Local Government Association

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	**DGS CCG Dartford, Gravesham and Swanley (DGS)**
	Swale CCG
Boundary Differences	DGS: While the local authorities of Dartford and Gravesham are co-terminus with the CCG boundaries, the Swanley area falls within the boundary for Sevenoaks District Council, with approximately 42% of the Sevenoaks district population within the DGS CCG boundary. Swale: Swale CCG represents approximately two thirds (78%) of the population of Swale borough council. Local Health & Well Being Boards (CCG level) will review plans, as well as a review by the Kent-wide HWB to ensure any gaps or issues are minimised.
Date agreed at Health and Well-Being	**<dd/mm/yyyy>**

Board:	
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of BCF pooled budget for DGS CCG: 2014/15	**£0.00**
Minimum required value of BCF pooled budget for Swale CCG: 2014/15	**£0.00**
DGS CCG 2015/16	**£14,947**
Swale CCG 2015/16	**£6,556**
Total agreed value of pooled budget: DGS CCG 2014/15	**£0.00**
Total agreed value of pooled budget: Swale CCG 2014/15	**£0.00**
DGS CCG 2015/16	**£14,947**
Swale CCG 2015/16	**£6,556**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	DGS and Swale CCGs
By	Patricia Davies
Position	Accountable Officer
Date	18th September 2014

<Insert extra rows for additional CCGs as required>

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

<Insert extra rows for additional Councils as required>

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

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

c) Related documentation

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

Document or information title	**Synopsis and links**

CCG 2 & 5 year plans	**Attachment removed to email**
Better Care Fund Vision document v11	See 5yr strategy documents above
Integrated Discharge Team service specification / Heads of Agreement	**Attachment removed to email**
NHS DGS CCG and NHS Swale CCG Community Services Review Developing the Future Model based on Patient Insights DEEP DIVE REPORT	**Attachment removed to email**
The Oaks Group review	These files are available on request but were too large to include here.
Demographic profile – Dartford Gravesham & Swanley	Detailed demographic breakdown information available on request
Demographic profile - Swale	Detailed demographic breakdown information available on request

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

Key recommendations from the JSNA refresh are addressed within the BCF plans including:

- Increase in sharing of data, information and referrals between health and local authority to identify vulnerable patients, particularly those over 65 with circulatory or respiratory conditions that are at risk of ill health or morbidity especially due to cold weather.
- Working with multiple agencies to integrate data at a population level in order to map areas of need, service activity and better inform future commissioning intentions to reflect the whole system for patients.
- Improve integrated care pathways for dementia, such as geriatrician outreach, provide training and support to hospital staff such as Buddy Scheme and support for carers through crisis response in the event of carer breakdown.
- Ensure that mental health services supporting primary care are sufficiently resourced and equipped to meet demand and unmet need

While the Kent Health and Wellbeing Strategy is under review at the time of preparation of these plans, the current strategy outlines the following outcomes and therefore underpins these plans:

- Effective prevention of ill health by people taking greater responsibility for their health and well-being – these plans aim to support people to take responsibility by providing appropriate information, advice and signposting.
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support
- People with mental ill health issues are supported to live well
- People with dementia are assessed and treated earlier.

At the end of last year, we asked local patients and public groups what was important to them when they needed support. People told us they want choice and to be more in control of their care. They want their care to be planned; with health and social care staff working together to help them reach their goals of living longer and living well. Specifically, they told us that what's important to them is:

- Communication between health and care professionals
- Communication between professionals, patients and carers
- Provision of information – accessible, relevant and clear
- Services to be of a high standard and to be shown dignity, compassion and respect at all times
- Access to support and care out of hours/in an emergency
- Personalised care plans developed with and held by patient
- Integration of all services so that service transfers/changes are seamless and all are kept informed of any planned changes
- More help to help themselves
- More services available in community settings

These principles remain at the heart of this new way of working to provide ***better local care***.

There are good examples of integrated service delivery and commissioning (evidenced in our working relationships, willingness to work together for the benefit of our population, a number of key developments that have or are being implemented), in NK we are building on these foundations. There is much to be done if we are to truly ensure that health and social care services are seamlessly delivered, commissioned in ways that maximise value for money and avoid duplication, simple to navigate with optimal communication across professionals to maximise the outcomes and experiences of those who need our services.

We recognise that realising the vision will mean significant change across the whole of our current health and care provider landscape. Whilst our GPs will play a pivotal role within this, all providers of health and care services will need to change how they work, and particularly how they interact with patients and each other.

In recent years, experiences of commissioning and delivery of health and social care services from a population and public service organisation perspective could be characterised as at times disjointed, complicated, un-integrated with less than optimal communication across the sectors leading to inefficient use of public money and less optimal patient/client outcomes and experiences.

However the CCGs and local authority commissioners who make up the North Kent Health and Social Care economy are committed to working together to create a marketplace, and to effect the required behavioural and attitudinal change across all care providers, to ensure that this happens at scale and at pace.

We aim to provide care and support to the people of North Kent (Swale and DGS) in their homes and in their communities. We want to achieve a health economy that is sustainable for the future. Our vision is of primary, community, mental health and acute care services working seamlessly together, with local authority, voluntary, and other independent sector, organisations, to deliver improvements in both health and well-being for local people and their communities.

We recognise and will build into our vision recommendations from the report of the commission on future models of care delivered through Pharmacy.

We will:

- Keep people at the heart of everything we do, ensuring they are involved and listened to in the development of our plans
- Maximise independence by providing more integrated support at home and in the community and by empowering people to manage their own health and well-being
- Ensure the health and social care system works better for people, with a focus on delivering the right care, right time, right place, providing seamless, integrated care for patients, particularly those with complex needs
- Safeguard vital services, prioritising people with the greatest health and social care needs and ensuring that there is clinical and professional evidence behind every decision.
- Get the best possible outcomes within the resources we have available; delivering integrate services wherever possible to avoid duplication

This will require a different way of working from our service providers and will require us to develop an infrastructure that will allow both the voluntary and community sectors to play a

greater role of supporting people more effectively in their communities. If we are successful, funding for unplanned admissions to hospital will be reduced because people will not need to go to hospital in the same numbers as they do at the moment, and lengths of stay will be shorter and people will not need to access long term care.

Further detail is provided in the 2yr operational and 5yr strategic plans for the CCG which have been attached.

Further detailed demographic information is attached in the related documentation.

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

The BCF programme for North Kent is based on 3 core principles:

- People will be empowered to direct their care and support, and to receive the care they need in their homes or local community.
- GPs will be at the centre of organising and coordinating people's care.
- Our systems will enable and not hinder the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.

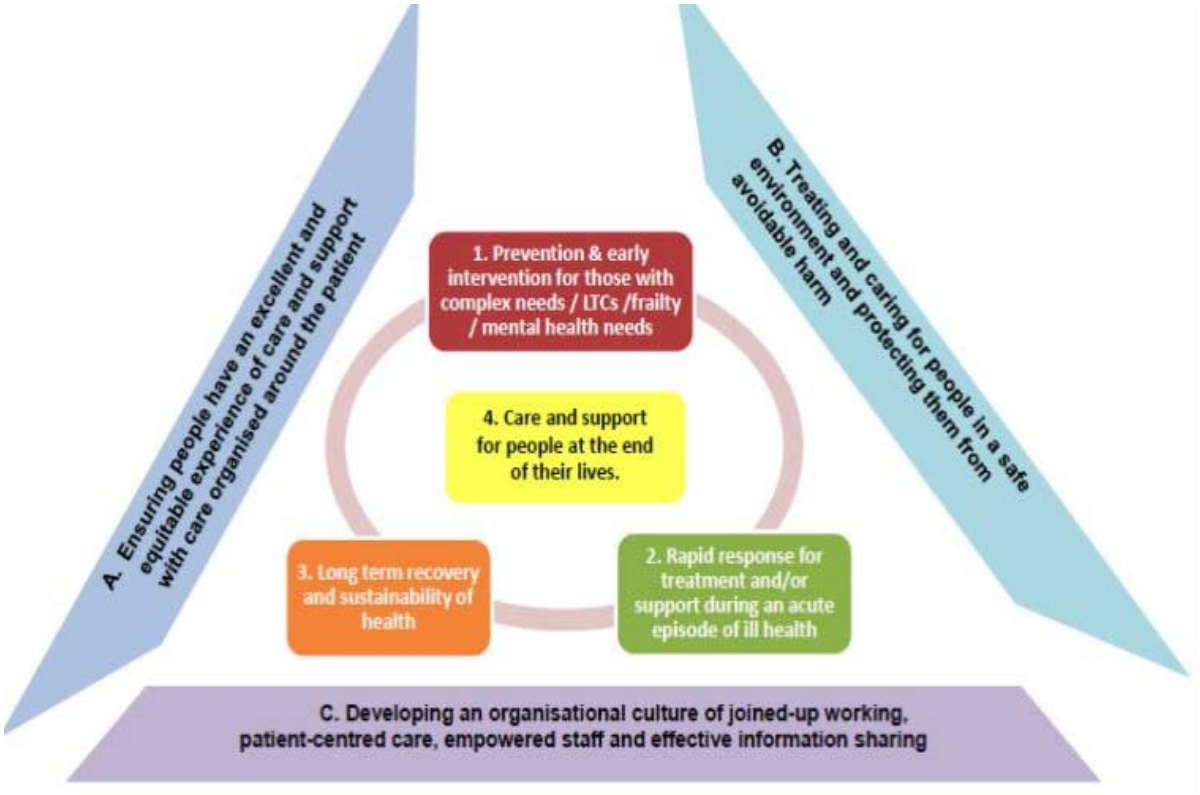
To achieve this we are engaging with local health and care providers, and associated public, private and voluntary and community sector groups, to "co-design" models of care that will engage with and meet people's aspirations and needs. The following sections provide a summary of what this will mean, in practice, and the specific BCF investment areas for the next 2 years that will deliver on our aims and objectives.

Modelling work has identified that projected populations of DGS and Swale can expect to see a significant percentage increase in older people. In addition, the rate of projected growth for those defined as "frail elderly" is steep for both CCGs (modelling undertaken by Whole System Partnerships). In addition, plans for DGS include significant housing and commercial developments likely to house young families and there will be a clear demand for healthcare for the younger population in this area. Overall, the Public Health priorities will include managing the older population with multiple long term conditions as indicated in the development of the integrated primary care teams and integrated dementia team (see below). Ensuring a good start in life for North Kent children is another key priority given the projected increase in young people and the inequalities that currently exist around maternal and child health (smoking at time of delivery, low birth weight babies and low breastfeeding rates – particularly in Swale). The CCGs are actively involved in multi-agency partnerships to promote best beginnings for children, maximising access for mental health resources for children and young people and working with GPs to reduce variation in practice across the area.

Working closely with KCC Public Health department, the CCGs are also addressing the significant health inequalities that exist across North Kent, in part due to varying deprivation levels, ethnic groups including a significant Gypsy and Traveller community in Swale and an increasing African population in DGS. Health Needs Assessments for both CCGs have been conducted and a separate HNA for Swanley is being undertaken given that significant health needs and inequalities are often overlooked when Swanley is categorised under Sevenoaks LA (significant affluence in the south of the borough counters marked deprivation and ethnic diversity in the north). These have identified key public health priorities including obesity, diabetes, smoking prevalence and mental health.

It is recognised that health and social care services for older people make up a major part of activity in health and social care generally; but we will also focus proposals on reducing demand amongst working age people with disabilities and people of all ages with mental health issues. There is a need to ensure that the skills of service users continue to be developed thorough integrated approaches by providers, to reduce the level of service required to meet people's needs. The approach will focus on the skills and abilities of each individual and seek to build on these to achieve greater independence and less reliance on services. Therefore, proposals under the Better Care Fund will not be solely focused on supporting older people at the expense of others.

We will measure our success primarily by analysis of demand for acute health services (such as emergency bed days) and formal social care services (such as a paid agency carer supporting someone at home, or someone moving into residential or nursing care home), using current levels of demand as a baseline (and allowing for the impact of demographic change so the 'baseline' keeps pace with population change and growth). We will build on the Outcomes Framework which has been developed to support the CCG. This has a major focus on patient and carer experience, and triangulating data from several sources to measure outcomes. The Outcomes Framework structure is shown in the diagram below:



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

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

By 2016 we will have reduced the need for hospital acute admissions by 15% by having co-ordinated health, social and community services that meet the needs of our Kent citizens 24

hours a day, seven days per week. We will have shared information systems with integrated care plan sharing, monitoring people in their own home including self-monitoring and fully supporting independent living

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

In the north of Kent the local model for integration encompasses the 3 areas described below which are the basis of the Better Care Fund programme. The model of integration will be developed over the next five years recognising the work that has been done over the last year. Evidence suggests that successful models of integration are both vertical and horizontal and require therefore time, system leadership and education to emerge and develop fully. This should not be under-estimated. Successful models for example Torbay, Trafford and Canterbury (New Zealand) all demonstrate success over a gradual period, based around iterative service improvement that constantly evaluates and adapts the model to achieve the greatest success and outcomes. The need for pace and the financial climate is understood and dictates that the system needs to change in the short, medium and longer term. There is a commitment from the whole system, to deliver quick wins now, to release funds and create operational head-room to provide the foundations for the next stage towards full integration. We will design and commission new system-wide models of care that ensure the financial sustainability of health and social care services; a proactive, rather than a reactive model that means the avoidance of emergency hospital and care home admissions. The current plans with providers, KCC and North Kent District Councils, will be built on to deliver the critical transformational changes required to deliver the key priorities identified by the public and patients. These will include;

1. **Integrated Primary Care Teams (iPCTs) - GPs will be at the centre of organising and coordinating people's care.** We will invest in primary care, through the reconfiguration of enhanced services and the secondary to primary care shift / shared-care and funding arrangements with other providers. We will ensure that patients can get GP help and support in a timely way and via a range of channels, including email and telephone-based services. The GP will remain accountable for patient care, but with increasing support from other health and social care staff to co-ordinate and improve the quality of that care and the outcomes for the individuals involved.

   We will deliver on the new provisions of GMS, including named GP for patients aged 75 and over, member practices determining the model for out-of-hours services, which should be integrated and as seamless as possible with mainstream primary and community services. Flexible provision over 7 days will be accompanied by greater integration with mental health services, and a closer relationship with pharmacy and voluntary services. Our GP practices will be grouped into neighbourhoods of practice populations of between 20-40k, within given geographies, with community nursing, social care, mental health and specialist services, organised to work effectively within these neighbourhoods. A core focus will be on providing joined-up support for those individuals with long-term conditions and complex health and social care needs. People with long-term conditions will be able to expect that all members of the iPCT will work together in partnership to ensure the best possible care, with shared care records linked via IT systems. This will include support from pharmacists and their teams to enable self-management of patient's conditions so that they can stay well remain out of hospital wherever possible. Early detection of problems or deterioration in their condition will be identified and addressed through proactive management and routine monitoring.

   The core iPCT neighbourhood team will comprise the following:

- District Nursing Service
- Care Managers who together with district nurses will take responsibility for case management (inclusive of enablement and reablement services)
- Named Community Pharmacy of patients choice
- Primary Care Mental Health Practitioner
- Primary Care Dementia Practitioner
- Primary Care Health Visitor linked to vulnerable adults using public health skills (NHS England responsibility)
- Palliative Care Nurses
- Health & Social Care Coordinators – to be further considered and agreed
- Outreach Acute Physicians and Geriatricians
- Future consideration depending, the teams may also include, Paramedic Practitioners

The core team would have strong working links with community support services using voluntary sector providers such as the voluntary sector and District Councils and housing providers to ensure full packages of care, equipment and adaptations are provided to meet the needs of the patient, carers and the wider community.

Further consideration is being given to the most effective way of managing referrals and coordination within the iPCT's. Evidence elsewhere points to a specific health and social care coordination role and this is being explored. Currently there are local referrals units in place which, through a degree of joint working, manage referrals to both health and social care practitioners, but this does not fulfill the aims of the new teams and needs further development.

We would expect the acute sector and specialist clinicians to work increasingly flexibly, within and outside of the hospital boundaries, supporting GPs to manage complex needs in a "whole person" way. In particular we see acute geriatricians, respiratory consultants and diabetologists supporting risk stratification and maintenance management as required.

2. **Integrated Discharge Team (Hospital in-reach and links to Local Referral Units for early supportive discharge and admission avoidance. 7 days per week (8am – 10pm) –** (See attached specification and Heads of agreement).
   Under the heading of this work stream, work is underway on developing an approach to joint commissioning to accommodate the multiple services working into one team from different providers. There is also a major review and re-procurement exercise around out of hours care which will be jointly commissioned to improve access to care services out of core hours and focused on avoiding unnecessary attendance at hospital and subsequent admissions.

3. **Integrated Dementia Service.** The current community service provision remains fragmented for older adults with dementia and the Acute Hospital is experiencing high numbers of admissions for people with physical problems coupled with dementia that results in longer lengths of stay. When interventions are focussed on one aspect of a person's care needs they commonly enter the health system in crisis and contribute to long lengths of stay in or early admission to long term care.

   The scheme seeks to improve both the coordination and consistency of care through implementation of an integrated care pathway for dementia. The pathway sets out the process of assessment, care and treatment for service users with dementia with a particular focus on diagnosis, post diagnostic support, crisis management and supporting carers to maintain their caring role

The care pathway outlines the need for mental health expertise to become an integral function within Integrated Primary Care teams to provide post diagnostic support and effective case management for people with dementia in the community. The ambition is to treat dementia under the long term condition model of care where a person's needs are treated holistically factoring in physical and mental health needs together where services are responsive to individual need and carers are supported through the journey with dementia.

This project will also include some focussed work on carer support including mechanisms and plans for caring for people with dementia if their carer becomes unable to either for short periods of time or on a longer term basis.

Our aim by 2019 is clearly articulated in section 2.2 of the 5 year strategy in terms of the transformational change that we expect to achieve. This includes:

- reduced mortality and morbidity
- integrated commissioning related to children and young people, people with mental health, older people and those with long term conditions and people with a learning disability
- embedded delivery of integrated services in hospital and in the community
- an appropriate bed base across community and hospital settings based on optimal care delivery in the most appropriate setting
- a revised 24/7 primary care model ensuring responsive services to local people
- optimal pathways of care commissioned and delivered enabling people to receive their care at home or as close to home as possible.

3) CASE FOR CHANGE

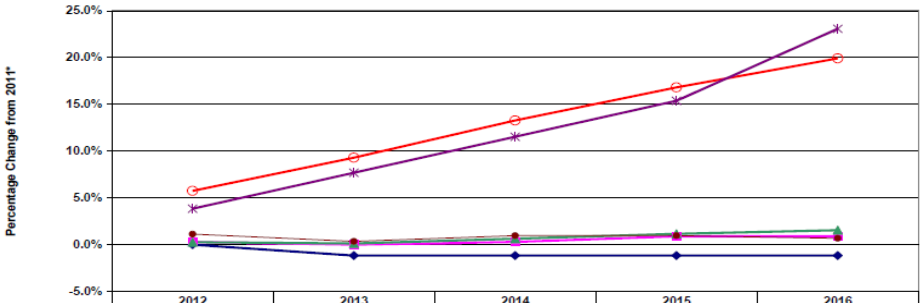
Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

The population projections used are from the KMPHO who use ONS population data. In addition the extensive work undertaken as part of the Oaks review (attached) has been referenced as well as extra system and community bed modelling which was carried out by the CCG, KMPHO and Whole System Partnerships using IThink software, including review of risk stratification to assess predicted health needs for the population.

The Joint Strategic Needs Assessment (review at January 2014), and local modelling confirms a number of key issues across DGS and Swale which these plans aim to address:

- Significant increase in the older population – by 2020 there will be a 34% increase in people over 85 years in DGS and 22% increase in Swale (with an overall increase in the population by 8% and 4% respectively).

Projected Population Change in 2012-2016 from 2011* for Swale Local Authority by Broad Age Groups



	2012	2013	2014	2015	2016
0-4	0.0%	-1.2%	-1.2%	-1.2%	-1.2%
5-19	0.3%	0.0%	0.3%	0.9%	0.9%
20-64	0.3%	0.1%	0.6%	1.2%	1.5%
65+	5.8%	9.3%	13.3%	16.8%	19.9%
85+	3.8%	7.7%	11.5%	15.4%	23.1%
All ages	1.1%	0.3%	1.0%	1.0%	0.7%

* derived from ONS 2008 based projections

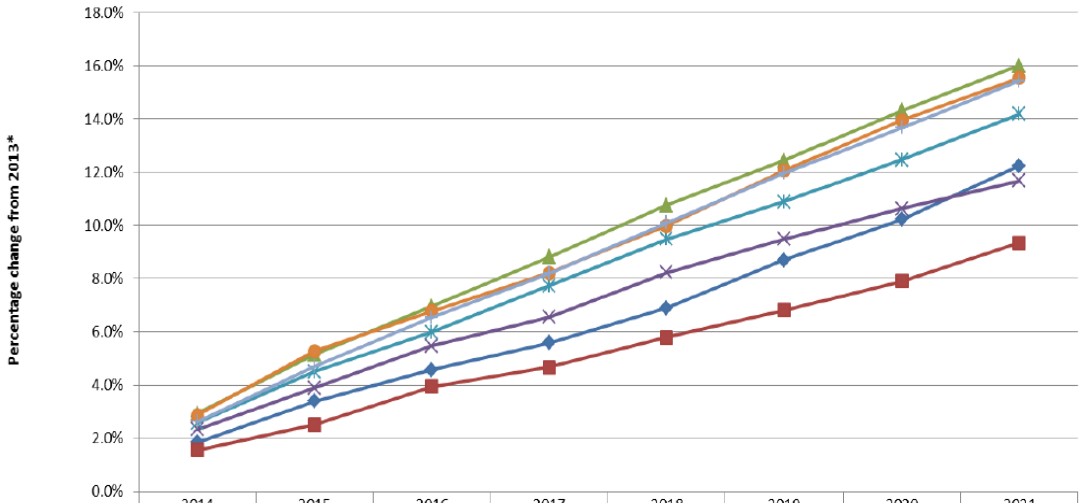
Projected Populations in Swale Local Authority by Broad Age Group - figures in thousands

AGE GROUP	2012	2013	2014	2015	2016
0-4	8.6	8.5	8.5	8.5	8.5
5-19	33.7	33.6	33.7	33.9	33.9
20-64	78.1	78.0	78.4	78.8	79.1
65+	23.9	24.7	25.6	26.4	27.1
85+	2.7	2.8	2.9	3.0	3.2
ALL AGES	**144.3**	**144.8**	**146.2**	**147.6**	**148.6**

Columns may not sum due to rounding

*Derived from 2008-based ONS sub-national projections

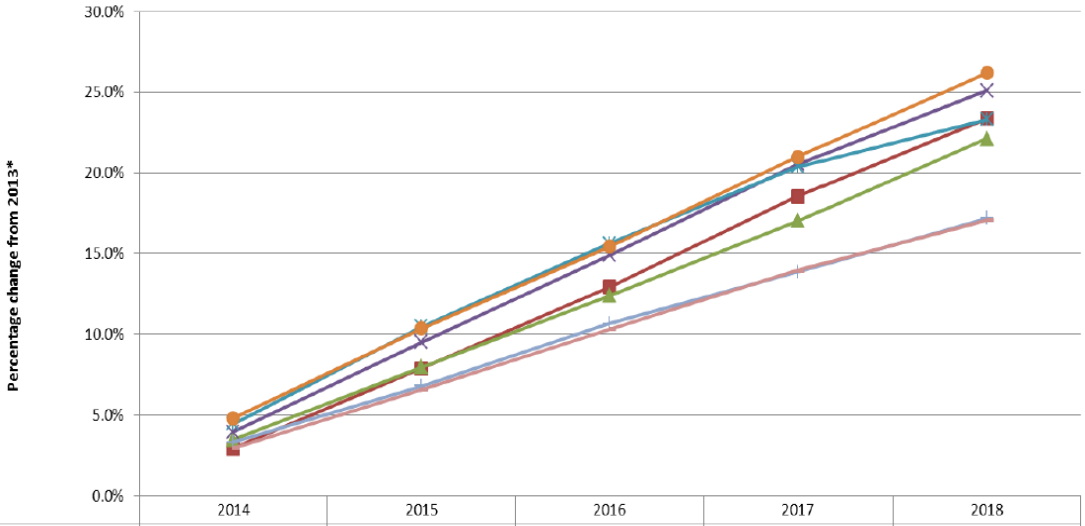
Projected population change in 2014 - 2021 from 2013* for Local Authorities in West Kent for people aged 65 - 84



	2014	2015	2016	2017	2018	2019	2020	2021
Dartford	1.8%	3.4%	4.6%	5.6%	6.9%	8.7%	10.2%	12.2%
Gravesham	1.6%	2.5%	3.9%	4.7%	5.8%	6.8%	7.9%	9.3%
Maidstone	2.9%	5.2%	7.0%	8.8%	10.8%	12.4%	14.3%	16.0%
Sevenoaks	2.3%	3.9%	5.5%	6.6%	8.2%	9.5%	10.6%	11.7%
Tonbridge and Malling	2.6%	4.5%	6.0%	7.7%	9.5%	10.9%	12.5%	14.2%
Tunbridge Wells	2.9%	5.3%	6.8%	8.2%	10.0%	12.1%	13.9%	15.5%
Kent	2.6%	4.7%	6.5%	8.2%	10.1%	12.0%	13.7%	15.4%

*derived from ONS 2011 based projections

Projected population change in 2014 - 2021 from 2013* for Local Authorities in West Kent for people aged 85+



	2014	2015	2016	2017	2018
Dartford	2.9%	7.9%	12.9%	18.6%	23.4%
Gravesham	3.5%	8.0%	12.4%	17.0%	22.1%
Maidstone	4.0%	9.5%	14.9%	20.6%	25.1%
Sevenoaks	4.4%	10.5%	15.6%	20.4%	23.3%
Tonbridge and Malling	4.8%	10.4%	15.4%	21.0%	26.2%
Tunbridge Wells	3.3%	6.8%	10.7%	13.9%	17.2%
Kent	3.0%	6.6%	10.3%	14.0%	17.1%

*derived from ONS 2011 based projections

- The emerging importance of multiple morbidities of patients and the impact on our health and social care services. The latest risk stratification analyses indicate that the highest intensive users (approximately 5% of the population) of hospital services are mostly elderly patients with complex needs and multiple morbidities. These patients represent almost 60% of the total unscheduled hospital admission spend. This need has increased considerably and it requires a whole system change to move towards a proactive integrated care approach, irrespective of single disease or single programme areas
- Local system modelling has been carried out linking data across organisations to identify those cohorts of patients who can be managed more appropriately out of hospital. Linking this to risk stratification allows the CCG to inform compositions of local integrated primary care teams and manage community bed provision to ensure optimal delivery of care to patients, tailored to their local needs. Further detail regarding this is included in section 7) d i.
- DGS CCG is an area with greater ethnic diversity compared to Kent as a whole and both CCGs have high levels of deprivation. Coupled with some significantly affluent areas there is a large health inequality gap within the North Kent as a result and many patients often fail to engage with services. Risk stratification has indicated that many North Kent patients present late to services, requiring intensive acute treatment for conditions that are potentially preventable. Integration of care will have a significant impact on ensuring patients successfully navigate the health and social care system, not falling through the gaps and potentially improve early diagnosis and intervention.

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

Summary project plan to be added

As projects leads continue to develop their detailed plans for full implementation of the main service developments, i.e. dementia integrated pathways, IPCTs, IDT and single point of access, management of the BCF programme will ensure key interdependencies and critical path activities are identified and completed. This includes specifying and delivering the necessary supporting infrastructure, including IT, governance, and organisation development. Communications and engagement plans are also linked to key milestones within the programme.

The key programme milestones are identified below, with supporting activities shown in italics.

Key milestones:

- Configuration of new integrated primary care teams confirmed – end Aug 2014
- Shared care plans in place for "frequent flyers" by Sept 2014
- Baseline KPIs set by end Sept 2014
- Phase 1 of IPCTs launched on 27th October – district nurses, community matrons and mental health nurses working within groups of practices
- Enhanced summary care record pilot commences October 2014
- Re-assigned adult social care staff within IPCTs from Nov 2014
- Multi-agency training, including IPCTs, IDT, primary care – October – November 2014
- Engagement event for all stakeholders by end Nov 2014
- Integrated pathways in place for dementia, respiratory, cardiology and diabetes by end Nov 2014
- Initial programme evaluation by end Dec 2014
- Phase 2 of IPCTs in place by end Jan 2014, including end of life care services and other voluntary sector organisations

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

Local Health and Wellbeing Boards for each borough remain central to the development and oversight of the proposed schemes making up our Better Care Fund, with a principle of pooling as much health and care funding as is sensible to do so, and with a focus on developing our joint commissioning and outcomes frameworks to drive quality and value.

Regular briefings to the Health and Well Being Boards are designed to help to ensure effective debate and engagement at a borough level, and ensure plans are directionally aligned with the priorities of local communities.

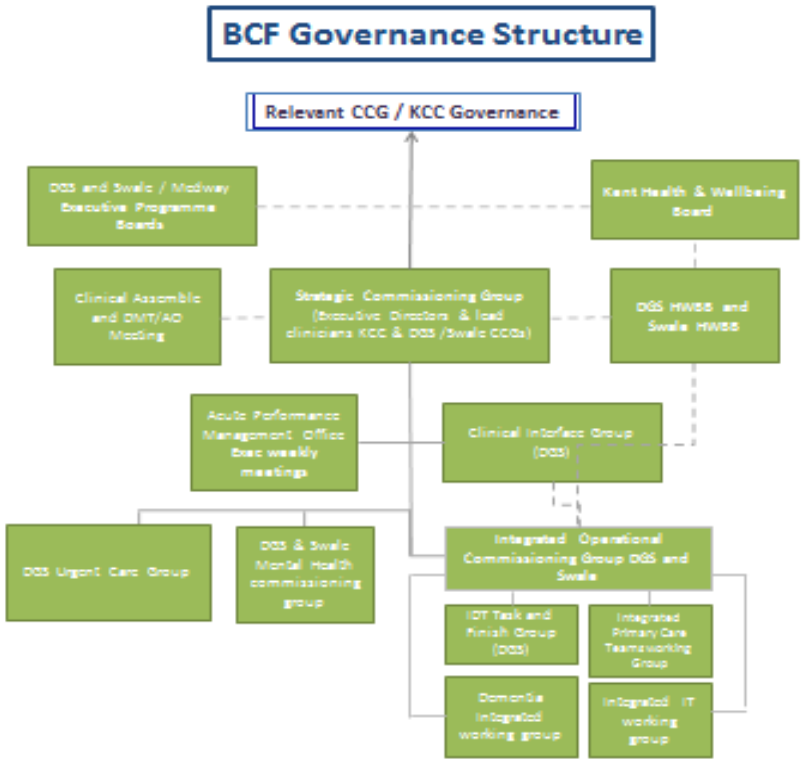
Across North Kent, the Executive Programme Boards, combining health and local authority membership, provide direction and sponsorship of the development of integrated care across the geography. This ensures we have a comprehensive view of the impact of changes across North Kent, and that we are able to make the necessary shared investment across our region in overcoming common barriers, and maximising common opportunities.

Additional director level leadership is in place to drive critical initiatives to implementation. The BCF programme is supported by a range of health and social care staff matrixed to it.

The following governance structure has been approved by the DGS and Swale Strategic Commissioning Group and Joint Executive Programme Board (EPB). Swale CCG participate in both the DGS and Swale EPB and the Medway and Swale EPB, due to interdependencies on work programmes in both health and social care systems. KCC and the CCG hold each other to account through the Strategic Commissioning Group and this informs the local and Kent HWBBs on progress in the North Kent area. Constituent projects within the BCF programme have their own working groups, reporting to the Integrated Operational Commissioning Group.

Accountability for delivery is through the relevant organisations governance structures but they are informed by the recommendations from the Strategic Commissioning Group.

Resolution of issues or conflict is relative to the level at which the issue or conflict may exist, culminating in escalation to the Kent Health and Wellbeing Board and therefore individual organisation Boards should a conflict or issue remain unresolved. In the event that a significant conflict is not resolved locally and if this is ultimately in relation to government policy then the secretary of state will be informed directly or via NHS England escalation of the policy and/or nationally driven system impact locally in relation to achieving our transformational change.



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 Integrated Operational Commissioning Group was established to oversee the implementation, monitoring, promotion and delivery of the key commissioning programmes that relate to the BCF. This group has core membership from all partner organisations, with additional co-opted members as required.

A common project planning process has been developed to enable project leads to define and then measure progress against their plans. From these individual plans, a summary programme plan has been produced, showing all major milestones. This enables interdependencies between projects to be identified as well as monitoring project and programme delivery.

Each of the main BCF project areas are managed by their respective working groups, as illustrated in the above governance structure. The projects leads for each area are responsible for achievement of their project milestones, and for meeting the agreed objectives of each project. Monthly progress updates, highlighting progress, issues and risks are provided to the BCF delivery group.

In addition, a comprehensive set of key performance indicators (KPIs) and other project metrics have been developed for each element of the key commissioning programmes. Mechanisms for data collection are in place for some projects, and under development for newer workstreams. Overall impact of the BCF programme is evidenced by a top-level set of indicators, including the impact on non-elective admissions to Darent Valley Hospital for DGS and Medway Maritime Hospital for Swale. Progress is reported on a monthly basis to the Integrated Operational Commissioning Group, Strategic Commissioning Group, and to the EPB.

The Integrated Operational Commissioning Group is responsible for

- Managing the progress of projects within the implementation programme in line with the individual project plans, and resolving issues that could impact on overall delivery timescales and objectives

- Evaluating the achievement of constituent project objectives, and the overall programme outcomes, in order to make necessary adjustments to overall programme content

- Identifying and managing interdependencies and priorities between work streams and projects.

  Identifying and managing the resources needed to deliver the programme, and highlighting any capacity issues to the Strategic Commissioning Group (SCG) and as required to the Executive Programme Board (EPB).

- Identifying and mitigating operational risks and issues in the implementation of the integration programme. Risks rated a very high or above are escalated to the SCG for resolution.

- Ensuring comprehensive engagement and a collective understanding of the work in progress across all stakeholders, including patients, carers and the public

The Integrated Operational Commissioning Group (IOCG) is accountable to the SCG for delivery programme. Issues that cannot be resolved by individual projects or by IOCG are taken to the SCG and EPB where wider provider issues need to be discussed. Where necessary, EPB members will then seek resolution within their own organisational governance structure. Should resolution not be achieved with all organisations, the issues will be escalated to the CCG Accountable Officer / KCC Director Management Team meeting and /or the Clinical Assembly, for

support in reaching an agreed way forward. Ultimately, the commissioners will need to consider the commissioning options available to them to progress the actions required.

d) **List of planned BCF schemes**

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

The following main schemes each have a completed Annex I. Each scheme details the broad range of services (delivered under contract with Providers) that contribute to the delivery of the changes that will be delivered in the pattern and configuration of services over the next five years (see 2 C in the Vision for Health and Care Services). The read across to the financial templates is also explained and is detailed in the worksheet "HWB Expenditure Plans" within the financial template.

		DGS (£k)	Swale (£k)
1.	**Integrated Primary Care Team**		
	Integrated Primary Care Team	3,544	2,181
	Community Adult Mental Health Team	200	
	Palliative Care Grant	1,000	
2.	**Dementia Services**		
	Dementia Care	500	
3.	**Single Point of Access**		
	Community Liaison and Single Point of Access	154	
4.	**Integrated Discharge Team**		
	Integrated Discharge Team		
	Out of Hours Service	1,654	
	Intermediate Care	193	1,248
	Facilitating Initiatives		
	IT and Communications	225	
	Joint Commissioning	250	
	3.5% reduction in non-electives	1,248	548
	KCC S256 agreements	4,792	2,067
	Care Bill	603	252
	Carer's Break	584	260

	Better Care Fund Total	***14,947***	***6,556***

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.

Health & Social Care Providers were consulted and provided risks as perceived by their organisations. These were share between them and each invited to describe their mitigating actions on behalf of the whole economy. The CCG & KCC likewise contributed risks from a commissioning perspective.

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)*	Owner/by when	Mitigating Actions
Ongoing imbalance between admission & discharges poses disproportionate risk on acute hospital	5	5 Activity over plan results in significant fines	25	CCG By 31/03/16	Whole system joint working Prog. Management approach Contract review
Fragility within the local health environment compromises service development and capacity for successful delivery	4	5	20	CCG /AT On going	Work with AT, CQC & Monitor to ensure support available in the local system Review of services and re-procure where appropriate. This includes a phased approach to co-commissioning.
A+E national target missed	4	4	16	CCG On going	Whole system working IDT implemented PMO oversight

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)*	Owner/by when	Mitigating Actions
Sufficient resource within social care to support current and increased demand in acute and community services	4	4	16	KCC	Social care is currently entering phase two of a comprehensive transformation programme which has led to increase in efficiencies and ability to meet increased demand. However a 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.
Workforce – issues with recruitment across all sectors due to proximity to London / aging workforce and impact of co-commissioning.	4	4	16 (RED)	CCG – Commissioning Assembly On going	Liaison with Education providers required to support longer term delivery of workforce Integration of health and social care teams and use of technology to improve pathways and processes releasing capacity. Ensure all avenues explored and exploited to improve retention. Phased approach to co-commissioning
Financial sustainability of NHS Providers both insufficient income and	4	4 D&G NHS Trust – forecast overspend of £2m SECAmb NHS Trust	16 (RED)	CCG 31/03/15	To be considered through contract negotiations. Whole system working Close or reduce

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)*	Owner/by when	Mitigating Actions
application of fines					services
Staff/organisations not fully trained or prepared for the changes	4	4	16	Each organisation	Develop full training & OD package of support aimed at teams. Joint approach x-org to support and share resources Joint approach to agreeing sharing of expertise and responsibilities across teams.
Failure to deliver the reduction in acute emergency admissions	3	4	12 (AMBER)	CCG Whole System 31/03/15	Provider agreement to the reduction by 6% of emergency admissions in 14/15. Detailed BCF plan and project management approach to implement the System changes Governance systems in place for monitoring impact
NHS services in the community do not have the capacity to manage an increase in demand for 24/7 services.	3	4	12	CCG 31/03/16	Service transformation Use of voluntary sector, Whole system planning and escalation policies
Lack of GP engagement in supporting the integrated primary care teams	2	3	6 (GREEN)	CCG Board 31/03/15	GP Board and member practice support for this development. Service re-design being led by GP Board members BCF funding prioritising the development of this service. Phased

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)*	Owner/by when	Mitigating Actions
					approach to co-commissioning.
Poor patient experience	2	3	6	CCG Board On going	Ensure good engagement with patient & public group to ensure model meets need Good communication at points of service change Undertake regular checkpoint reviews to ensure delivery is meeting need
Lack of patients behavioural change to affect reductions in A&E attendances and admissions	3	3	9 (AMBER)	CCG On going	Implemented a Health Help Now App for patients to help them navigate the health system (currently has reached 14,000 contacts) Improving access through the integrated primary care team and minor injury / walking services. Supporting patients that attend A&E for a primary care condition, to access their GP or alternative service.

b) Contingency plan and risk sharing

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

The amount of pooled funding at risk is the 3.5% reduction in non- electives amounting to £1,248k for DGS and £548k for Swale as included in the Expenditure Plan in Part 2. This is a

total of £1,796k for North Kent CCGs.

Total planned activity reduction in non-elective admissions for DGS and Swale is 1205 (Q4 14-15 to Q3 15-16), this is based on a 3.5% reduction of activity in the previous year. At £1,490 per episode this amounts to £1,796k, as shown in benefits template. The Payment for Performance amounts to £4,320k for DGS CCG and £1,895k for Swale CCG, which is a total £6,215k for North Kent CCGs.

The planned reductions in non-elective activity will generate resources that will be invested in Integrated discharge Teams as described in Annex 2. In 14/15 the IDT is funded from non-recurrent funds. It is anticipated that funds will be released in the first quarter of 2015/16 and that the contract for patients' services with acute providers will have this built into it. Financial and contract management will be in place to direct and monitor this plan.

The HWB has been consulted upon the plan and the risks and contingencies contained therein.

Contracts for 15/16 have not yet been agreed but it is likely that providers will require IDT funding in their contracts. We will then be obliged to meet the costs of the IDT service but bear the risk of reductions in activity not being made and hence having a cost pressure. This highlights the need for regular monitoring of KPIs to ensure that the reduction is achieved.

As part of the NHS contract for services in 2014/15 between DGS CCG and Dartford and Gravesham NHS Trust a Contingency Plan (agreement) was reached on a financial ceiling for services and a cost sharing agreement on potential risks. It is, however, clear that further work needs to be pursued to share the complexity of risks. A solution has to be found to deal with the PbR regime which reimburses hospital based activity whereas a largely "block' based contract exists for community services. There is a need to be more creative in contractual and financial terms to reward the intended drive to treat and care for people outside of a hospital based environment and not financially reward providers on the basis of increased volumes of activity. There is no such arrangement between Swale CCG and Medway Maritime NHS Foundation Trust at present so currently the risk is with the CCG. The risk for future years will depend upon what is decided during contract negotiations and whether payment is dependent on certain targets being achieved.

6) ALIGNMENT

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

The CCGs have identified the BCF initiatives in their 5 year Strategic Plans and 2 year Operating Plans. Additional aligned initiatives that support the BCF schemes also include:

- Reviewing and re-procuring of a new 24/7 community services model for OOH / MIU / WIC and NHS111. The aim of the new model is to provide a primary care service that works alongside local GP practices to provide an alternative to A&E for our population. The new model will be procured in 2015.

- Review and re-procurement of integrated community services to align district nursing with GP practices, ensure effective single points of access in place to deliver integrated care, improve integration with acute services to deliver improved management of complex patients and reductions in emergency admissions and care home placements

- Implementing a joint accommodation strategy with KCC that provides improved supportive accommodation for the ageing population and that also links to housing & technology

advancements that supports independent living
Implementing with KCC a 2 year contract to Porchlight to roll out the existing Primary Care Community Link Worker pilot. The aim of the service is to provide individually tailored, one to one and time limited support to individuals with mental health needs to access community resources and to promote social inclusion.

- A jointly commissioned with KCC Dementia Crisis Support Service, provides short-term home based emergency support in crisis or emergency situations. The service is designed to support people with dementia through times of emergency or crisis whether or not they have a carer. The support is provided in the person's normal home to cover emergency or crisis period or to provide sufficient time to make alternative arrangements. In exceptional cases the support will be provided for the full 6 weeks but if only if clearly articulated in a care plan and needed to promote independence and a return to no formal care being provided.

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

The Five Year Strategy and 2 year Operational Plan shows the key priorities for the period of 2014 to 2019. It was produced after listening to the public, our GP members and those that provide our services. The plan makes clear that the Better Care Fund offers an important opportunity to transform the system in North Kent to meet the needs of a rapidly ageing population better.

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

The plan is clear that system transformation is required and there is complete alignment between the initiatives reflected in this document and those within the 2 and 5 year plans. Our plans, so that it is focused on supporting people, wherever possible, with person-centred and professionally-led care, with the goal of living as independently as possible. This plan as well as the 2 year operational plan and 5 year strategy was developed between CCGs and Kent County Council, to ensure more integrated health and social care around the patient.

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.

DGS and Swale CCGs have not applied for primary co-commissioning status at this time.

Both Swale CCG and DGS CCG have their own Primary Care Strategy Groups who meet for the purpose of developing, in conjunction with the LMC, NHS England and member practices, the vision of primary care for their respective health economies. They include membership from the internally purchased public health resource, KCC public health, pharmacy, commissioning, practice management and nursing and quality.

The groups' links into the respective subcommittees of each CCG's structure for public and membership engagement and will be the vehicle to work through the programme for co-commissioning for DGS and Swale CCG. This work will also be linked to membership events held throughout the year.

The plans and time frame for development towards joint commissioning arrangements and possible pooled budgets is being developed through the primary care strategy groups; these will act as the steering group for progression. Movement to this stage will be dependent on the evaluation at each stage of the development process. The North Kent Education, Research and Innovation Hub, with its linked researcher and links with local universities and the Academic Health Science Network, could provide a vehicle for independent evaluation.

The risks generally to the CCGs associated with co-commissioning are well understood and therefore our decision making and/or speed of progress in relation to co-commissioning could represent risks to delivery of our transformational change in relation to the integration of health and social care. These are reflected in section 5.

However, there is no doubt that co-commissioning of primary care services could more effectively support the delivery of the agreed 5 year plan and achieve the health and social care transformational change. The CCG welcomes the opportunity to design a model of co-commissioning with NHSE and sees the majority of the expressions of interest options as a trajectory to be worked through. This will ensure the risks to delivery of our transformational change are minimised.

Please see attached the Primary Care Strategies of DGS and Swale CCG


DGS Primary Care Strategy v3 19 Jun 1


Swale Primary Care Strategy 091114(2).p

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

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

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

deteriorate.

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

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

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

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

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

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

Kent total for protection of social care £28254m

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

Multiagency Executive Programme Boards are in place within the DGS and Swale/ Medway care economies. These boards consist of senior level representation from health and social care commissioners, and health providers. Within these Boards, key programmes have been agreed and are monitored. This includes the delivery of schemes to reduce emergency admissions and facilitate discharge of patients, as outlined within the Urgent Care plans for each area, and funded during 2013/14 by additional winter funds.

These schemes include the implementation of an Integrated (social care, acute and community, GP, mental health) Discharge Team who are based within the local acute trusts 7 days per week to reduce emergency admissions and facilitate patients discharge. Monitoring is in progress, and the CCG's have committed to continue commissioning this team while impact can continue to be demonstrated.
In addition, emergency care redesign projects are in progress within the local acute trusts to ensure consultant level leadership is available with Emergency Departments 7 days per week.

During the NK Executive Commissioner (CCGs and KCC) and Provider planning and agreement meeting on the 29th January 2014, it was agreed that in order to be in the best place possible to achieve our joint vision current integrated working across acute, community, mental health and social care needs to be accelerated in 2014/15. Three priority areas were agreed for 2014/15 and these are included in the BCF.
These were:

- **Integrated Discharge Team model expansion** – achievement of full recruitment and implementation of the team as per the specification provided linked to an in year 10% reduction in conversion to admission within contracts. The areas of conversion reduction will be drawn predominately from the HRG categories as highlighted within The Oaks

Group review.

- **Integrated Dementia service** within the community and rapid response teams to prevent unnecessary attendance to acute care and facilitate timely and appropriate discharge where an episode of acute care is required or when acute services have been accessed inappropriately.
- **Integrated Primary Care teams** – There is recognition that this will not happen overnight across the whole area as skill shift, enhancement, recruitment and trust will be required as well as the process for working through appropriate clusters of GP neighbourhoods. It has been proposed to cluster practices across the two CCG geographies using collaborative agreements in the first instance with practice population sizes of between 20-40,000. This will be fully developed in terms of detail for the final submission along with a timeline for implementation commencing in 2014/15.
- **Access to records** – the shared IT infrastructure and record is seen as an enabler to achieve the above. This work is currently being scoped and options considered. This will include availability of GP records in A&E, access to share information and care plans across health & care professionals and access to records for the patients.
- **Single point of access** - the integrated Local Referral Unit between health and social care will provide a single point of access into services which will improve ease of access and integration between teams

To accelerate the above initiatives, the CCG and KCC are proposing to jointly commit £1million each (subject to the plan being approved and allocation from NHS England being received) for a specific funding pot to pump prime the above initiatives in 2014/15. Work has commenced on the detailed specifications and heads of agreement for the Integrated Discharge Team, Integrated Primary Care Teams and the Integrated Dementia Care Service, and this work is being taken forward as part of contract negotiations for the 2014/15 year. These are included in Table 3 of section 6.3.
The Strategic commissioning Group will take forward the proposals and will inform the Executive Programme Board, HWBB and report to the organisational governance structures on progress.

Proposals from GPs are currently being worked through in terms of developing federated models of practices working with integrated teams 7 days per week.

Contracts – In the 2014/15 contracts significant work was done on incentivising the providers through CQUINs to work together to improve integrated working. As part of the commissioning and contract negotiations for 15/16, integrated 7 day working will be a key requirement and outcome for delivery with incentives and penalties included. This will assist in ensuring that the right resources and services are provided in the community that will support the reduction in non-elective attendances and admissions.

c) Data sharing

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

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

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

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

birth as the key identifiers at present.

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

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

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

There is system wide agreement to information sharing. KCC and the 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.

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

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

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

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

Within our Better Care Fund plan and as a Pioneer Kent will continue to ensure that IG does not act as a barrier to delivery of integrated health and social care.

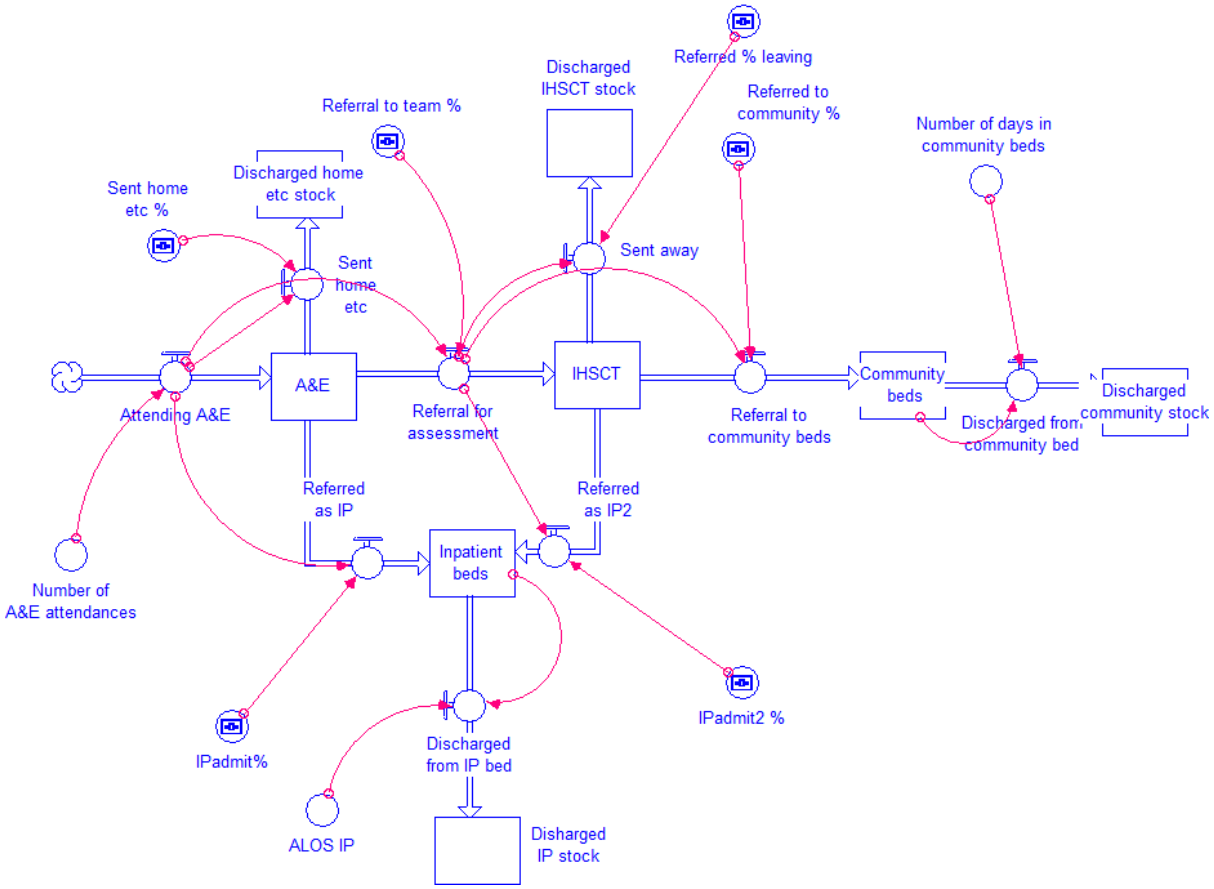
d) Joint assessment and accountable lead professional for high risk populations

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

There have been several areas of work looking at modelling the health system in order to inform workforce and impact on providers including utilisation review, bed audit and modelling the impact of the required reduction in admissions. Deriving a model to evaluate the flow of patients through the existing system and then in a system adapted to manage the admissions decrease, including integrated primary care teams and an acute integrated discharge team, was thought essential in order to forecast future community bed and workforce requirements to support this.

The CCG and Kent & Medway Public Health Observatory have constructed a model demonstrating flow through A&E, inpatients and to community beds in order that the impact of anticipated admission reduction on community service could be evaluated. As the data sets have been linked, this enables further analysis of the individual cohorts of patients identified in the pathways in terms of demographics and case mix. The multidisciplinary nature of the delivery of the Better Care Fund means that a multiagency interrogation of the model can be undertaken. Further areas for analysis have been identified in order to derive more qualitative data and this model is being triangulated with work previously undertaken looking at utilisation and activity of acute and community beds.

A baseline analysis has indicated high conversion rates, frequent re-attenders, a significant number of admissions related to falls and the majority of the admissions to community beds coming via A&E, the majority of whom are female and the majority of which return home from the community.



Further analysis is ongoing looking at the risk stratification of these cohorts of patients in order to identify their needs. Overall risk stratification analysis for DGS has indicated the higher rates of patients over 75 years who are in Band 2 and 3. It is clear that targeting those patients before

crisis is not only beneficial for the patient in potentially avoiding a hospital admission but is also financially cost-effective in pre-empting a costly acute admission. Similar work is being undertaken for Swale.

Risk stratification analysis by age group for DGS CCG as of 4.9.14

Rate per 1000 population	**Band 1**	**Band 2**	**Band 3**	**Band 4**	**Unknown**	**All Risk Bands**
00-04	0	2	5	59	2	68
05-11	0	0	1	86	1	88
12-17	0	1	3	67	1	71
18-30	0	3	14	148	3	168
31-50	0	5	21	251	4	282
51-64	1	5	20	140	2	167
65-74	0	5	14	72	2	93
75+	2	14	47	16	1	81
Total	**4**	**35**	**125**	**839**	**15**	**1017**

Impact of preventing the 'crisis year' on acute provider activity, cost and capacity across Dartford, Gravesham and Swanley CCG			
	Savings in non-elective admissions	Savings in cost	Savings in Bed days
Year 1 Top 0.5%	1852	£4,744,647	15,179
Year 2 Top 1%	2752	£7,034,138	23,023
Year 3 Top 2%	3663	£9,032,529	28,828

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

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

These are being implemented currently and will operate as follows.

GPs will identify high risk patients by:

- Using the risk stratification tool to identify the top 2% according to the risk stratification

tool criteria

- By assessing other patients who may not fit with the criteria but are known risks i.e. patients receiving palliative care.
- Through referral from hospitals where patients have become at risk following an admission or are new 'repeat attenders' who have yet to be highlighted through the formal stratification process.
- Liaison within the iPCT where the team members will highlight their respective caseload patients through regular MDT meetings, who may be deteriorating or becoming at increased risk through other health or social concerns.

Whilst the GP will be the lead accountable professional it is the team that proactively manage the care and provide the support infrastructure to maintain safe, effective, home based care providing the best and most appropriate experience and outcome. As part of the development of the iPCT's we are currently considering the role of the Health & Social Care Coordinator which has proved successful in other economies like Torbay. This coordination role will act like a conductor, operating across the practice populations at-risk and known patients to ensure that they are being monitored and managed by the most appropriate team member. A business case will be developed and costed and presented via the BCF governance for approval and funding agreement.

The iPCT will provide support across the entire adult population including for people with both physical and mental health, especially dementia, needs. The future plan will extend the iPCT to include children's services during 2015.

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

- In 2013/14 the number of people in DGS, identified at high risk of hospital admission, that had a patient centred multidisciplinary integrated care plan developed was 810 against an original target of 340.
- The number of people identified in Swale, at high risk of hospital admission that had a patient centred multidisciplinary integrated care plan developed was 366 against an original target of 300

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

A large scale programme of work was conducted in 2013 across Swale and Dartford, Gravesham and Swanley CCGs to develop a new integrated community services model to meet the needs of patients, by providing high quality coordinated health and social care, delivered in the right place at the right time and ensuring value for money.

It was agreed, early on in the programme, that work be conducted to understand users' and carers' experiences of community services as they are ***currently*** provided, to feed into the longer-term and wider engagement programme.

The initial work was conducted in two phases:

1. In the **first phase** existing insights gathered by providers and commissioners were mapped to understand and extract key themes, to gain a picture of patients'/carers' perceptions of their experiences, by service and provider and ascertain how this might contribute to the review. This mapping included data from a range of health and care providers to ascertain a range of different insights and perspectives from a range of people and community groups.

Phase 1 involved collating and reviewing existing patient experience regarding current services and the following organisations contributed to the work:

- Medway Community Healthcare
- Kent Community Health Trust
- Kent and Medway Partnership Trust
- LINk
- HASCIP
- IC24 Ltd. (previously SEH)
- Quality and Nursing Team (KMCS)

Previous work undertaken locally on a similar theme was also reviewed: this included a survey of about 50 people with long term conditions and carers in the west of Kent in 2009. Participants were sought through existing networks, an invite was sent out via voluntary groups to try and reach people that were not usually heard or involved and through discussion with Healthwatch Kent. A study undertaken by Kent LINk in 2009 in the east of Kent looked at Transforming Community Services and received feedback from 270 people, from a range of diverse backgrounds, on current experiences.

In the **second phase**, further work was conducted to capture patients' and carers' experiences, specifically within the context of 'person centred, coordinated care[1]' as outlined in '*Integrated Care and Support: Our Shared Commitment'*, published in May 2013. A survey was carried out in both CCGs, based on the integrated care 'I' statements – all statements were used, except for those under personal budget (not yet in place) to inform the next stage of development and act as a benchmark against which improvements can be measured in the future. The request to cascade the survey went to all voluntary organisations, providers, commissioners, local councils and diverse communities on the contacts databases. Specifically, hard to reach communities such as the gypsy community in Swale and the BME communities in Dratford, Gravesham and Swanley, were targeted by community development workers to ensure that we had representation from hard to reach groups.

These two stages were completed on the 30th September 2013 and a report submitted to the oversight group.

The key priorities for patients, identified in the final report of phase 1 and 2, were:

- Communication between health and social care professionals
- Communication between professionals and patients and carers
- Provision of information – accessible, relevant and clear

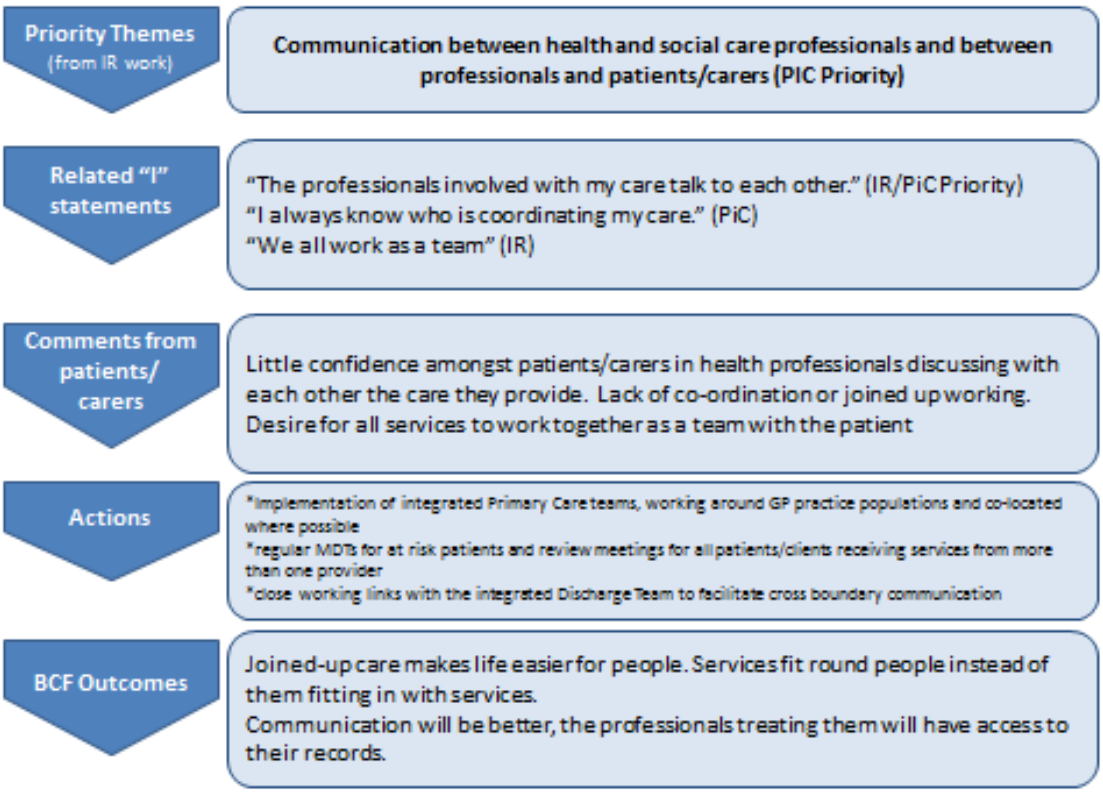
[1] National Collaboration for Integrated Care and Support, May 2013, Integrated Care and Support: Our Shared Commitment

- Maintaining service standards
- Access to support and care out of hours/in an emergency
- Personalised care plans developed with and held by patient
- Integration of all services so that transfers/transitions are seamless and all are kept informed
- More help to help self
- More services available in community settings

It was then agreed that the findings would be used to undertake a 'deep dive', looking specifically at the key priorities identified by patients and carers in the first two phases, to explore in more detail the issues underpinning each of the priorities. 36 people were involved in the 'deep dive' – both patients and carers, through in-depth interviews and focus groups.

Further work has been conducted in early 2014, as part of the regional Patients in Control Programme created and run by Kent & Medway Commissioning Support Unit, commissioned by NHS England as part of the Field Force programme, building further understanding the issues underpinning the priorities above.

The results from all these activities have been used to underpin the planning and development of the BCF vision and also to create public messaging, showing what patients, carers and public said and how this has been built into the programme's actions. An example of one key message, the related feedback and related actions is shown below:



The key messages (the BCF Outcomes) have been used to create a follow up survey which went live at the end of August 2014 and, again, was cascade out via voluntary organisations, diverse communities, councils, providers and commissioners. Early responses indicate that the most important areas for people regarding 'better care together' are:

- ‘Care that focuses on me as a whole person rather than my individual illness or need’
- ‘Services that fit me rather than me having to fit round the service’
- ‘Access to expertise to support me to keep my independence, stay well and manage my own condition/circumstances for as long as possible’

One respondent commented:

“Recognise the patient as part of an expert team - they know their own illness/problems, involving family/carers in all consultations and decision making”

Survey feedback will be used to inform follow up individual interviews and group discussions, to ensure involvement through every stage of the programme. These will particularly focus on groups/individuals who are less often heard and will reflect the demographics of the two areas (DGS and Swale). Case studies are also being collected, to show and share both positive and negative experiences.

Swale’s Patient Liaison Group and DGS’ PPG Chairs’ Group are key groups in checking documents/engagement plans and contributing to cascade of engagement activities. Discussions have started with Healthwatch regarding how they may contribute to ongoing patient and carer discussions. It is envisaged that, from the more focused work, a ‘hub’ of patients/carers will emerge that can become a ‘critical friend’ test group to share plans/ideas and to involve in working groups.

This engagement work is being linked to the Kent Integration Pioneer Programme and the existing feedback and priorities will be used as a baseline for discussion in groups being set up across Kent to ensure wider and deeper engagement, with particular focus on reaching groups that have traditionally been considered hard to reach.

Large stakeholder events are being planned in both CCG areas, to take place early November. The events will provide an opportunity to share the latest BCF vision paper, outline project plans and engagement to date (e.g. results from survey, interviews, focus groups). Healthwatch is part of the planning group for these events.

A dedicated BCF area on each CCG website is being designed, to keep people updated on the programme, with links from/to provider sites to help spread the messaging and demonstrate wider collaboration/partnerships. The programme will also be promoted through Twitter.

b) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

The proposed plans are underpinned by work already in progress within North Kent (including with Medway CCG and Medway Council) to review and understand the current health and social care landscape and develop the local vision and sustainable plans for the future. As such health and social care commissioners, and health providers have been part of two Kings Fund facilitated workshops (in each area) to review audit data , produced by the Oaks Group, rom acute and community hospitals and agree key actions aimed at ensuring that people are treated within the

most appropriate care setting for their needs. Workshops were held on 19th (DGS area) and 22nd (Swale / Medway area) November 2013 and the second stage workshops were held on the 6th (Swale / Medway) and 18th (DGS area) February. As part of the actions from the meetings in February was the development of the vision document and an agreement to a system wide CQUIN to reduced non-elective admissions across all main providers.

The CCGs in conjunction with KCC have been particularly mindful when developing the health and social care transformation programme initiatives to ensure parity of esteem in relation to mental health is positively affected by the changes proposed ensuring implementation of initiatives takes account of both physical and mental health needs. Our respective CCG 5 year strategies evidence the priority of mental health service development and improvement and how mental health needs should be built into all service delivery and commissioning.

Assessment of future capacity and workforce issues are addressed through sharing our planning with our local partners and via the Health, Research and Innovation Hub. This enables the CCGs to influence workforce development, training and research opportunities in NK due to its alignment to Health Education – Kent, Surrey and Sussex and NHS England.

ii) primary care providers

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

- Organisational form i.e. how practices will work together to facilitate any new arrangements.

  The size of practice required to enable full integrated work, should this be characterised by larger or smaller populations, will larger practices 'threaten' smaller ones. This needs to be based on demographics and geography. There doesn't appear to have been discussion around a new or changed organisation form but this may need exploring further. There was felt to be an inequality in provision currently as well as services being disjointed which a new model needs to compensate for. Also need to protect the ability to innovate and act independently.
- Team configuration and operation.

  This included the actual configuration of the team; should be based on geography and practice profiles; consider all possible members i.e. pharmacists. The nursing element is a given (including Practice Nurses) but how far should the team go in terms of other professionals. In addition the resource levels to support the new way of working; the capacity & capability availability of the resources including using staff appropriately. Are there gaps in role types i.e. physician's assistants?

  The hours of work were discussed and how cover would be arranged this included core hours and ensuring adequate coverage but also the need to cover absences.

  How MDT's would operate was discussed
- Don't throw the baby out…..

  Not all is perceived to be bad but an overwhelming view that it could be better. Evidence of good practice (Impact, Rapid Response, midwifery & diabetes care) which could be learnt from and mustn't be lost. There was a sense of 'been there, done that', or 'we already have good resources we just don't make them work efficiently'. There is an

evident lack of confidence in current arrangements or the persistence of a potential new model.

- Supporting structures are important – i.e. IT. Also practical support for patients to enable them to stay at home
- Communication is key
    - Between practices – where teams operate across practices. This may necessitate some relationship building.
    - Within the team
    - With patients – about their care, about the team and way of working.
    - With other agencies

A follow up session was undertaken at the June PLT events and these coincided with the distribution of a newsletter to every GP and practice. These presentations covered the BCF in context, generally all of the BCF schemes and also some specific information about the integrated Primary Care Team element.

Further comments and questions were sort in relation to the iPCTs and an email address was set up (ipctqueries@nhs.uk) specifically to enable primary care colleagues to contact the programme manager directly. Offers were made to visit practices, particularly to discuss accommodation for the new teams but also to discuss any element of the programme.

A further presentation to provide an updated iPCT position was given to the Swale PLT in July and since there was no corresponding meeting in DGS an email was circulated to update on progress. An updates was also provided to the DGS Primary Care Strategy Group in July and again in August.
The Project Lead for the integrated Dementia project attended a series of Primary Care Locality meetings in July and together one of the CCG Board GP's gave an outline of the BCF programme and more specific information about progress with the dementia plans specifically.

The Programme Manager is also booked to attend the Swale Practice Managers meeting in September to answer specific questions they may have.

Also in September a series of workshops are being arranged to bring members of the new integrated Primary Care Teams together to work through how the teams will work, their aspirations for the new ways of working and how they will ensure that the outcomes are delivered for the patients and the project.

In governance terms a CCG Board GP sits on the BCF Delivery Group and there are GP representatives on the IDT and IPCT working groups. In addition there is active GP involvement in the supporting work stream around IT.

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

The following forums have been used to discuss the Better Care Fund, as well as the wider issues outlined within the NHS Call to Action:

- Kent Health and Wellbeing Board
- Swale, and Dartford, Gravesham and Swanley Health and Wellbeing Boards
- CCG / KCC Integrated / Strategic Commissioning Meetings
- Attendance at District / Borough Council meetings

Executive Programme Boards for Dartford, Gravesham and Swanley and Medway / Swale.

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?

Appendix D of the 5 year commissioning strategy contains the NK planning footprint and details the impact on providers within NK based on modelling work undertaken as part of the development of the strategy.

At a time when we are planning to make significant investments in community-based, person-centred health and care services, pressures and demands on our acute services continue to grow, and local authority social care budgets are facing a prolonged period of real-term reduction, increasing the risk that individual care needs will not be met.
Our BCF plan is about applying targeted investments to convert this potentially negative cycle into a positive one, driven by improved outcomes for individuals, communities and the health and care economy as a whole.
This means:

- Supporting people to live independently and well
- Releasing pressure on our acute and social services
- Investing in high-quality, joined-up care in and around the home

The Better Care Fund proposal details how it will provide:

- protection for social care services
- seven-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- better data sharing between health and social care, based on the NHS number
- a joint approach to assessments and care planning and, where funding is used for integrated packages of care, an accountable professional
- agreement on the consequential impact of changes in the acute sector, with an analysis, provider by provider, of what the impact will be in their local area alongside public and patient and service user engagement in this planning, and plans for political buy-in. This work is being undertaken over the next few months and will be completed by the end of June 2014.

The key implication for the Acute sector will be the reduction of non-elective admissions (NEL),

based on audit work undertaken across North Kent by The Oak Group and The Kings Fund this ambition is set at 15% over two years:

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

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

Risks of non-delivery
The key risks of not achieving the reduction in emergency admissions are:

- Non-delivery of the A&E target of 95%
- Unsustainable financial position for both the providers and the CCG

The Annexes and Financial templates have been completed after ensuring consistency with the Five Year Plans of the CCG and this also include the QIPP programme.

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

ANNEX 1 – Detailed Scheme Description

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

Scheme ref no.
1
Scheme name
Integrated Primary Care Teams – iPCT's
What is the strategic objective of this scheme?
The Joint Strategic Needs Assessment (review at January 2014), and local modelling confirms a number of key issues across North Kent which the development of Integrated Primary Care Teams (IPCT's) are expected to improve: • There is a significant increase in the older population – by 2020 there will be a 34% increase in people over 85 years in DGS and 22% increase in Swale (with an overall increase in the population by 8% and 4% respectively). • There is emerging significance of the importance of patients who have multiple morbidities which impact more and more on our health and social care services. The latest risk stratification analyses indicate that the highest intensive users (approximately 5% of the population) of hospital services are mostly elderly patients with complex needs and multiple morbidities. These patients represent almost 60% of the total unscheduled hospital admission spend for the CCG's. While the current Kent Health and Wellbeing Strategy is under review, it outlines the following expected outcomes which underpin the rationale for IPCT's: • Effective prevention of ill health by people taking greater responsibility for their health and well-being – these plans aim to support people to take responsibility by providing appropriate information, advice and signposting. • The quality of life for people with long term conditions is enhanced and they have access to good quality care and support • People with mental ill health issues are supported to live well • People with dementia are assessed and treated earlier. These two significant strategy documents underpin the two and five year strategies for the CCG's. The challenge for health and social care nationally is predominantly 2-fold: • Resources, both financial and human are finite and require further efficiency gains • The number and complexity of morbidities within, particularly, the elderly population are increasing year on year. This is however, true for all age groups with long term conditions. The response to this cannot be to keep doing more of the same and the need to completely revise the way health and care services are offered has been accepted for a number of years. The need has become more acute and real action is required now to facilitate that change. The challenge across the North Kent health and care economy has been set to reduce non-elective admissions by 10% at Darent Valley Hospital in 2014/15 with a further 5% reduction in 2015/16. Similar aspirations are expected at Medway Hospital. Plans are in place to achieve this target using the Better Care Fund programme to support the change. A number of projects have been established under the BCF banner to achieve the aims associated with it of which integrating primary health care teams is one.

Overview of the scheme

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

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

The vision for community based care delivered by integrated primary care teams is that it should be centred round the patient with the GP as the named accountable person. The teams themselves should be grouped around this construct and developed to work in an integrated, multi-disciplinary model. In order to facilitate this, there needs to be a new framework in place for the team, which has the relevant staff 'allocated' to practice populations.

To that end the iPCT's are being developed around a combined practice population or neighbourhood of c20-40,000. This figure enables the team to remain small enough to promote good relationships but to provide the resilience and flexibility needed to operate effectively when dealing with annual leave, sickness and training absences.

Success of the teams will be reliant on the following:

- Effective communication and relationships between all team members
- Core membership commensurate with the demographic and local needs
- Skills and competence of the team members
- Effective coordination and care planning
- Effective and robust operation within pathways for secondary and tertiary healthcare and also out of hours services

Whilst there is no absolute requirement for primary care itself to re-structure or to adopt different organisational structures to support the iPCT's, there are a number of options which may want to be considered by some practices. Work undertaken by the Kings Fund specifically suggests that this may support the development of primary care more generally and improve the quality of care provided. These are detailed in the draft Primary Care Strategy, which is currently in development for DGS CCG and one for Swale CCG. However, for the purposes of developing and testing out the right configuration of the iPCT's the current plans are proposed around the current practice configuration.

The delivery chain

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

As the iPCTs will be multi-disciplinary teams the members of the teams will be commissioned by a number of commissioners and from various provider organisations.
Essentially it will be delivered as follows and under existing contractual arrangements:
DGS & Swale CCG's will commission:

- District Nurses and Matrons from Kent Community Health NHS Trust
- Community MH Nurses from Kent & Medway Partnership NHS Trust
- Palliative Care Nurses from Ellenor Lions Hospice (DGS only at this stage)
- Outreach acute, specialist services from Dartford & Gravesham NHS Trust and Medway Maritime NHS Foundation Trust
- Paramedic Practitioners from South East Coast Ambulance NHS Foundation Trust

NHS England will commission:

- Primary Care services

Kent County Council will commission:

- Care services
- Voluntary and carer services

DGS & Swale CCG's have jointly secured external consultancy support to lead the project with accountability to the CCG Accountable Officer for delivery. The Programme Manager works within the programme governance and is responsible for presenting regular reports on delivery of the project plan and the agreed KPI's. The project itself is managed through the iPCT Working Group which reports into the Integrated Operational Commissioning Group and has representatives from all member organisations.

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 concept of iPCT's is not new and has been implemented and further developed quite widely nationally and internationally. As such there is a wealth of evidence which supports such an approach and has demonstrated a positive impact in terms of avoided admissions, reduced length of stay and improved patient experience. The models from which local plans have been drawn include those in Torbay, Devon and Canterbury in New Zealand.

References to their work can be located at:

1. March 2011. The Kings Fund. 'Integrating health & social care in Torbay: Improving care for Mrs Smith'
2. September 2013. The Kings Fund. 'The quest for integrated health a social care. A case study in Canterbury, New Zealand'

In addition close watch is being kept on Pioneer projects nationally, in particular the work in inner North West London. As more evaluation becomes available any learning will be applied to the Nth Kent approach.

Investment requirements

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

Impact of scheme

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

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?

The impact of this scheme will be measured accordingly to the project KPI's which are listed below Dashboards tracking the local metrics are being developed and will be monitored by the Executive Programme Boards for DGS and Swale:

Category	Group	Sub-group
Pt experience	Improvement in patient reported outcomes	People report system is not as complicated
		People report no delays in referral or assessment
		People report being treated with respect
		People report being involved in the development of their care plan
		People know name of their Care Coordinator

		People know how to access care and advice from team members
		People feel supported in the management of their condition
	Reduced admissions related to their LTC	
Team Operation	Team establishment	Team configuration & establishment agreed
	Referrals made via the SPA	Actual number of referrals
		Reduced time from referral to first assessment visit
	MDT meetings	Dates and times agreed and set
		Evidence of meetings taking place
		Attendance for all members
		Care Coordinator reports access to specialist advice
		Practice based telephone advice line in place & operational – others
	Staff satisfaction	report improved communication within the team
		report improved morale amongst team
		report enhanced ability to provide a good quality service
Clinical Quality	Integrated Care Plans	in place for all patients on the caseload
		shareable and shared across all members of the team
	Risk stratification tool	applied monthly and reports shared with the team
		at risk patients discussed at MDT's

Using a risk stratification approach the 'at risk' patients will be identified enabling proactive management of individuals by all members of the iPCT as appropriate to the care required. This proactive involvement by the team will reduce the number of crises experienced by patients and a resultant early deterioration in their general health and wellbeing.

The contribution of these metrics to the overall BCF Programme for North Kent will be in terms of the contribution to avoiding hospital attendances from which might result an admission and the provision of a community based support infrastructure will enable a speedier discharge. These in turn will enable people to stay supported in their own homes for longer and thus reduce the number of admissions into long term care.

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

The local and care environment will need to ensure the following for this scheme to succeed:

- strong governance arrangements are in place to ensure senior level commitment and support
- a full and transparent approach to joint working, sharing resources and enabling delegated assessment and decision making powers within teams
- a pooled budget in support of the above
- a joint commitment to developing and retaining good staff to ensure sustainable services in a notoriously 'hard to recruit to' area.

Evidence elsewhere has been that a significant local imperative has been the key to innovative and true joint working. In Torbay it was a severely financially challenged local authority, in Canterbury NZ, it was an earthquake, In North Kent a similar outcome needs to be achieved based on learning from best practice elsewhere, whatever the catalyst.

Scheme ref no.
2
Scheme name
Integrated Dementia Care
What is the strategic objective of this scheme?
To establish an effective integrated care pathway for people with dementia. The ageing population in North Kent will continue to place significant financial challenges on the care system with an increase in the number of people with long term conditions, the concomitant increase in dementia and a subsequent increase in carers and the people they care for experiencing crisis situations People with dementia and their carers need a range of services, some of which will be dementia- specific and others which will be more mainstream in nature. These services need to respond well to people affected by dementia and in the main meet their needs within the home environment where possible, If people do need a hospital admission effective joint care planning is essential and better cross-organisational and inter-organisational working to improve discharge planning is essential. The development and implementation of an integrated care pathway for people with dementia will see their needs assessed through a framework of care management and coordination that ensures delivery of health and social care services by means of a combined shared care plan. The integrated care pathway is being jointly developed by health, social care and voluntary organisations within North Kent to provide guidance about effective services and interventions that deliver outcomes for people living with dementia and their carers from early diagnosis and throughout the course of the condition Transformation of dementia care within North Kent to a multi-disciplinary, multi-agency planned approach to the delivery of care and support for people with dementia and their carers will provide improved access to resources and services throughout the course of the disease. Effective joint care planning and crisis management will reduce the use of more intensive, higher cost services and incur a delay in the need for more intensive services in the later stages.
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?
At the present time there are various aspects regarding service provision for people with dementia that requires changing to ensure continuity of patient care and an effective pathway for patients from earlier diagnosis, integrated service provision within the community, effective crisis management through to end of life care. The dementia programme focuses on three elements of the pathway which will have the highest impact in reducing admissions to acute hospitals, all of which are designed to improve the experience of people with dementia as we progress to establishing a fully integrated care pathway. Effective co-ordinated care will be introduced by establishing mental health nurses within Integrated Primary Care teams based around practice populations of 30,000 people. Mental health expertise will become an integral function within Integrated Primary Care teams to provide post diagnostic support and effective case management for people with dementia in the community. The ambition is to treat dementia under the long term condition model of care where a person's needs are treated holistically factoring in physical and mental health needs

together where services are responsive to individual need and carers are supported through the journey with dementia. The Integrated teams will support the management of the higher risk stratified population and caseloads for dementia currently in Cluster 18 and 19.

A crisis service for people with dementia and their carers will be jointly commissioned by Kent County Council and North Kent CCGs and procured through the voluntary sector. The service will provide a short term rapid response to a physical and/or mental health crisis through intensive support and home treatment more often than not due to an escalation in difficult behaviour that results in carer breakdown and risks unplanned admissions to hospital or care homes.

This will be achieved by shifting current resources to improve care coordination, improve access to services, and provide greater support to carers by reducing inefficiencies and duplication without significant infusion of financial resources and subsequently reduce the use of more intensive, higher cost services.

An acute hospital bridging service provided by a specialist dementia voluntary sector organisation has been established to work within the Integrated Discharge Team. This will optimise effective client transfer to avoid admissions where it is safe to do so and to facilitate timelier discharge operating a 'pull' system via a single point of case management. The service will support people with dementia or other cognitive impairments by the provision of short term care support services to re-establish the patient in the community, including support to family carers, to allow time for decision making by health and social care for their future long term care needs if required.
All three initiatives are underpinned by integrated working between health, social care and the voluntary sector and the development of the shared care plan.
Commissioners and Providers are working together to develop local policies and protocols embedded within the shared care plan which cross professional boundaries to focus on meeting the needs of people with dementia within the community.
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The delivery chain

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

This service will be part of the wider multi-disciplinary iPCT's and the members of the teams will be commissioned by a number of commissioners and from various provider organisations. Essentially it will be delivered as follows and under existing contractual arrangements:
DGS & Swale CCG's will commission:

- Community MH Nurses from Kent & Medway Partnership NHS Trust

NHS England will commission:

- Primary Care services

Kent County Council will commission:

- Care services
- Voluntary and carer services

DGS & Swale CCG's have jointly secured external consultancy support to lead the project with accountability to the CCG Accountable Officer for delivery. The Programme Manager works within the programme governance and is responsible for presenting regular reports on delivery of the project plan and the agreed KPI's. The project itself is managed through the integrated Dementia Working Group which reports into the Integrated Operational Commissioning Group and has representatives from all member organisations.

DGS CCG has commissioned the Alzheimers and Dementia Support Service to work with the Integrated Discharge Team based within Darent Valley Hospital. The Integrated Discharge Team is a collaboration between DGS CCG, Darent Valley Hospital and Kent Community

Healthcare.
A change in approach to crisis management will be required and joint working is already taking place between the CCG and Kent County Council. Kent County Council short breaks for carer's contract started on November 2013 continuing through to 31st March 2016 (18 months plus an additional year extension). The service builds on the objective of the current crisis service and moves to a more holistic and proactive approach to preventing crisis' arising focusing on the capacity and capability of carer to continue their caring role, alongside building greater links with existing services. The CCG can access the contract through expanding the scope of the existing Section 256, allowing CCG transfer of a corresponding allocation to KCC buying into the service outlined in the service specification

The development of the Integrated Care Pathway for dementia is a collaborative planning process working in partnership with
DGS/Swale CCG
GP Dementia Clinical Leads
Darent Valley NHS Trust
Kent and Medway Partnership Trust
Kent Community Healthcare Trust
Kent County Council
Crossroads Care
Alzheimer's and Dementia Support Services

Dementia Leads from all listed organisations participate and take forward specific tasks within their respective organisations**.**

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

There are numerous examples of evidence for the improvement and development of consistent high quality care for dementia that has influenced the service transformation within North Kent most notably:

National Strategies

- Department of Health (2009), Living Well with Dementia: A National Dementia Strategy
- Dementia: A NICE–SCIE Guideline on supporting people with dementia and their carers in health and social care, National Clinical Practice Guideline
- National Audit Office (2007), Improving services and support for people with dementia. London: TSO.
- Alzheimer's Society (2008), Out of the Shadows. London: Department of Health.
- Department of Health/Care Services Improvement Partnership (2005), Everybody's Business – integrated mental health services for older adults.
- The National Dementia Declaration (Alzheimer's Society, 2010)

There are a number of areas within the UK that have implemented the same approach to dementia care and the evidence has been recognised nationally as good practice and improving overall outcomes for people with dementia and their carers. Although service provision cannot always be replicated exactly the main driver of integrated care for dementia has provided the catalyst to base our joint plans around the needs of the person with dementia.

The models that have proved beneficial in improving care for people with dementia and influenced service redesign and pathway development are:

South Devon Partnership Integrated Care Pathway for dementia

Healthcare for London Dementia Services Guide: Integrated Care Pathway
Torbay Care Trust – Integrated Care for Older People

Investment requirements

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

Impact of scheme

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

In North Kent we have a number of active forums that have been the vehicle for delivering changes in the dementia pathway. These are listed below:

- Dementia Strategic Oversight Group (People with dementia and Carers)
- Dementia Forums
- Kent Dementia Action Alliance
- Practice Participation Groups
- Dementia Friendly Communities forums

The feedback from people living with a dementia type illness and people who care for them .gives a valuable insight into the perceptions of the local community as well as their ideas on how to improve things.

Many of those who had either first hand or experience as a carer of someone with a dementia type illness expressed concern about how there is no obvious pathway to guide those affected. Some people had struggled to manage and cope, often only getting assistance at a crisis point.

This is reinforced in the Dementia in Kent 2010, Public Health Annual Report which highlighted that 37% of admissions of patients with dementia resulted from patient and/or carer being unable to cope (in conjunction with fall with no bone injury, poor mobility and/or increased confusion). This is supported by results released by Kent County Council (Personal Social Services Research Unit, 2008) highlighting that carer breakdown was a contributory factor in 31% of all care home admissions.

We will continue to work with these groups and the improvements will be evaluated by the use of questionnaires to both staff within the hospitals and community services and families of people with dementia.

Feedback loop

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

A range of key performance indicators will be developed for regular monthly reporting, and there will be monthly meetings between the commissioner and provider to monitor performance against these. Baseline measures on all indicators will be collated to accurately measure quantifiable benefits. . A central database has been developed to enable regular monitoring of performance and activity against agreed key indicators, assist resource planning, support service audit (e.g. equity of service) and evaluation.

The metrics for monitoring the impact of the integrated care pathway are contained in service specifications and information is provided on a monthly basis to measure the success of the contract and to control spend and measure savings. The metrics form part of an overall dashboard measuring achievement against all BCF projects to achieve a 10% reduction in admissions to Acute Hospitals and support the key performance indicators relating to the Integrated Discharge Team and Integrated Primary care teams in reducing unplanned admissions and reducing lengths of stay and includes the following:

.
Metrics for dementia service improvements include:

- Reduced lengths of stay for non-elective >65s
- Reduction in admissions to Acute Hospital for people with cognitive impairment
- Reduction in the number of patients presenting monthly at A&E with cognitive impairments
- Reduction of crisis episode
- Reduction in people progressed to permanent support (Residential/Nursing care)
- Increase in dementia diagnosis rate to 60% predicted prevalence25% people with confirmed diagnosis of dementia with a shared integrated care plan

To assess the qualitative impact of the service improvements, patients, carers and staff (managerial and clinical) views will be sought to help shape the services, develop the protocols and meet the needs of the community whilst operating to national frameworks and standards. Each provider must complete regular surveys, act upon the results, feedback to the patients and provide opportunities for patients to become involved in service improvement

Systems are in place to involve the following stakeholders in the ICP development process:

- multi-agency and multidisciplinary workforces (including advocacy services and
- voluntary organisations)
- service users, and
- informal carers.

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

The development of the Integrated Care pathway follows the 8 pillars of care from raising awareness through to early diagnosis, living well in the community to end of life care. The pathway will be developed in a phased approach with the initial phase focussing on integrated community care establishing mental health expertise in Integrated Primary care teams in the community, effective interventions in times of crisis and timelier discharge from acute hospitals by the provision of home care, night sitting and support for the carer.

The three areas of initial focus were identified from collaborative working between health, social care, Acute hospitals, Community services and voluntary sector organisations. A process mapping exercise was conducted in the early stages of the ICP development to:

- identify current patterns of service delivery and available resources
- examine the journey of care for service users and informal carers
- establish the strengths and weaknesses of current service provision
- quantify demands on the services
- identify the gaps in services
- identify gaps in staff skills and competencies, and
- identify how the journey of care can be improved

A range of case studies highlighted gaps and fragmentation within the current system
Agreement was reached on a number of service improvement standards and the introduction of revised processes as people move through the care system.

The introduction of a fully operational service user held care plan shared between agencies underpins the development of the integrated pathway

Scheme ref no.
3a
Scheme name
Integrated Discharge Team, Medway and Swale
What is the strategic objective of this scheme?
Our vision for health and care services is to deliver the right care at the right time in the right place, providing seamless integrated care for patients, particularly those with complex needs. Evidence shows that patients with complex needs often stay longer than necessary in an acute hospital bed. By providing appropriate care outside of the acute hospital setting, patients can be discharged more timely and supported in the community, in or as close to their homes as possible, with effective personalised care plans. To deliver our vision, the strategic objective of the Integrated Discharge Team (IDT) is to facilitate safe, timely discharge while reducing emergency admissions by working to a 'home is best' philosophy. The service delivers a multi-agency approach to facilitate discharge for complex patients from acute care whilst ensuring:- • The best possible outcome for the patient • Timely access to a range of community based health and social care services • Optimum use of acute/community and social services resources. By working with the 'home is best' principle, the IDT ensures patients are discharged home, wherever possible, with the appropriate care package to maximise independence and empower people to manage their own health and wellbeing.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Integrated Discharge Team (IDT) was introduced towards the end of 2013 to support complex discharges at Medway Foundation Trust. This is a multidisciplinary team comprising of health and care professionals working together to facilitate safe and timely discharges for patients with complex needs, 7 days a week. The team brings together the Community Navigation Team, Social Care Teams, Rapid Response, Community Nursing, Hospital Discharge Team, Acute Fragility and the Swale In-Reach Team. The population focus is mainly, but not restricted to, those over the age of 65 with one or more long term condition, with the aim of facilitating 15 discharges per day. Providing a 7 day service, this equates to 5475 per year. The aim of the IDT is to • deliver a multi-agency approach to facilitate timely discharge for patients whilst ensuring the best possible outcome • provide optimal care packages in the community to support patients on discharge in retaining independence in their usual place of residence, where possible • avoid premature admission of patients to acute care and transfer them to where care

can be delivered in a more appropriate environment that is conducive to patient's need. Admission to acute hospital care will not be prevented, where it is clinically required.
- avoid the premature admission of patients into long-term care, where clinically appropriate.
- reduce the number of re-admissions of patients with chronic long term conditions.

Hosted by Medway Community Healthcare, the IDT sits within Medway Foundation Trust and facilitates the co-ordinated admission, navigation and transfer of care across the Medway and Swale health economy.

The team expedites all complex patient discharges across all hospital wards, Emergency Department (ED) and the assessment/observation units 7 days a week - 8.00am-8.00pm Monday to Friday, 8.00am-4.00pm weekends and Bank holidays.

The IDT is structured in three cluster teams supporting ward staff with discharge planning. A fourth cluster is responsible for the emergency wards, including A&E, Observation ward, CDU, AMU and SAU, focussing on admission avoidance, where appropriate, by assessing and implementing care packages to support a return to home with support. A physiotherapist, occupational therapist and dedicated care manager are part of the forth cluster.

Planned discharges that do not take place are reviewed and shared daily with hospital managers to understand what the delay is attributable to, enabling improvements to be identified and actioned.

The delivery chain

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

The IDT is jointly commissioned by Medway and Swale Clinical Commissioning Groups and implemented and hosted by Medway Community Healthcare (MCH). The team consists of members of staff from the following organisations

- Medway Foundation Trust
- Medway Council
- Kent County Council
- Medway Community Health Trust
- Kent Community Health Trust

Kent and Medway Partnership Trust provide in reach mental health support.

The team is overseen by the IDT Clinical Service Lead, employed by MCH with each employing organisation responsible for the management of their staff.

The team operate within agreed criteria ensuring the whole discharge pathway is considered and patients are actively managed post discharge.

All Parties are responsible for meeting the outcomes and Key Performance Indicators set down by the CCG and work together to address all issues that arise.

Overall operational performance is reported weekly by the Operations Director of MCH through the whole system executive conference call. The weekly executive conference call, chaired by the Chief Operating Officer of the Medway Clinical Commissioning Group, has representation from all key provider organisations across Medway and Swale therefore operational issues requiring whole system input or support are addressed at executive level.

KPIs are reported on a monthly basis to the commissioners with the strategic governance of the IDT being led by the Medway and Swale Executive Programme Board.
Any operational issues requiring whole system input or awareness are reported through the weekly executive conference call.

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

Driven by an increasing number of delayed discharges and transfers of care from Medway Foundation Trust, a whole system discharge process planning workshop was hosted in June 2013 by Medway and Swale CCGs. The aim of the workshop was to bring together the organisations who play a role in facilitating discharge from both the acute and community hospitals. 50 delegates (operational and strategic leads) representing all key stakeholders were involved in the workshop.

Delegates reviewed the existing processes to identify the 'As Is', starting from the time a patient presented in the emergency department to the time of their discharge home or transfer to an alternative care setting. From this necessary steps and key actions to support effective and rapid discharge from hospital, for patients deemed medically fit, were determined.

A number of recommendations from the workshop were signed off by the Medway and Swale Executive Programme Board. Priority was given to the rapid development of single integrated discharge team, hosted by Medway Community Health Trust, working within MFT, to support proactive admission avoidance and timely effective discharge planning for complex patients.

In recent months, the Emergency Care Intensive Support Team (ECIST) have undertaken work with the local health economy both at a Trust and whole system leve and continue to provide support to improve timely discharges 7 days a week.

The Emergency Care Intensive Support Team (ECIST) have undertaken work with the local health economy both at a Trust and whole system level in recent months and continue to support key whole system pieces of work.

In addition to the work with ECIST, the Oak Group were commissioned in the latter part of 2013 to undertake audits of acute (admissions and beds) and Community (beds) across North Kent. At a headline level the audits demonstrated:

Acute (patients already in a hospital bed)

- 44% of non-qualified admissions could have been prevented by providing a variety of services at home.
- 46% of all continuing days of care could have been provided at home with a variety of services
- A discharge plan was present in 37% of records.
- 95% of these were started post admission and documentation was poor.
- An estimated date of discharge (EDD) was listed for 13% of patient records.
- 41% of patients with an EDD were in hospital beyond the EDD.

Acute admissions (All patients who were admitted though A&E or the assessment units during the prior 24 hours were retrospectively examined)

- 21% could have been prevented with only GP or other routine follow-up.
- 78% of patients came through A&E of which 27% were non-qualified.
- 21% came through GP referral of which 37% were non-qualified.

An audit of A&E attendances was undertaken in August 2014, the results of which will help to

identify gaps in community service provision to manage people better in the community in future.

Investment requirements

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

Impact of scheme

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

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?

KPIs have been developed for the IDT which are monitored by the Urgent Care group to measure outcomes of the scheme. The agreed KPIs will enable success in admission avoidance and the discharge planning process to be highlighted and quantified.

The current measures are

- % of patients with EDD set within 24 hours of admission
- % of patients discharged within 24 hours of planned EDD
- % of patients with DTA who have baseline assessment
- Reduction in the number of patients on the medically stable list
- % patients on medically stable list with a discharge plan Reduction in the number of patients with a length of stay > 15 days, >30 days
- Reduction in the number of placements into social care
- Reduction in the number of readmissions
- Reduction in the number of high cost packages
- Increase in the number of early discharges facilitated by Continuing Health care

This is existing data, generated automatically, which has been reported on previously through various existing data systems.
Dashboards tracking the local metrics are being developed and will also be monitored by the Executive Programme Boards for DGS and Swale:

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

For patients, success factors are defined by improved patient experience as a result of high quality, seamless care. Being aware of and supported to work towards an expected date of discharge. Feeling supported to live at home with appropriate enablement services

Success factors for the workforce are defined by improved partnership working which breaks down organisational barriers to be enable them to deliver optimum care to patients.

Scheme ref no.

3b

Scheme name

Integrated Discharge Team - DGS

What is the strategic objective of this scheme?

The objective of the scheme is to reduce emergency admissions ensuring people are treated in

the right place at the right time by the appropriate person.

There is empirical evidence that too many patients are inappropriately staying in hospital beds. It is believed that care can and should be more appropriately delivered in the community rather than in an acute hospital bed, using highly responsive, effective and personalised services outside of hospital and in or as close to people's homes as possible.

The aim of the service is to deliver a multi-agency approach to facilitate discharge for patients from acute care whilst ensuring

- The best possible outcome for the patient
- Timely access to a range of community based health and social care services
- Optimum use of acute/community and social services resources.

Overview of the scheme

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

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

The IDT is a team made up of Nurses, Doctors, Therapists, Pharmacists, Care Managers and Mental Health Specialists working across the acute and community settings. The team operates 8am – 8pm, 7days a week.

The goal is to ensure that patients receive the most appropriate treatment, delivered by the most relevant health care worker in the most appropriate setting – all the time.

The aim of the IDT is

- to deliver a multi-agency approach to facilitate timely discharge for patients whilst ensuring the best possible outcome
- ensure timely access to a range of community based health and social care services and optimum use of acute/community and social services resources.
- avoid the premature admission of patients to acute care and transfer them to where care can be delivered in a more appropriate environment that is conducive to patient's need. Admission to acute hospital care will not be prevented, where it is clinically required.
- avoid the premature admission of patients into long-term care, where clinically appropriate.
- reduce the number of re-admissions of patients with chronic long term conditions.

This is achieved through the following objectives

- that Discharge Planning begins at the point of admission to acute care.
- providing ward staff with support, advice and training regarding discharge planning of both simple and complex patient discharges.
- working collaboratively with community agencies such as Intermediate Care, Continuing Health Care, Therapists, Social Services and Community Matrons to ensure that patients' needs have been correctly assessed and are appropriately met on discharge.
- ensuring the development of existing discharge services and transfer of care into community settings by developing key relationships with Mental Health, Alcohol Liaison Nurses, Nursing and Residential Homes and Community Nursing Services.
- providing all groups of staff with education and training with regard to discharge planning.
- developing and produce discharge information and literature for patients regarding the discharge process to assist them and prevent delays in their discharge.
- the assessment of complex patients' needs prior to discharge
- development of a "one team" approach

The population focus is mainly over 65's with 1 or more long term condition although not

restricted to.

The delivery chain

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

There is an SLA in place between all providers – see attached

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

Pressure on local hospitals particularly in winter results in substandard care of patients and evidence shows that In the UK up to one million emergency admissions were avoidable last year.

Work carried out for DGS CCG by the Oaks Group in October 2013 identified that within Darent Valley Hospital:

- 58% of acute admissions could have been avoided by providing a variety of services at home.
- 15% of acute admissions could have been provided for on sub-acute wards.
- 8% of all admissions required supported living environments.
- 36% of continuing stay days were due to discharge planning issues.
- 37% of continuing stay days could have been avoided by providing a variety of services at home.

Examples of successful Integrated Discharge teams and models of provision were identified including, Mid Cheshire, East Cheshire, Nottinghamshire and Glasgow, St Helens.

Investment requirements

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

Impact of scheme

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

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?

Comprehensive KPIs have been developed for this scheme and are monitored by the Urgent Care Group. Data is compiled to highlight and quantify the successes in admission avoidance. There are Whole health Economy KPIs and the IDT has a set of proxy measures that have been developed to identify success and also where the delivery model may need changing.

Current measures are:

- % of patients discharged within 24 hours of planned EDD
- Reduce number of patients on medically stable list
- Reduce patients with Length of Stay > 15 days
- % patients on medically stable list with a discharge plan
- % of patients on medically stable list with diagnosis of dementia / Mild Cognitive Impairment
- % of patients with a LoS > 15 days on the medically stable list
- % of patients reviewed by the IDT (exclude IDT GP) in A&E
- % of patients reviewed by IDT (exclude IDT GP) in A&E and discharged back to usual

place of residence • Patients seen by IDT GP • Total number of patients seen by IDT GP appropriate for Primary Care • Decrease in readmissions to an acute bed for same condition within 30 days • Decrease in readmissions to an acute bed with an exacerbation of a Long Term Condition (HF/COPD/Diabetes) • Numbers admitted to long term care Dashboards tracking the local metrics are being developed and will be monitored by the Executive Programme Boards for DGS and Swale:
What are the key success factors for implementation of this scheme?
Success factors are defined by patient experience reporting high quality seamless integrated care, a reduction in emergency admissions and admissions to long term care. Increase in the number of people living at home with enablement services.

ANNEX 2 – Provider commentary (DGS)

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

Name of Health & Wellbeing Board	Kent Health & Wellbeing Board
Name of Provider organisation	Dartford & Gravesham NHS Trust
Name of Provider CEO	Susan Acott
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	28237
	2014/15 Plan	26961
	2015/16 Plan	26016
	14/15 Change compared to 13/14 outturn	-1276
	15/16 Change compared to planned 14/15 outturn	-945
	How many non-elective admissions is the BCF planned to prevent in 14-15?	1276
	How many non-elective admissions is the BCF planned to prevent in 15-16?	945

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?**	I agree that this BCF initiative represents an agreed plan with other partners. The reduction in activity is net of the growth related to local housing development and demographic growth.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	We have a plan to deal with the consequences

ANNEX 2 – Provider commentary (Swale)

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	Medway Health & Wellbeing Board
Name of Provider organisation	Medway Maritime NHS Foundation Trust
Name of Provider CEO	Phil Barnes
Signature (electronic or typed)	Covered in the Medway submission

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	8917
	2014/15 Plan	8840
	2015/16 Plan	8530
	14/15 Change compared to 13/14 outturn	-77
	15/16 Change compared to planned 14/15 outturn	-310
	How many non-elective admissions is the BCF planned to prevent in 14-15?	77
	How many non-elective admissions is the BCF planned to prevent in 15-16?	310

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?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	