services need to change as there is a widening gap between what people in West Kent need and what can currently be afforded within the funding available. Based on current trends, and specifically linked to the ageing population, the demand for healthcare will increase by 20 per cent over the next five years with no increase in funding.



NHS West Kent CCG has a budget of £489 million per year to spend on healthcare in the area. If we continue to deliver the services in the way we do now and meet new demands for care, we will have a funding gap of approximately £60 million by 2018/19. In 2013/14 although the local system has met the vast majority of constitutional pledges to its population, it has struggled to maintain performance in a number of key areas, specifically those around waiting time in A&E, delayed discharges from hospital, and the 18 week Referral To Treatment (RTT) target.

Key National Challenges

- Fiscal constraints and rising costs
- Unwarranted variation in care
- Examples where patients have been badly let down, as in the recent tragic experiences at Mid Staffordshire and Winterbourne View
- An ageing population, changing disease patterns and rise in long term conditions
- Changing life styles with associated risks such as excess alcohol, smoking, lack of physical activity and poor diet
- Greater public expectations

In addition to these large, ubiquitous challenges that face health systems across the world, CCGs also need to respond to a range of local challenges, depending on their context and history. Together, these challenges constitute an inescapable case for change: the NHS must change to survive. Without bold and transformative change to how services are delivered, a high quality yet free at the point of use health service will not be available to future generations. Change does not mean top-down re-organisation. It means a reshaping of services to put patients at the centre and to better meet the health needs of the future.

In addition, there are a number of challenges facing the health system in West Kent:

- Increasing needs of ageing population
- High demand for A&E services amongst the 0-5 population.
- Significant increases in the number of children entering in to the adoption system.
- Lack of integrated information systems
- Lack of integrated health & social care teams in the community to support vulnerable patients in their usual place of residence
- Increasing number of children with highly complex health needs being discharged from hospital requiring specialist multi-agency support and children's continuing care packages.
- Recruitment and retention of the GP workforce
- Recruitment to specific specialist roles
- Inability to move patients onto rehabilitation pathways, especially neurorehabilitation and slower stream rehabilitation
- At times of pressure there is over-reliance on key individual members of staff
- Insufficient level of capacity outside of acute hospitals meaning patients stay in acute beds longer than is necessary, creating bottlenecks and pressures elsewhere in the system i.e. A&E and acute medical wards
- Insufficient number of Elderly Mental Infirm (EMI) placement beds
- Delivering on 18 week referral to treatment time constitutional commitment
- Delivering timely reporting of diagnostic investigations, although the tests are achieved within the target time
- Higher than desired number of patients admitted to acute hospitals for end of life care
- Gaps in expected levels of detected disease leading to health inequalities
- Opportunity for patients with long term conditions to be more involved in their own condition management and for them to receive more of their necessary care in a planned way outside of hospitals
- Timely provision of equipment to keep patients at home
- Ambulance conveyance rates
- Achieving timely access to Children and Adolescent Mental Health (CAMHS) and Improving Access to Psychological Therapies (IAPT) services
- Increasing demand for high cost residential children's care resulting in out of county placements for those with complex needs and challenging behaviours.
- Increasing demand for speech and language therapy, occupational therapy and physiotherapy services amongst disabled children.
- Access to a wider range of mental health services e.g. services for adults with ADHD and to eating disorder services and for those needing perinatal mental health services

In developing our Mapping the Future blueprint, we have followed a population segmentation and risk stratification approach to identify population segments with similar needs and at the highest risk that new interventions should target. A spend heat map highlights that savings are required from all areas but identifies high cost services and population cohorts that will need to be especially focussed on. The greatest savings are likely to come from high cost emergency admissions of older patient and patients with LTCs

Overview of current West Kent CCG spend by age and service – 50% of the entire CCG budget is spent on people over the age of 65

2011/12 West Kent CCG spend broken down by service type and age band in £k

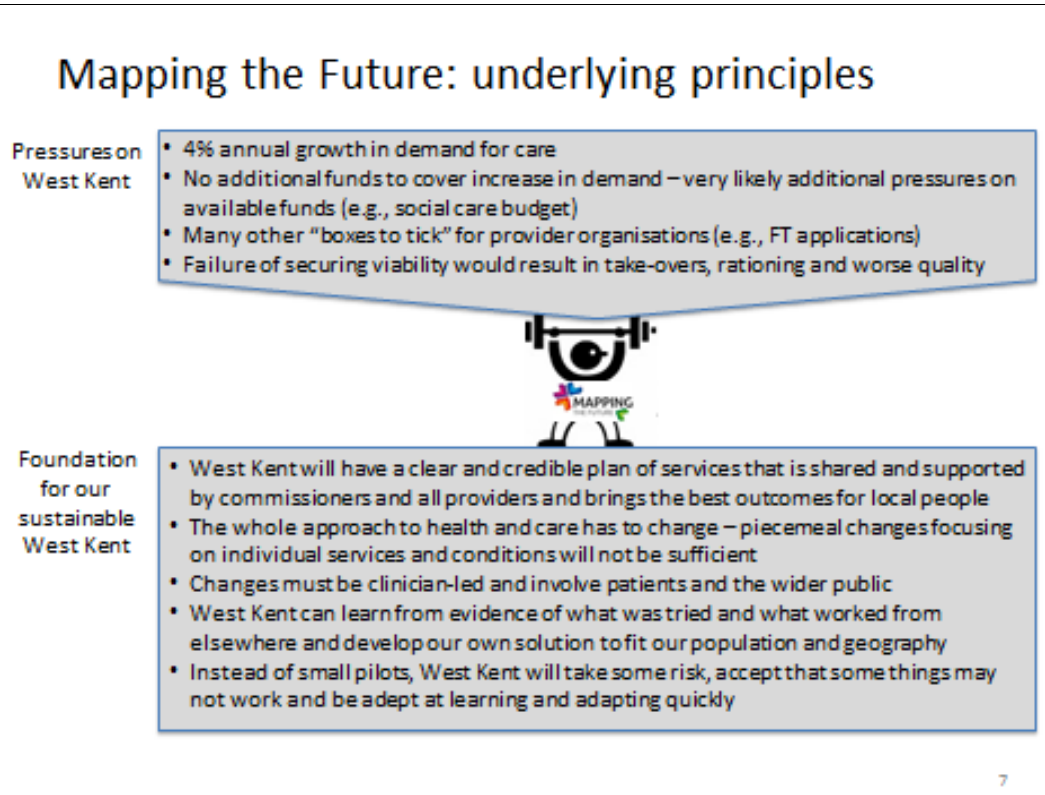
Age band	A&E	Emergency admissions	Maternity admissions	Outpatient	Day case	Elective inpatient	Other acute			Mental Health	Community	Prescribing	Continuing care	Other	Total health spend
							Ambulance	High cost drugs	Other acute						
0-4	504	1,594	0	1,165	465	715	511	517	1,114	0	1,897	1,925	0	425	10,234
5-9	218	1,094	0	1,450	750	670	215	507	1,079	69	1,457	2,313	0	415	9,997
10-14	532	1,075	0	1,596	556	495	250	288	1,012	414	901	2,507	0	590	9,398
15-19	426	1,739	367	1,592	791	750	355	422	1,462	1,422	634	2,651	0	545	13,116
20-24	423	1,677	1,592	1,255	691	507	576	474	1,665	2,739	470	2,070	0	615	14,750
25-29	556	1,795	2,605	1,724	900	590	552	596	2,092	2,550	536	2,845	0	734	17,677
30-34	517	1,925	3,925	2,060	972	727	567	744	2,612	2,576	662	3,456	0	662	21,233
35-39	285	2,152	2,852	2,165	1,175	996	400	720	2,535	2,655	586	3,607	0	661	21,206
40-44	345	2,680	922	2,584	1,622	1,485	435	705	2,477	3,181	669	3,938	0	906	21,808
45-49	346	2,606	80	2,666	1,691	2,060	516	756	2,566	4,162	607	4,406	0	991	23,857
50-54	299	3,106	5	2,767	1,965	2,475	556	795	2,792	5,235	536	4,604	0	1,017	24,490
55-59	269	3,306	0	2,815	1,945	2,427	586	804	2,826	2,106	934	4,650	0	962	23,652
60-64	269	4,266	0	3,449	2,509	3,649	746	1,075	3,771	2,685	1,577	5,697	0	1,257	31,002
65-69	294	6,064	0	4,252	2,940	4,942	1,041	1,560	4,649	2,644	2,155	6,992	4,041	1,800	43,354
70-74	266	5,946	0	5,622	2,567	4,545	1,017	1,236	4,549	2,665	2,741	5,964	3,964	1,675	40,399
75-79	262	7,107	0	5,560	2,209	4,196	1,210	1,506	4,566	2,542	4,517	5,914	4,736	1,824	43,912
80-84	300	8,592	0	5,021	1,594	3,245	1,456	1,252	4,597	3,106	7,162	4,992	3,726	1,944	46,806
85-89	279	8,555	0	3,625	875	1,462	1,410	954	3,555	1,670	8,317	3,012	3,555	1,614	38,855
90-94	173	5,561	0	760	315	454	942	544	1,912	1,056	6,019	1,255	1,720	955	23,715
95+	54	1,699	0	141	51	74	320	166	585	191	2,223	255	1,266	512	7,511
Total	5,849	72,964	12,330	44,075	26,578	36,547	12,904	14,820	52,067	42,066	44,727	72,816	29,006	20,223	486,972

2011/12 West Kent CCG spend broken down by age band and weighted LTCs in £k

Age band	WLTC						Total
	0	1-5	6-10	11-15	16-20	21+	
0-4	8,751	1,432	51	0	0	0	10,234
5-9	8,040	1,944	13	0	0	0	9,997
10-14	7,770	1,533	96	0	0	0	9,398
15-19	9,734	2,696	686	0	0	0	13,116
20-24	9,758	2,291	2,639	67	0	0	14,750
25-29	11,802	2,952	2,854	69	0	0	17,677
30-34	14,625	3,784	2,768	46	0	0	21,233
35-39	14,126	4,097	2,904	79	0	0	21,206
40-44	12,601	5,623	3,127	441	15	0	21,808
45-49	11,730	6,748	4,547	648	189	0	23,857
50-54	11,108	9,188	3,692	416	86	0	24,490
55-59	10,008	9,945	3,187	475	43	0	23,652
60-64	9,916	14,902	4,800	1,136	248	0	31,002
65-69	10,954	24,006	6,136	1,971	287	0	43,354
70-74	8,348	22,207	6,574	2,544	709	17	40,399
75-79	6,821	24,263	9,569	2,659	507	93	43,912
80-84	5,923	24,177	12,047	3,971	678	9	46,806
85-89	3,950	18,993	11,598	3,520	766	28	38,855
90-94	2,348	10,951	7,942	2,096	361	36	23,715
95+	813	3,623	2,304	547	225	0	7,511
Total	179,126	195,357	87,532	20,640	4,114	203	486,972

- People over the age of 65 and those with LTCs represent 25% of the West Kent population but consume 71% of the total CCG budget
- This is the group where integrated care is most beneficial
- Key focus of Blueprint

Given the resource outlook for both the public sector and the NHS in the coming decade, the cost of additional demand facing the NHS will need to be mitigated to be financially sustainable, and the effective use of the Better Care Fund is one key way in which the health system will secure best value through the transformation of services in West Kent.



Mapping the Future is a programme of work which has been started in West Kent to describe what the system needs and what a modernised health and care service for the 463,956 people who live in West Kent will look like. The programme has produced an initial future picture of the modern, efficient health and care services that we will need to provide in order to meet the changing needs of people in West Kent over the next 5 years. This programme is delivering the NHS Call to Action within West Kent.

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

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

The key programme milestones are identified below

April 2014	Personalised health budgets offered to continuing health care patients
April 2014	GP Local Incentive Scheme focusing on outpatient referrals introduced
April 2014	Medicines optimisation local incentive scheme introduced with GPs
May 2014	Pharmacy first common ailment scheme launched
July 2014	GPs agree clustering arrangements for microsystem working
Spring 2014	CAHMS review commenced
Summer 2014	Additional talking therapies commissioned
Summer 2014	West Kent Health and Well-being Board development sessions held –
Summer 2014	New outpatient advice and guidance system identified

September 2014	Live testing of orthopaedics, rheumatology and chronic pain referral advice	
Autumn 2014	Community Hospital review undertaken	
30 September 2014	GPs undertake risk stratification exercise to identify 2% most complex patients	
September 2014	Training on clinical microsystem coaching model	
September 2014	Street triage commences	
September 2014	GP in A&E commences	
October 2014	Care Plan Management System procured	
October 2014	wider roll out of personalised health budgets	
Autumn 2014	Health inequalities pilots rolled out across West Kent	
Autumn 2014	Recruitment of complex care nurses and health and social care coordinators -	
November 2014	Alignment of complex care nurses and health and social care coordinators to GP practices	
November 2014	24/7 psychiatric liaison services commences	
30 November 2014	Care home strategy agreed	
31 December 2014	Self-care strategy developed	
December 2014	Learning Disability in reach community provision commences	
December 2014	All GPs signed up and using new outpatient advice system	
3 January 2015	Care Plan Management system ready for live testing -	
January 2015	New West Kent system leadership and governance arrangements introduced -	
2 March 2015	Care Plan Management system live -	
31 March 2015	Clinical microsystem coaching model piloted with 4 practices completed	
April 2015	Reprocurement of integrated loan and equipment store	
April 2015	Care home strategy implemented	
June 2015	GP in A&E, GP Out of Hours, Enhanced Rapid Response Services jointly procured	
Spring 2015	Integrated commissioning for Learning Disabilities commences	
Summer 2015	Telecare/telehealth solutions explored	
Summer 2015	Ambulatory Care Sensitive Conditions delivery model transformed	
Summer 2015	Reprocurement of integrated therapy service	
September 2015	Clinical microsystem coaching rolled to all practices	
September 2015	Care Home strategy reviewed	

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

Kent's governance for delivering as an Integrated Care and Support Pioneer has been set out in the cover paper. The responsibility and management of the Better Care Fund sits within this by using existing governance structures with the Kent Health and Wellbeing Board as systems leaders, informed by local governance arrangements.

Local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group providing advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within Whole System Boards, the HWB and on the Integration Pioneer Steering Group.

At a local CCG, care economy and system wide level there will be monitoring of the financial flows associated with implementation of the Better Care Fund. It will be possible to identify what is working well and where schemes should be driven forward at greater pace, or where schemes are not achieving desired outcomes and need to be amended or stopped. Any additional local governance for delivery of area plans is outlined in appendices

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

The Kent HWB will retain a county wide oversight of delivery of the BCF in line with CCG plans attached and local governance structures.

A county wide performance and finance group supported by the Area Team and involving all CCGs and KCC will be established in 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.

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

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
WK001	HEALTH & WELLBEING SYSTEM
WK002	SELF AND INFORMAL CARE
WK003	NEW MODEL OF PRIMARY CARE
WK004	MOBILE CLINICAL SERVICES
WK005	URGENT TRANSFER SERVICE
WK006	NEW SECONDARY CARE
WK007	SYSTEM ENABLERS

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**
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.
Shifting of resources will destabilise existing providers, particularly in the acute sector.	3	5	15	• The development of our plans will be conducted within the framework of our Kent Pioneer Programme. This facilitates whole system discussions and further work on co-design of, and transition to future service models.
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 Bill is part of the schemes within the BCF; further work is required to outline impact and mitigation required.
Shifting of resources will destabilise existing providers, particularly in the acute sector	2	5	10	• The development of our plans for 2014/15 and 2015/16 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.

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**
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.
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.
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / care home activity by 2015/16, impacting the overall funding available to support core services and future schemes.	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.
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
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.

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.

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 work stream within Kent's Integration Pioneer Programme. This ensures that outcomes identified by Kent as a Pioneer are aligned with delivery of the BCF.

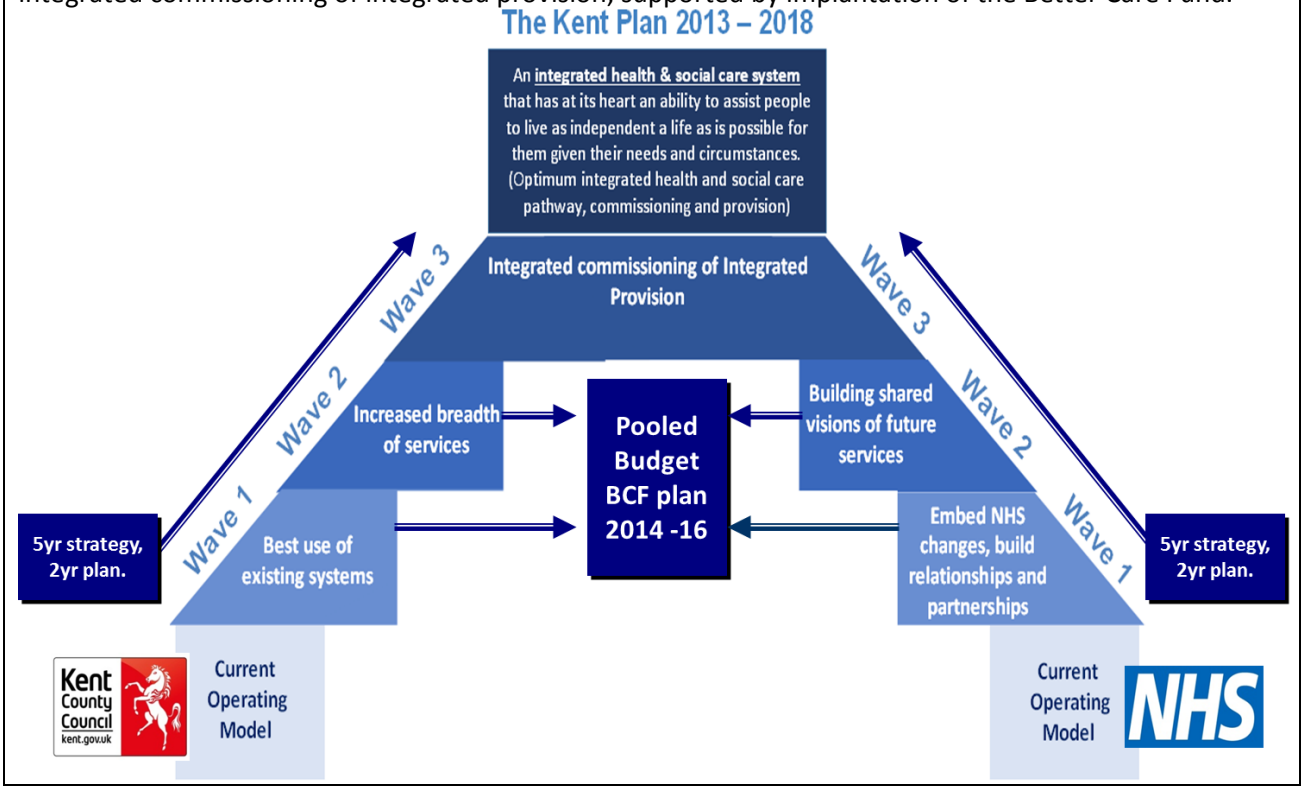
It also enables the plans to link to other existing care and support initiatives taking place as part of Kent's Pioneer such as Year of Care and Going Further Faster.

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

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

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.



The West Kent Better Care Fund (BCF) Plan is a critical part of, and aligned to, the NHS West Kent Clinical Commissioning Group (CCG) two year operational plan and five year strategic plan. The BCF will act as an enabler in West Kent helping to support the delivery of *Mapping the Future* that underpins the West Kent contribution to the county-wide Integrated Care and Support Pioneer Programme and supports delivery of the 5 outcomes identified within the Kent Health and Wellbeing Strategy. Across Kent, it will drive forward our integration programme, developing more community based services alongside the re-design and commissioning of new systems-wide models of delivery that ensure the financial sustainability of health and social care services; a proactive, rather than a reactive model that improves outcomes for people and means the reduction of hospital and care home admissions.

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.

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

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

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

7) NATIONAL CONDITIONS

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

a) Protecting social care services

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

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

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

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

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.

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

Kent total for protection of social care is £28254m, and the West Kent contribution is £8708m. Kent total

for The Care Act £3552m – for example to support carers assessments and support services, safeguarding adults boards and national eligibility.

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

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

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

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

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

Kent total to develop specific carers support, including carers breaks, : £3443m

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

There has not been significant change to budget from the original BCF plan, however failure to deliver all or part of the required Better Care Funding mentioned above (£28254m), 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. Adult Social Care has recently shifted working hours to be 8-8, 7 days per week as standard.

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.

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))

West Kent CCG is taking a leadership role in Information Management & Technology to ensure that all inter-connected parties will use these interoperability standards and that their activities are coordinated. As part of our risk stratification approach we have also explored using a data warehouse to aggregate data from different sources into a consistent format.

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

Public Health will lead on an integrated intelligence initiative, linking data sets from various NHS & non NHS public sector organisations across health and social care which will underpin the basis for integrated commissioning.

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.

West Kent CCG is taking a leadership role in IM&T to ensure that IG controls are in place across all NHS system users.

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

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

The risk stratification exercise that underpins Mapping the Future examined the 2018/19 West Kent CCG forecast spend broken down by service type and weighted LTC band in £000. It showed that the share of resources for people with long term conditions and older people will need to increase and that the greatest savings will be achieved by reducing emergency admissions from these two groups.

The GP will be the co-ordinator of people's care, with the person at the centre and services wrapped around them. This is already being delivered through an MDT approach across Kent, and health and social care using common assessment documentation and the development of a shared anticipatory care plan.

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

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

- All people in care homes to have agreed care plans including EOL understood by the citizen and the relatives where appropriate.
- Citizens and health and social care professionals to have access real time to agreed health and

social care information.
- Consultants (in long term conditions) to increasingly no longer have caseload but outreach to support primary care to deliver high quality complex care.
- Expanded and co-ordinated community capacity to meet the citizen's priorities without necessarily having to utilise NHS and social care services and resources.

Kent's whole system 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.

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.

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

- All people in care homes to have agreed care plans including EOL understood by the citizen and the relatives where appropriate.
- Citizens and health and social care professionals to have access real time to agreed health and social care information.
- Consultants (in long term conditions) to increasingly no longer have caseload but outreach to support primary care to deliver high quality complex care. Expanded and co-ordinated community capacity to meet the citizen's priorities without necessarily having to utilise NHS and social care services and resources.

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

There are currently no digitised shared care plans in place, we will be piloting the Care Plan Management System with End of Life Care patients during the last 6 months of 2014/15. The Care Plan Management System will deliver shared digital planning across health and social care providers.

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. On a local level there is sustained involvement with the public through patient participation groups and the local health and social care integration implementation group.

Across Kent there is a commitment to meaningful engagement and coproduction with the public and wider stakeholders and as a Pioneer we will use the Integrated Care and Support Exchange (ICASE) as a mechanism to provide updates on our progress within integration and the implementation of the Better Care Fund.

To help develop the Mapping the Future programme workshops have been held involving patient representatives, clinicians, health and care professionals, hard to reach groups and managers. Discussions have also taken place at West Kent CCG Governing Body Board, West Kent Health and Well Being Board, and the West Kent CCG Annual General Meeting for all West Kent GPs.

We will seek to further engage the public on the contents of the BCF plan on an on-going basis via local networks.

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

Kent is an Integrated Care and Support Pioneer – providers from across the health and social care economy are partners and stakeholders in our Pioneer programme and were involved in developing the blueprint for our integration plans which the Better Care Fund (BCF) is based upon. Delivery of Mapping the Future is the West Kent integration work plan included in the successful Kent wide Integration Pioneer bid. The Integration Pioneer Working Group who have produced the Kent plan is a mixed group of commissioners and providers

Mapping the Future is a programme of work which has been started in West Kent to describe what the system needs and what a modernised health and care service for West Kent will look like. This programme will deliver the NHS Call to Action within West Kent. *Mapping the Future* involved more than 200 people from a wide range of stakeholder groups to produce a blueprint of how services should be provided to maintain quality while at the same time remaining affordable. The blueprint is the foundation of this plan.

As part of the development of the BCF plan engagement events have taken place with providers via our existing Health and Social Care Integration Programme, the Integration Pioneer Steering Group and through a facilitated engagement event led by the Kent Health and Wellbeing Board under the Health and Social Care system leadership programme. The Kent HWB undertook a mapping exercise across the care economies to review current activity and priorities. A workshop is planned for late summer to further discuss the detail of how the delivery of the BCF plans which will consider opportunities for integration and joint delivery.

During February and March 2014 further engagement activities have taken place on a local area basis to ensure providers are aware and engaged with the contents of the plan. This has included commissioning intention discussions as part of contracting monitoring and negotiation meetings. During early March discussions around the on-going governance and implementation of the BCF have taken place with both the West Kent Integrated Commissioning Group, and the West Kent Health and Social Care Integration Programme (HASCIP). Presentations on the BCF and how it fits into the context of the West Kent CCG Strategic Commissioning Plan have taken place at the West Kent HWB (18 March 2014) and the Kent HWB (26 March 2014) and also to the West Kent CCG Governing Body on 25 March 2014.

ii) primary care providers

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

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

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.

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

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

Scheme ref no.
WK001
Scheme name
JOINT HEALTH AND WELLBEING SYSTEM APPROACH
What is the strategic objective of this scheme?
A coordinated whole system approach in which all health and wellbeing partners use their individual and collective efforts to tackle the root causes of health and wellbeing problems.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
A coordinated whole system approach for West Kent in which all health and well-being system partners use their individual and collective efforts to tackle the root causes of health and wellbeing problems (including alcohol and tobacco use and addiction and obesity). The change levers include health education, environmental health improvements, housing eligibility and maintenance, trading standards, licensing and the standards and specifications of health and social care contracts and community development support. It includes efforts to encourage and support people so that they take more responsibility for their health and to make the healthy choices easier for people to make. It also includes an asset based approach, enhancing the capacity of communities and individuals to support themselves and each other Community based support and prevention will be available to residents of West Kent. A core offer will be developed and commissioned which will ensure a comprehensive range of universal support services are available to people. Some will be targeted services for particular populations e.g. smoking cessation, weight management, and employment support. Other support services commissioned via voluntary sector organisations will help reduce demand on more specialist health and social care services through preventative activities. Some will be linked to care pathways, for example, falls prevention classes, while others will offer universal access e.g. carer support, or dementia support. NHS 111 will continue to provide advice online and by phone to patients and carers supported by GPs. This will be complemented by an integrated Information, Advice and Guidance service which will enable residents to access information and will enable those working within health, social care and housing services to signpost people to other support available within local communities.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council. The providers will include the NHS Acute Provider, the NHS Community Provider, the private sector, the following local authorities (Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council) as well as the voluntary and community sector. As this programme develops this will be specified further.
The evidence base

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

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

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

Investment requirements

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

£8,708,000 to deliver BCF outcomes

Impact of scheme

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

System Requirements

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

Expected Benefits

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

Feedback loop

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

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

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

- Co-ordinated campaigns across health, social care, general public work, with consistent messages
- Consistent prioritisation across all agencies avoiding fragmentation of efforts
- Holistic approach that tackles underlying causes for ill-health

- People become true partners in care: manage parts of pathways themselves, take part in active prevention and make healthy lifestyle choices
- Greater awareness of health/social needs and more looking out for each other in community (neighbours and volunteers helping)
- Increase in patients feeling supported to manage their long term condition

Scheme ref no.

WK002

Scheme name

SELF AND INFORMAL CARE

What is the strategic objective of this scheme?

The Mapping The Future blueprint places self and informal care at the centre, enhancing the capacity of communities and individuals to support themselves and each other. People are fully informed and take part in planning their care helping are supported to stay at home and independent longer.

Overview of the scheme

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

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

Self and informal care will be an important part of the new system, with more people and their families being supported to manage their own care and long term conditions through the use of smart technology and the development of a self-care/self-management model. Integrated telecare / telehealth solutions will be backed up, where necessary, by trained staff working in an integrated telecare / telehealth monitoring centre, who will be pro-actively monitoring changes in activity and health condition, alerting integrated community teams where further intervention to prevent increases in care needs

- People are supported to take responsibility for their health and care. This includes intensive education about their conditions and how they can manage them, peer support, information and supported signposting to find appropriate voluntary and community options, fast and easy access to daily living aids
- People are kept fully informed about the need for changes to health and care and are encouraged to take part in discussions about future plans
- People are encouraged to make early decisions about treatment options and end of life preferences: they are active partners in planning their care
- People are supported to stay independent and at home for as long as possible, e.g., using telehealth, patient held records and personal health budgets
- Supported housing and domiciliary care is commissioned in a way that enables people to remain in the home as long as possible: short term stays are possible for those that have immediate needs
- Local communities and voluntary organisations are encouraged to provide health and care support to people and carers

The delivery chain

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

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

The evidence base

Please reference the evidence base which you have drawn on

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

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

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

Investment requirements

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

£3,092,000 to deliver BCF outcomes

Impact of scheme

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

System Requirements

- People willing to take on responsibility for own care (culture change)
- Suitable, easily accessible information
- Accessible, responsive and reliable support 24/7 when questions and issues arise
- Incentives (?)
- Easy access to easy-to-understand information
- Access to up-to-date care plans and care records
- Info about EOLC service options
- Cultural acceptance of “natural” death
- 24/7 responsive and reliable support service for crises
- Well-co-ordinated social/domiciliary care services
- Culture of helping each other
- Info/education for volunteers and community at large

Expected Benefits outlined in Part 2 Tab 4 HWB Benefits Plan

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

Feedback loop

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

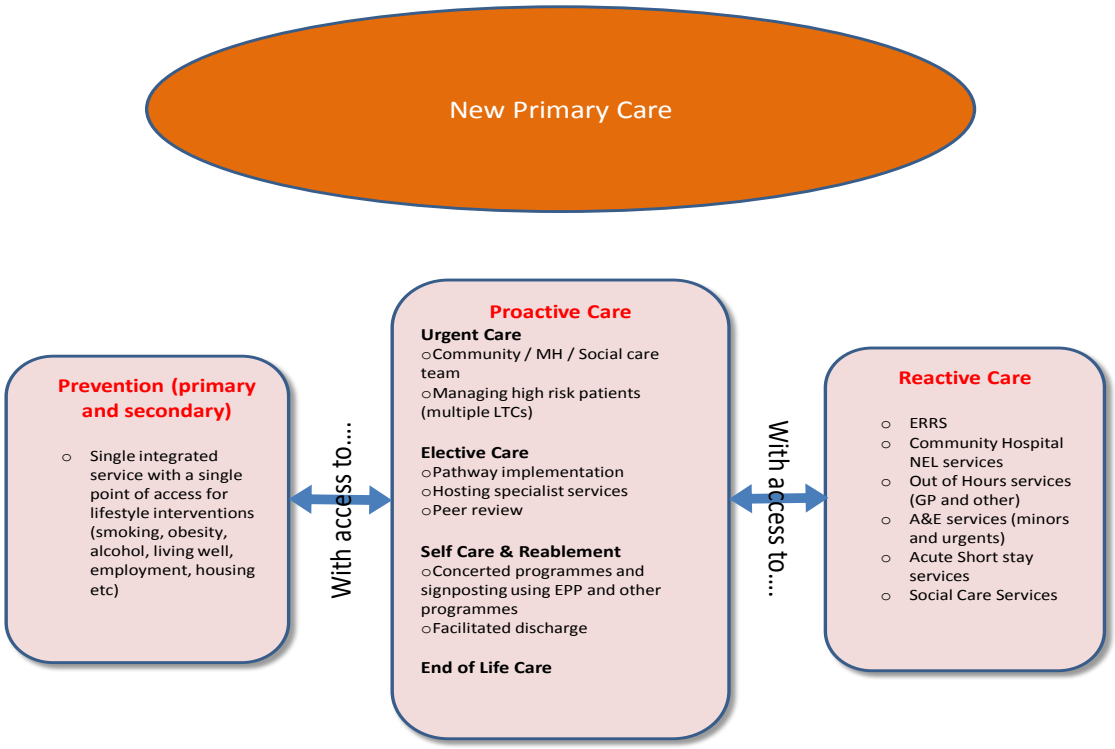
Local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group providing advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within Whole System Boards, the HWB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

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

- People become true partners in care: manage parts of pathways themselves, take part in active prevention and make healthy lifestyle choices
- Avoiding unnecessary and ineffective care
- People take more of their own care decisions

- Earlier discussion on EOL patient preference with reduction of excessively aggressive treatments
- Reduce avoidable hospitalisations
- Ability to receive treatments that otherwise would have needed hospital (greater convenience for patients)
- Avoid unnecessary admissions for “social” reasons
- Healthier homes (e.g., less cold/damp, less falls risk)
- Support at home by neighbours and volunteers and within the community by volunteers
- Overall greater awareness of “look out for each other”
- Increase in patients feeling supported to manage their long term condition

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



It supports the provision of more capable and cost effective out of hospital proactive care and brings together elements of urgent care, elective care, self-care, reablement services and end of life care.

The teams will include clinically-led professionals that take a care management and coordination role for patients who are elderly and those with the most complex needs. They will operate within a framework of clear clinical pathways spanning the health and care system and will have access to consultant opinion to enable them to support patients, most often without the need to send them to hospital.

The focus will always be to support citizens to manage and coordinate their own care whenever possible

This will include:

- Comprehensive New Primary Care responds 24/7

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

The delivery chain

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

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

The evidence base

Please reference the evidence base which you have drawn on

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

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

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

Investment requirements

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

£14,335,000 to deliver BCF Outcomes

Impact of scheme

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

System Requirements

- Call handling protocols
- Call centre
- Sufficiently senior clinicians (e.g., GPs) on call
- Suitable facilities (within some GP practices or community centres?)

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

Expected Benefits outlined in Part 2 Tab 4 HWB Benefits Plan

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

Feedback loop

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

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

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

- The new primary care teams comprise GP practices, community services, social work and mental health support working as an integrated team that can respond to patient needs round the clock
- All members of the New Primary Care have a clear understanding of each other's role
- All practices networked into clusters so that patients can receive a consistent range of services wherever they live in West Kent. The clusters have local access to essential diagnostics, where this is cost effective for the population size: quality assurance, calibration and training provided by hospital services reduces the need for tests to be repeated in different settings
- The new primary care teams make it easy for people to see them, e.g., by offering consultations by telephone, longer opening times and efficient appointments systems. For the patient it feels seamless whether they contact during the day or at night, although night and weekend care may be

offered by another organisation
- All members of the primary care team use the same unified electronic patient records – these are also available to mobile clinical services and to other specialist services
- The multi-professional and multi-skilled teams may be virtual or based around larger health centres or community hospitals
- Primary and community teams use risk profiling and disease registers to plan the team's work: they are proactive in targeting people at risk of developing conditions or of deteriorations in their condition. They call people who might be at risk in to see them rather than waiting for them to seek help
- The traditional out-of hours services are redesigned and integral to the new primary care rather than a separate element. They may take on a wider range of functions supporting GP practices
- The teams plan their work so that they offer both planned and urgent care - these elements may need to be separately organised to provide greatest efficiency
- The new primary care teams see population health as their responsibility. They 'own' their patients and follow them up when they need specialist care, planning their return home as quickly as possible. They are supported by real time information about available services and system performance
- The teams can access intermediate/step up care where adults or children can get short term observation and treatment
- The teams have advanced skills in the diagnosis and treatment of patients with long term conditions and use agreed pathways of treatment and care to plan the support for individual patients – these are designed around the principles of encouraging self-management and early intervention to prevent conditions from getting worse
- The MDT enables interdisciplinary overlap and partial substitution so that one professional can cover potentially multiple specialities' services
- Use agreed assessment protocols the teams have reduced duplicated assessments for some conditions
- Within the team there are professionals that take a care management and coordination role for patients with the most complex health needs
- The new primary care teams can access consultant opinion and advice to enable them to support patients without the need to send them to hospital
- Increase in patients feeling supported to manage their long term condition

Scheme ref no.
WK004
Scheme name
MOBILE CLINICAL SERVICES
What is the strategic objective of this scheme?
Mobile clinical services (MCS) will provide direct care to people at the point it is needed by taking care to the patient wherever possible and clinically appropriate to do so. The MCS will work as a complementary workforce to the new Primary Care System using similar pathways, protocols and medical records.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
MCS will be supported to help people remain at home, through the development of a new integrated (health and social care) intermediate care/ reablement service with a workforce trained to deliver comprehensive care that supports independence, recovery, maintenance of existing situation or for some people, quality end of life care. The breadth of these services will be enhanced to include best practice use of assistive technologies to complement hands on care and where appropriate clear referral pathways to non-clinical partners. Community based integrated care teams will be established to provide targeted, proactive co-ordinated care and support to those people identified as being of highest risk of hospital attendance or increasing use of care services. • NHS 111 call centre gives helpful advice and is supported by GPs • Call handlers know what local services are available and when • See-and-treat by paramedics in the field • MCS are integrated part of NPC team (same care protocols/processes and medical records), or at least integrated operationally
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council. The providers will include the NHS Acute Provider, the NHS Community Provider, Ambulance Service and the private sector.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
The Mapping the Future exercise conducted in West Kent CCG has identified the financial impact of expected levels of demand growth arising from the change in demography of West Kent. This has been based upon ONS population growth forecasts by age band. The charts set out in the West Kent CCG Strategic Commissioning Plan show the anticipated growth in expenditure on services as a result of demographic pressures. Significant cost growth is anticipated in the following areas: People who have multiple Long Term Conditions; People who are aged 70 and over; People who would require services in: Urgent care, Community services, Continuing Care and Funded Nursing Care services.

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

Investment requirements

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

£94,000 to deliver BCF outcomes

Impact of scheme

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

System Requirements

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

Expected Benefits outlined in Part 2 Tab 4 HWB Benefits Plan

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

Feedback loop

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

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

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

- The NHS 111 number provides valuable advice and help to patients and carers on line and by phone. The call handlers are supported by GPs and well supervised so they feel part of an accountable system not individually responsible
- Call handlers have a strong understanding of local services in West Kent and what they can offer: this plus access to the real time information means they are confident in the advice they give
- Mobile Clinical Service clinicians (could be paramedics, doctors, specialist nurses, etc.) provide direct care to people at the point where they become ill – this is a more common approach than taking the patient to hospital, or to intermediate beds (e.g., in community hospitals)
- MCS clinicians work as a complementary workforce to the new primary care teams. They use similar pathways and protocols, have access to the unified electronic patient records and provide systematic handovers of patients back to the primary care team
- Increase in patients feeling supported to manage their long term condition

Scheme ref no.
WK005
Scheme name
URGENT TRANSFER SERVICE
What is the strategic objective of this scheme?
To transfer patients with urgent care needs to the best setting (this may not necessarily only to A&E), to provide a range of treatments and diagnostic tests to patients on the way and to make more use of transport services by voluntary and community organisations
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
• Enhanced assessments and diagnostics/start more care enroute • Urgent care protocols the same regardless of care setting • All care professionals have access to universal records all the time • A&E is not automatic destination but patients could be taken to GP practice or other community-based care setting • More non-urgent patient transport to be provided by others than ambulance e.g. volunteer and community support teams
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council. The providers will include the NHS Acute Provider, the NHS Community Provider, the Ambulance Service and the private sector.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
The Mapping the Future exercise conducted in West Kent CCG has identified the financial impact of expected levels of demand growth arising from the change in demography of West Kent. This has been based upon ONS population growth forecasts by age band. The charts set out in the West Kent CCG Strategic Commissioning Plan show the anticipated growth in expenditure on services as a result of demographic pressures. Significant cost growth is anticipated in the following areas: People who have multiple Long Term Conditions; People who are aged 70 and over; People who would require services in: Urgent care, Community services, Continuing Care and Funded Nursing Care services. The Mapping the Future programme sets out a planned redistribution of resources across settings of healthcare. Over a five year period, WKCCG aims to deploy a greater share of its resources towards investment in New Primary Care services, and relatively less in the acute care setting
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
No direct funding identified but included for completeness of Mapping the future vision

Impact of scheme

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

System Requirements

- Qualified staff
- Protocols and clinical governance
- Suitable equipment
- Agreed, standardised protocols
- Suitable record system
- Urgent care services outside of A&E
- Clear protocols for triage
- Suitable transport organisations/capacity

Expected Benefits outlined in Part 2 Tab 4 HWB Benefits Plan

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

Feedback loop

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

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

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

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

Scheme ref no.
WK006
Scheme name
NEW SECONDARY CARE
What is the strategic objective of this scheme?
New Secondary Care will seek to manage urgent and planned care as separate entities for optimum efficiency with some highly specialised services concentrated in larger centres. Hospital based urgent care will work as part of the total system connected with primary and community services and mobile clinical services. Together they will optimise patient flows to deliver the most cost effective service with coordinated care around people with complex needs
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
It is anticipated that this will allow secondary care services to be provided with a more community base model that reduces dependency on beds and buildings. • Concentration of highly specialised services in larger centres • Hospital-based urgent care is integrated with NPC and mobile services , providing access to senior clinical input as early as possible when needed and ensuring rapid response and rapid turnaround so that patients can be supported in most appropriate setting • Specialists and GPs work as one team with one lead clinician • Ongoing monitoring and rapid learning to adjust care supply to demand so that provider capacity responds to demand, rather than supply inducing demand • Proactively link physical and mental health, with psych liaison services at hospitals • Coordinated and simplified care for patients with complex needs
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council. The providers will include the NHS Acute Provider, the NHS Community Provider, the private sector, and the following local authorities (Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council).
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
The Mapping the Future exercise conducted in West Kent CCG has identified the financial impact of expected levels of demand growth arising from the change in demography of West Kent. This has been based upon ONS population growth forecasts by age band. The charts set out in the West Kent CCG Strategic Commissioning Plan show the anticipated growth in expenditure on services as a result of demographic pressures. Significant cost growth is anticipated in the following areas: People who have multiple Long Term Conditions; People who are aged 70 and over; People who would require services in: Urgent care, Community services, Continuing Care and Funded Nursing Care services. The Mapping the Future programme sets out a planned redistribution of resources across settings of healthcare. Over a five year period, WKCCG aims to deploy a greater share of its resources towards

investment in New Primary Care services, and relatively less in the acute care setting

Investment requirements

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

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

Impact of scheme

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

System Requirements

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

Expected Benefits

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

Feedback loop

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

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

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

- Hospital based urgent and planned care services can complement each other but they are managed as separate entities to provide optimum efficiency
- Some consultant led services are concentrated in larger centres where there is evidence that they can improve quality and offer more cost effective care
- Hospital based urgent care works as part of a total system connected with primary and community

services and mobile clinical services. Together they work to optimise patient flows to deliver the most cost effective service

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

Scheme ref no.

WK007

Scheme name

SYSTEM ENABLERS

What is the strategic objective of this scheme?

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

Overview of the scheme

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

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

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

The delivery chain

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

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

The evidence base

Please reference the evidence base which you have drawn on

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

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

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

Investment requirements

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

£165,000 to delvier BCF outcomes

Impact of scheme

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

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

Expected benefits

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

Feedback loop

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

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

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

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

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	
Name of Provider organisation	Maidstone & Tunbridge Wells NHS Trust
Name of Provider CEO	Glenn Douglas
	Glenn Douglas

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	44102
	2014/15 Plan	46895
	2015/16 Plan	46143
	14/15 Change compared to 13/14 outturn	6.3%
	15/16 Change compared to planned 14/15 outturn	1.6%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	1,315,000

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?**	No
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	The Trust has not been involved in the construction or estimation of impact of the schemes described in the BCF. However, the Trust supports the direction in reducing non-elective admissions, and is keen to work with CCG colleagues in implementing whole systems, collaboratively constructed approaches to non-elective reductions
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	The Trust has considered the impact on services from a reduction in non-elective admissions as part of its strategic planning.