AGENDA

HEALTH AND WELLBEING BOARD

Wednesday, 26th March, 2014, at 6.30 pm	Ask for:	**Ann Hunter**
Darent Room, Sessions House, County Hall, Maidstone	Telephone	**01622 694703**

Tea/Coffee will be available 15 minutes before the start of the meeting in the meeting room

Membership

Mr R W Gough (Chairman), Dr F Armstrong, Mr I Ayres, Dr B Bowes (Vice-Chairman), Mr A Bowles, Ms H Carpenter, Mr P B Carter, CBE, Mr A Scott-Clark, Dr D Cocker, Ms F Cox, Cllr J Cunningham, Ms P Davies, Mr G K Gibbens, Mr S Inett, Mr A Ireland, Dr M Jones, Dr L Lunt, Dr N Kumta, Dr T Martin, Mr S Perks, Cllr P Watkins, Mrs J Whittle and Dr R Stewart

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

1 Chairman's Welcome

2 Apologies and Substitutes

3 Declarations of Interest by Members in Items on the Agenda for this Meeting

4 Minutes of the Meeting held on 12 February 2014 (Pages 3 - 6)

5 Better Care Fund (Pages 7 - 264)

6 Commissioning Plans (Pages 265 - 580)

The Health and Wellbeing Board is asked to discuss and endorse the following commissioning plans:
Seven clinical commissioning group plans
Adult Social Care Commissioning Plan
NHS England Area Team Commissioning Plan

7 Children's Health and Wellbeing Board (Pages 581 - 584)

8 Date of Next Meeting 28 May 2014

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services
(01622) 694002

Tuesday, 18 March 2014

KENT COUNTY COUNCIL

HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Health and Wellbeing Board held in the Darent Room, Sessions House, County Hall, Maidstone on Wednesday, 12 February 2014.

PRESENT: Mr R W Gough (Chairman), Dr F Armstrong, Mr I Ayres, Dr B Bowes (Vice-Chairman), Ms H Carpenter, Mr P B Carter, CBE, Dr D Cocker, Ms F Cox, Ms P Davies, Mr G K Gibbens, Mr S Inett, Mr A Ireland, Dr L Lunt, Dr N Kumta, Dr T Martin, Ms M Peachey, Cllr K Pugh (Substitute for Mr A Bowles), Dr R Stewart and Mrs J Whittle

ALSO PRESENT: Mr E Howard-Jones

IN ATTENDANCE: Dr A George (Consultant in Public Health), Ms M Varshney (Consultant in Public Health) and Mrs A Hunter (Principal Democratic Services Officer)

UNRESTRICTED ITEMS

57. Chairman's Welcome
(Item 1)

The chairman opened the meeting by looking ahead to the next meeting of the Health and Wellbeing Board on 26 March 2014. He said the items for consideration would be the agreement of the final submission for the Better Care Fund and the endorsement of the CCG operating plans, commissioning plans for area teams, the integrated commissioning strategies, the multi-agency framework for children and young people in Kent and other related plans. To overcome the logistical challenge of considering these plans he suggested that an executive summary and a check list of key points be presented to the HWB.

58. Apologies and Substitutes
(Item 2)

Apologies for absence were received from Cllr A Bowles, Cllr J Cunningham, Dr M Jones, Mr S Perks and Cllr P Watkins.

59. Declarations of Interest by Members in Items on the Agenda for this Meeting
(Item 3)

There were no declarations of interest.

60. Minutes of the Meeting held on 20 November 2013
(Item 4)

RESOLVED that the minutes of the meeting of the Health and Wellbeing Board held on 20 November 2013 are correctly recorded and that they be signed by the chairman.

61. The Better Care Fund
(Item 5)

(1) The report presented the first draft of the Kent Better Care Fund (BCF) plan and outlined the further steps required in advance of the final submission.

(2) Dr Robert Stewart gave a presentation about the Integration Pioneer project and the steering group's proposed model of integrated services. This was followed by short presentations from North, East and West Kent about their proposals for integrating services and putting the patient at the centre of care.

(3) During the discussion the following points were made:

- The submission to the Better Care Fund needed to be clearer about the way in which some of the proposed schemes would be implemented and on their impact on citizens;
- The submission also lacked sufficient detail to explain adequately what would be different;
- Some detail was not yet available and would take time to develop;
- The case studies quoted in the submission were relatively simple ones and the submission could be enhanced by the inclusion of case studies showing the management of people with complex and multiple conditions;
- As the BCF was being funded by transferring resources from elsewhere there was a need to be clear about how integrated services would be delivered to avoid increasing the risk to providers and users of current services where budgets had been top sliced;
- There was a need to involve other agencies such as acute hospital trusts and the South East Coast Ambulance Service to ensure the correct vertical and horizontal integration;
- Delivering services using multi-disciplinary teams would require changes to medical and nursing education as well as the development and teaching of leadership skills for managing multi-disciplinary teams;
- The long term role of community care and the associated manpower planning needed further consideration; and
- The integration of the community and voluntary sector needed to be explored further and included in the submission.

(4) RESOLVED:

(a) That the first draft of the Better Care Fund plan be agreed for submission to NHS England subject to the inclusion of the points made during the discussion;

(b) That progress to achieve a final submission be noted and the plan for continued activity be endorsed.

62. Assurance Framework
(Item 6)

(1) Malti Varshney (Consultant in Public Health) introduced the report which provided performance figures on a suite of indicators based on Kent's Health and Wellbeing Strategy. This report detailed the indicators relating to the

performance of the health and wellbeing board, progress towards achieving the Kent Health and Wellbeing Strategy Outcome 2 – *Effective prevention of ill-health by people taking responsibility for their health and wellbeing,* as well as some stress indicators across the whole system. Stress indicators were considered important as they demonstrated where there was pressure in the system and made it possible to assess the impact of measures (such as better integration of health and social care) put in place to alleviate those pressures. For example, a low take-up of flu vaccines could have an impact on admissions through accident and emergency departments and on bed occupancy

(2) Additional indicators had also been added to the report to reflect the evolution of local and national data sets.

(3) Ms Varshney said the report was an iterative process and would welcome comments. The HWB was also asked to consider future reporting of the Assurance Framework at district and local health and wellbeing board level to facilitate meaningful local action planning to achieve local targets and reduce the risk that good performance across Kent as a whole might mask local variations.

(4) During discussion the following points were made:

- Data relating to patient experience was important and mechanisms for its collection were being discussed with Healthwatch and others;
- Obesity indicators and indicators relating to access to mental health services for children and adolescents should be included;
- Consistency in measurement of data was important and should be in line with the national guidance for data collection, particularly around acute services;
- As far as practicable data about the range of service provision and performance across Kent should be provided;
- Data that enabled the board to monitor progress in achieving key outcomes was needed;
- There was a distinction between assurance and performance; and this report was intended to provide assurance across the system as a whole although some performance indicators were used to inform it.

(5) RESOLVED:

(a) That the report be noted;

(b) That the additional indicators proposed following discussions with stakeholders be agreed for inclusion in future reports;

(c) That data at local and CCG-level be provided to local health and wellbeing boards where it was available.

63. Children and Young People's Mental Health and Wellbeing Services
(Item 7)

(1) Ian Ayres (Accountable Officer, West Kent CCG) said there had been a number of developments since he had written the report and suggested that the recommendation be amended.

(2) Mr Ayres said the current service was not meeting the needs of children and young people. This was partly due to the fragmented approach to commissioning the various tiers of service and the separation of these services from children's services, drug and alcohol services as well as some issues that were being managed with the current provider.

(3) Mr Ayres suggested that it was worth considering how the services could be integrated and provided seamlessly before they were commissioned.

(4) Concerns were raised about issues at the point of transition from children and adolescent mental health services to adults' services

(5) RESOLVED:

(a) That the principle of moving towards the integrated commissioning of a range of services for children and young people be endorsed;

(b) That Mr Ayres and Mr Ireland convene a group to consider how best to bring forward the integrated commissioning of a range of services for children and young people including CAMHS.

64. Joint Strategic Needs Assessment - 2013/14 Exception Report
(Item 8)

(1) Abraham George (Consultant in Public Health) introduced the report which said that the Joint Strategic Needs Assessment was a set of reports, chapter and interactive maps and was kept under constant review and development. Almost all of the summary chapters had been reviewed and updated to reflect the latest policy, guidance and data trends. The report also included a list of new and emerging priorities and highlights. Dr Abraham drew particular attention to: the changes made to the chapters on smoking cessation and breast-feeding; issues identified relating to the quality of data for assessing mental health needs: and the completeness of registers for certain vulnerable groups including those with learning difficulties and sensory impairment.

(2) The need for detailed data at local and CCG level was emphasised during the discussion and it was confirmed that such data would be provided to local health and wellbeing boards. The need for data from various organisations, including accident and emergency departments and the Police, to inform local activities to influence outcomes was also identified.

(3) RESOLVED that the report be noted.

65. Date of Next Meeting - 26 March 2014
(Item 9)

By: Dr Robert Stewart, Chair Integration Pioneer Steering Group

To: Kent Health and Wellbeing Board, 26 March 2014

Subject: **The Better Care Fund**

Classification: Unrestricted

Summary: This paper presents the final submission of the Kent Better Care Fund Plan and outlines the steps taken following the assurance process.

Recommendations:
The Kent Health and Wellbeing Board is asked to:

1. **Agree** the BCF plan and **endorse** submission to NHS England.

2. **Endorse** the clear commitment to closer integration across health and social care to a programme of clear integration and radical transformation evident within the Bertter Care Fund Plan based upon:
   - A 15% reduction of hospital admissions by 2016
   - Availability of services on an extended hours basis
   - Integrated commissioning of health and social care
   - Continued development of enablement services, telecare/teleheatlh, self care and prevention

3. **Note** the progress made to meet the areas of development in achieving the final submission.

1. Introduction

1.1 The Better Care Fund was announced in June as part of the 2013 Spending Round. Its aim is to act as the enabler to take the integration agenda forward at scale and pace. The development of a Better Care Fund plan is also an integral part of developing the CCG 5 year strategic plans – although must be able to be seen as a stand-alone plan.

1.2 The draft submission was presented to the HWB on 12 February prior to first submission, an assurance process has taken place and the final plans will be submitted on 4 April 2014.

1.3 The Local Government Association identified at the South East Area Health and Social Care Integration workshop on the Better Care Fund the expectation that by September all areas will be expected to provide clarity on ability deliver and the finance and metrics associated with plans.

2. Outcomes of Assurance

2.1 On 6 March a joint letter was provided to CCGs and Social Care outlining the outcomes of the initial assurance. The scope of the Kent plan and the strategic aspirations were noted as ‘encouraging’. Further assurance was sought across a

number of areas, the table below summarises these and identifies the steps taken to ensure these have been addressed in the final plan.

Key Development Areas	Update
Reflects joint responsibility of health and social care in design of metrics and delivery of outcomes of plan.	Agreement and discussion on the metrics via the Integration Pioneer Working Group, plans updated to reflect outcomes.
Confirmation of Section 256 schemes, outcome measures and health and social care deliverables.	Clearer outcomes and deliverables have been identified and linked to individual schemes.
Present an east, west and north economy overview.	Summary provided within Template Part 1 based on care economies.
Confirmation or planned timetable for agreement on metrics and outcome benefits for health and social care.	Majority of metrics identified and included within plans. Missing information to be provided by 4 April submission. Still some further work based on boundary changes required. Agreement this will be in place by Sept 2014.
Confirmation or planned timetable for formal governance arrangements.	Governance arrangements identified within plans, further work may be required up to Sept 2014 on ensuring whole system governance across all care economies.
Confirmation or planned timetable for assurance mechanisms.	Assurance mechanisms identified within plans – some further work may be required up to Sept 2014, utilising revised governance arrangements.
Confirmation or planned timetable for safeguards of non-delivery.	Safeguards identified within plans.

3. Timetable

3.1 Following assurance by the Health and Wellbeing Board the plans will be submitted to NHS England on 4 April alongside CCG Commissioning plans.

3.2 Further work will then take place within each care economy to develop detailed implementation plans.

4. Conclusion

4.1 It was agreed the first draft submission set out the required level of ambition for how Kent will use the Better Care Fund. Work has taken place to address the areas requiring further development and the final plan further identifies how ongoing work be delivered.

5. Recommendation

The Kent Health and Wellbeing Board is asked to:

5.1 **Agree** the BCF plan and **endorse** submission to NHS England.

5.2 **Endorse** the clear commitment to closer integration across health and social care to a programme of clear integration and radical transformation evident within the Bertter Care Fund Plan based upon:

- A 15% reduction of hospital admissions by 2016
- Availability of services on an extended hours basis
- Integrated commissioning of health and social care
- Continued development of enablement services, telecare/teleheatlh, self care and prevention

5.3 **Note** the progress made to meet the areas of development in achieving the final submission.

6. Contact details

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Jo.Frazer@kent.gov.uk

0300 333 5490

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2. Our Vision
3. Our Plan
4. Measuring Success
5. Governance and Management

Appendices

Appendix A	Kent BCF Template
Appendix B	Kent BCF Outcomes and Finances
Appendix C	East Kent BCF Plans (Ashford and Canterbury / Thanet / South Kent Coast)
Appendix D	North Kent BCF Plan (Dartford, Gravesham and Swanley / Swale)
Appendix E	West Kent BCF Plan

Owner: The Kent Health and Wellbeing Board

Date: 26 March 2014

Version No: 2

1. Introduction

Health and social care integration in Kent is about improving outcomes for our 1.5million population by transforming services within the community so they support independent living, empower people and place a greater emphasis on the role played by the citizen and their communities in managing care.

Kent will continue to be bold in developing new and different solutions to the challenges facing health and social care and as Integrated Care and Support Pioneers continue to work through partnerships that support integrated commissioning and deliver the provision of integrated services. We will use the Better Care Fund to continue provide us with the opportunity to go further faster and start the longer programme of transformation provided by being a Pioneer.

By 2015 you will see integrated health and social care teams working 7 days, 24/7 in your local community, wrapped around your GP as the coordinator of your care, bridging the gap between your GP, social care, community health services and your hospital. You will have access to a shared care plan so you and everyone around you know about your care and support.

By 2016 you will be able to access services through a local referral unit, with crisis teams and rapid response and the creation of 'hospitals without walls'. There will be one team, one estate working towards one budget, all with the continued focus on enablement, admission avoidance and crisis intervention.

To reflect the complex picture of health and social care within Kent the Better Care Fund is built from a local level, with 7 area plans, across 3 care economies – giving a complete Kent plan.

"They want to keep us in our home, we want to stay in our own home – and we're going to be!"

2. Our Vision

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

By 2018 we want to achieve an integrated system that is sustainable for the future and crosses the boundaries between primary, community, hospital and social care with services working together, along with voluntary organisations and other independent sector organisations. There will be improved outcomes for Kent's 1.5 million population and includes the Kent £ across the entire health and social care economy.

<u>What does this mean for the people of Kent?</u>

We will use the Better Care Fund to:

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

The Kent Vision – the citizen at the centre with services wrapped around what's important to them.

SERVICES
COMMUNITIES
RELATIONSHIPS
DIGNITY

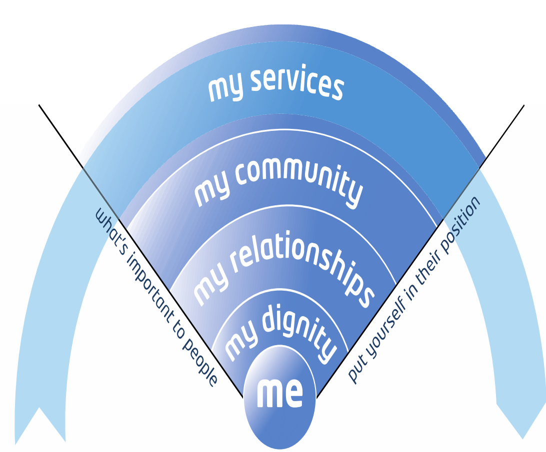
The Kent Better Care Fund

Our Vision of Transformation

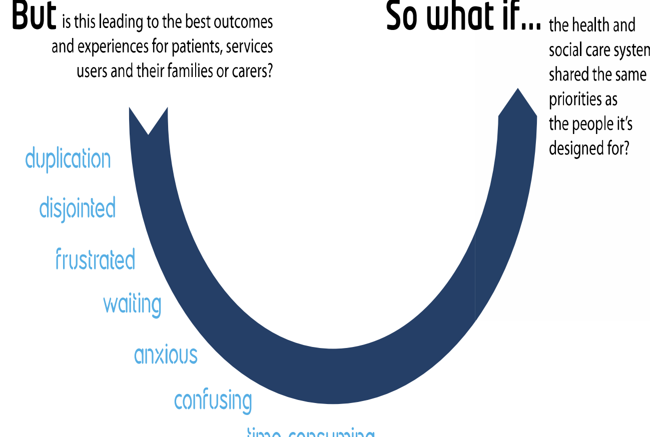
Wellbeing priorities that tend to be held by organisations, practitioners and professionals:

target save managing treatment helping risk effective process safety

Shared wellbeing priorities



But is this leading to the best outcomes and experiences for patients, services users and their families or carers?



So what if... the health and social care system shared the same priorities as the people it's designed for?

Seeing things this way puts the citizen at the centre of the system...

"treating me as a whole person not just my condition"

...and will help us all to create...

...an integrated health and social care system able to assist people to live as independent a life as their needs and circumstances allow.

Bring care closer to home – health and social care in Kent by 2018

Amanda knows that she can receive 24/7 access to community health services and preventative services through her GP or by contacting the local single point of access.

She knows that if the worst should happen and an ambulance is called they will have immediate access to her care plan through her online record. A record of what she wants to happen has been discussed with her by her care co-ordinator, so Amanda has confidence that she is in charge of her support team.

Amanda's family know they can receive an update on her condition when they need it as they've been given access to her care plan.

All services that Amanda comes in to contact with are focused on treating her – a person and not just her condition – she feels confident in the quality of services she's receiving.

3. Our Plan

Kent has an established record of joint commissioning through learning disabilities, mental health and older peoples services. Our plan involves building on existing joint working whilst recognising that we need to increase the scale and pace of what we want to achieve and do some things differently.

The value of the Better Care Fund across Kent is £27m in 2014/15 and £101m in 2015/16, however Kent as a Pioneer wants to go further than this and by 2018 be considering the Kent £ across the entire health and social care economy. This will be achieved through Kent's Pioneer programme, the successful implementation of the Better Care Fund and supported by the updated Health and Wellbeing Strategy.

System Change

It is recognised that the basis of the funding for the Better Care Fund is money that is already committed to health and social care services of many different types. The schemes we have identified in our plan are about applying targeted investment to transform the system and improve outcomes for citizens and the entire care economy. Detailed investment and benefit management plans will be designed throughout 2014/15 in line with CCG and Social Care commissioning plans.

Our Model of Integrated Services

The diagram below outlines the detail Kent will achieve through the Better Care Fund, the tables then capture our plans on a thematic Kent wide level, full detail of local implementation is provided in the appendices. As a whole system Kent is committed to delivering the following:

By 2015 there will be integrated health and social care teams working 7 days, 24/7 in your local community, wrapped around your GP as the coordinator of your care. This will include a focus on dementia and mental health support for patients and carers. Changes in workforce will mean there will be a core team of the GP, generic community nurse teams, named social care professionals, primary care mental health and dementia workers, adult health visitors, health trainers & public health workers. During 2014 we will develop shared information systems with integrated care plan sharing.

During 2015/16 there will be further integration across mental health, community, social care with acute care, palliative care specialist with the voluntary sector/third party providers extending in as required to meet patient needs.

By 2016 you will see acute inpatient services to those who need acute care and the creation of 'hospitals without walls'. There will be a clear interface with out of hours services, local referral units, crisis teams and rapid response with fast community responses within 4 hours to mirror the targets and pressures in the acute trusts.

By 2016 we will have reduced the need for hospital acute admissions by 15% - through having one team, one estate working towards one budget with a focus on enablement, admission avoidance and crisis intervention.

The Kent Better Care Fund

Our Model of Integrated Services

Integrated
days a
week working.

Non Acute Bed Provision:
Consultant and GP support; Integrated Care Centres; Extra Care; Rehab Units; Community Hospital beds; Private Residential and Nursing bed provision.

Integrated Enhanced Rapid Response:
Rapid Response; active reablement; “Going Home Teams”

Crisis Response Services:
Access to shared anticipatory care plans by the ambulance service, enhanced rapid response, enablement services and voluntary sector based crisis response services.

Integrated Long Term Conditions/ Neighbourhood teams:
24/7 access to multi-disciplinary teams coordinated by the GP, inc mental health/dementia; risk stratifying patients; access to one shared care plan for patient & professionals.

Integrated Care and Support: Our Shared Commitment
May 2013
National Collaboration for Integrated Care and Support

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

Integrated Care Home Support:
Integrated teams including Consultant and GP support; Use of technology to Care Homes / Extra Care Housing providers.

Integrated Access:
Integrated Locality Referral Unit;
7 days a week direct access and 24/7 crisis response; Access to shared care plan on an integrated platform.

Integrated Equipment, DFGs, capital adaptations & assistive technologies at the front end of all services, video conferencing with clinicians and development of new pathways.

Improved data sharing
Promotion of NHS number, better exchange of health information, use of the health and social care information centre, patients accessing own health records, GPs linked to hospital data.

Operating model:
Integrated skill mix, assessors accessing integrated care direct: i.e. nurses accessing social care and case managers nursing care, skills for mental health/dementia/learning disability.

Integrated Therapy Services:
in the acute community, social care and housing settings.

The Better Care Fund in action:

The GP practice has a nurse, case manager and dementia nurse working as part of the Neighbourhood Practice team. They also have access to an Enhanced Rapid Response Service. The multi-disciplinary team has agreed with the Clinical Commissioning Group, Social Care and the Acute Trust that they will work to a 4 hour target in responding to acute needs of their patients.

The Ambulance Trust knows that if a 111 call comes in then the community team will respond in 4 hours. The Enhanced Rapid Response Team will come out and will have 24/7 access to health and social care practitioners and a social care private and voluntary sector Crisis Response team who can provide a 72 hour sitting service if needed. The Acute Trust has a Consultant on standby for video consultation and the Out of Hours GP service is able to be involved in a video-conference or come out to the person's home or residential / nursing home for a consultation if needed.

If the ambulance was called out via a 999 call and needs to transport the person to A&E then the A&E triage team is able to call on the Rapid Response Service and take the person back home after an initial assessment. After the Enhanced Rapid Response service has finished , the Intermediate Care or Enablement service will take over for up to 6 weeks reablement and will fully utilise tele-technology in order to make the person as independent as possible.

The professionals, the patient and their carer will be able to communicate through a shared communication system with, at its heart, a shared care or advanced care plan.

The Kent Better Care Fund

First Draft Submission

2014/15 Schemes	Summary Description	Investment £000
Enabling people to return to/or remain in the community.	Working together to improve pathways and ensure “own bed is best”. Ensuring people are provided active reablement and enabled to return home from hospital through enhanced rapid response.	**16527**
Ease of Access to Services / Access to health and social care information.	Continue to improve and enable ease of access to services through extended working hours across 7 days. Providing multi-disciplinary community teams – including GPs and mental health wrapped around the citizen. Citizens and health and social care professionals to have access real time to agreed health and social care information with NHS number as prime identifier, through an integrated platform and shared care plan.	**1611**
Enabling Prevention and Self Care.	Expanded and co-ordinated community capacity to meet the citizen’s priorities without necessarily having to utilise NHS and social care services and resources, working in partnership with Public Health.	**3228**
Expand integrated commissioning of schemes that produce joint outcomes.	Initiatives such as Health and Social Care Co-ordinators improve outcomes across health and social care and help avoid admissions to hospital and residential care. Jointly commissioned services with private providers and the voluntary sector. Development of a joint accommodation strategy to support the needs of Kent.	**531**
Falls prevention exercise classes.	Falls are the principal cause of hospitalisation in the elderly. Implementing a programme of exercise classes has been proven to significantly reduce the risk of falling through improvement of postural stability, muscle strength, balance and confidence. Postural stability classes can support the delivery of fitness, confidence and social interaction. In partnership with funding from Public Health.	**166**
CCG area schemes to increase pace and scale of transformation.	Including developing enhanced rapid response, integrated discharge referral service, integrated urgent care/LTC model, Neighbourhood Care Teams, shared information systems with integrated care plan sharing.	**5136**
	Total	**£27m**

The Kent Better Care Fund

First Draft Submission

2015/16 Schemes	Summary Description	Investment £000
Integrated working through local models that deliver 7 day access including: Enhanced Rapid Response Integrated Discharge Referral Service Integrated urgent care/LTC model. Neighbourhood Care Teams	Improved services wrapped around the citizen, accessible 24/7 through the commissioning and delivery of: Wider use of enhanced rapid response services. Integrated Long Term Condition Teams, with GPs coordinating care and involving mental health and dementia services. Integrated contacts and referrals, where possible through a single point of access. Workforce development and access to specialist input such as community geriatricians. Provision for mental health and dementia within all services.	Total across all CCG areas on schemes: **77132**
Enhanced support to residential and nursing homes	Ensure people have anticipatory care plans in place. Enable consultant access via technology – video-conferencing, improved access to integrated health and social care team. Community Geriatrician projects – to support care homes out of hours and at weekends.	
Develop models that support pro-active care	Support the principle of unequal investment to close the health inequality gap by addressing specific needs in specific areas to improve health outcomes. Minimise the use of physical resources i.e. hospital buildings and maximise the use of human resources i.e. a skilled workforce with a multi-disciplinary health and social care approach.	
Self-Care/Self-Management	Co-produce with patients, service users, public and voluntary and community sector improvements in self-care. Including care navigators, advanced assistive technology, patient held records and the development of Dementia Friendly Communities.	
Section 256 Social Care to Benefit Health	Ensure existing services commissioned under 256 agreements are aligned to the objectives of transforming integrated working and continue to protect social care.	**27200**

Disabled Facilities Grant	Equipment and adaptations are a key enabler to maintaining independence we will work with Districts to consider future actions required in delivering DFG.	**7208**
ASC Capital Grants	Home support fund and equipment.	**3432**
Implementation of the Care Bill	Carers assessments and support services; Safeguarding Adults Boards; and national eligibility.	**3541**
Carers support	Continue to develop carer specific support – including carers breaks.	**3443**
	Total	**£122m**

4. Measuring Success

Kent will continue to measure success against the outcomes identified as being an Integrated Care and Support Pioneer, including using the I Statements to measure improved outcomes for people.

The Kent plan will also contribute to meeting the 5 outcomes identified within the Kent Health and Wellbeing Strategy:

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

As part of the Better Care Fund Plan we will also measure against the national metrics and Kent's agreed local metrics. Local area plans may have additional metrics as required.

Metric	Definition
Permanent admissions to residential and care homes	Reduction in admissions based on rate of council-supported permanent admissions to residential and nursing care.
Effectiveness of reablement – those 65+ still at home 91 days after discharge.	Range to be between 82-88% and not show a reduction over 2 years.
Delayed transfers of care	Reduction in DTOC using total number of delayed transfers of care for each month.
Avoidable emergency admissions	Up to a 15% reduction in admissions.
Patient / service user experience	Kent will use the national metric implemented in 2015/16.
Local Metrics: Social Care Quality of Life Injuries due to falls in people aged 65 and over	Further local metrics may be used at CCG level; however as part of the Kent HWB dashboard improvements will be required in quality of life and reduction in injuries due to falls.

5. Governance and management of the Better Care Fund

Kent's governance for delivering as an Integrated Care and Support Pioneer is set out below, the responsibility and management of the Better Care Fund will sit within this. Existing governance structures will ensure delivery and the Integration Pioneer Steering Group provide advice and guidance.

The risks and mitigations associated with the Better Care Fund are outlined in Appendix A. Any additional local governance for delivery of area plans is also outlined in appendices.

Kent is committed to engaging and involving with the public and wider stakeholders and as a Pioneer will use ICASE (www.icase.org.uk) as a mechanism to provide updates on our progress within integration and the implementation of the Better Care fund.

The Kent Health and Wellbeing Board
Health DMT
Integration Pioneer Steering Group

Delivery through existing governance
Local HWBs
Whole Systems / Urgent Care Boards
CCG/ District/ KCC/ Provider Level Boards
Integrated Commissioning Groups
Additional Programme/ Project Groups

Kent £ BCF
Communication

Working on aims, principles and priorities
Personalisat ion
Contracting Models
Self-care
Innovation Hub
Year of Care
EOL Care
Workforce
Engagement
Research
Evaluation
Housing
IT

Outcome Measures

The Better Care Fund in action:

"The professionals involved with my care talk to each other. We all work as a team."

Sarah (care manager and trained nurse) is making a home visit today to re-assess Dorothy after she experienced a fall. Sarah is updating Dorothy's electronic anticipatory care plan with both Dorothy and her son. Sarah is able to carry out both routine health and social checks on Dorothy and update her plan accordingly.

Sarah has noticed Dorothy had previously been in attendance at the falls clinic and makes contact directly to update on the recent fall an appointment is made to attend the clinic for a routine check-up. Sarah noticed Dorothy's blood pressure was a little high: From reading Dorothy's patient held record she can see Dorothy was supported by the NCT after a discharge from hospital, Sarah makes contact with the named nurse and informs of current health check, again a routine appointment is made for one of the community nurses to visit and check Dorothy's blood pressure over the next few days.

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Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission. Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Kent County Council**
Clinical Commissioning Groups	**Dartford Gravesham and Swanley**
	Swale
	West Kent
	Ashford
	Canterbury and Coastal
	South Kent Coast
	Thanet
Boundary Differences	**There are some boundary differences between CCGs and District authorities. Swale CCG has a 20% flow from Swale to Medway Foundation Trust. In developing the plan discussions with these areas has taken place to ensure consistency of outcomes.**
Date agreed at Health and Well-Being Board:	**26 March 2014**
Date submitted:	**4 April 2014**
Minimum required value of BCF pooled budget: 2014/15	**£5136m**
2015/16	**£101m**
Total agreed value of pooled budget: 2014/15	**£27m**

2015/16	**£122m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**Dartford Gravesham and Swanley**
By	Patricia Davies
Position	Accountable Officer
Date	<date>
Signed on behalf of the Clinical Commissioning Group	**Swale**
By	Patricia Davies
Position	Accountable Officer
Date	<date>
Signed on behalf of the Clinical Commissioning Group	**West Kent**
By	Ian Ayres
Position	Accountable Officer
Date	<date>
Signed on behalf of the Clinical Commissioning Group	**Ashford**
By	Bill Millar
Position	Chief Operating Officer
Date	<date>
Signed on behalf of the Clinical Commissioning Group	**Canterbury and Coastal**
By	Bill Millar
Position	Chief Operating Officer
Date	<date>
Signed on behalf of the Clinical Commissioning Group	**South Kent Coast**
By	Hazel Carpenter
Position	Accountable Officer
Date	<date>
Signed on behalf of the Clinical Commissioning Group	**Thanet**
By	Hazel Carpenter
Position	Accountable Officer
Date	<date>
Signed on behalf of the Council	**Kent County Council**
By	Andrew Ireland
Position	Corporate Director, Social Care, Health and Wellbeing
Date	<date>

Signed on behalf of the Health and Wellbeing Board	Kent Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Roger Gough
Date	<date>

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c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it.

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

The current work on the Health and Social Care Integration Programme takes place through HASCIP Steering Groups which are groups of commissioners and providers from health, social care and the voluntary and community sector.

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

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

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

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

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

West Kent

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

North Kent

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

East Kent

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

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

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

Further work will be taking place with providers on the design and implementation of the Better Care Fund schemes through the Integration Pioneer Programme and Whole System Boards. This will include a number of "summit" events at a care economy level engaging with commissioners, providers and local government representatives. An example of this approach took place in North Kent on 29th January 2013.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

The blueprint for Kent becoming an Integrated Care and Support Pioneer is based on detailed engagement with patients, service users and the public. Kent Healthwatch has assisted in the development of the Kent Pioneer Delivery plan and is assisting in outlining the evaluation of objectives and outcomes against I Statements. Further engagement activity has also been undertaken as part of Call to Action.

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

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

North Kent
The plans are aligned with commissioning plans, which are informed by stakeholder engagement via a series of open forum workshops. Further patient engagement took place during a review of community services in 2013. Outcomes from this have been used to inform the BCF proposals.

East Kent
Elements of the BCF include schemes already in included in CCG operational plans for 2014/15 and a range of local engagement activities have been undertaken in preparation for this. For elements that are an enhancement or an addition to the operational plans ongoing engagement activities will be undertaken to ensure our clinically led plans are tested on the patients and service users the plans impact upon.

KMCS have undertaken work with CCG patient participation groups to explore how the I Statements relate to integrated care currently being received and future developments. This has informed the development of CCG plans.

On a local level there is sustained involvement with the public through patient

participation groups and the local health and social care integration implementation groups. HASCIP Steering Groups on a local level have patient and service user representatives and as part of the operational integration programme regular surveys on integrated care are undertaken with patients by Kent Community Health NHS Trust and inform operational implementation and strategic planning. Adult Social Care is currently undertaking a survey with service users on their current experiences of integrated care and support. The outcomes of this survey will be used to inform further development within integration and can help inform implementation of the BCF plan. Kent is committed to meaningful engagement and co-production with the public and wider stakeholders and as a Pioneer will use ICASE (www.icase.org.uk) as a mechanism to provide updates on our progress within integration and the implementation of the Better Care fund. The communication leads from across all partners are working together to develop and integrated communication strategy. Following the Kent Health and Wellbeing Board on 12 February the Kent plan has been shared via www.kent.gov.uk with a link to the HWB webcast, the draft plans, a summary presentation and questionnaire on the contents of the plan. Kent Healthwatch have assisted in the promotion of the feedback mechanism for the draft BCF plan and are engaged on developing an action plan to further involve the public on design and delivery of the schemes within the plan.

e) Related documentation

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

Document or information title	Synopsis and links
Joint Strategic Needs Assessment	**http://www.kmpho.nhs.uk/commissioning/needs-assessments/**
Kent Health and Wellbeing Strategy	**http://www.kmpho.nhs.uk/commissioning/needs-assessments/**
Kent Integrated Care and Support Programme Plan	**Pioneer Delivery Plan** 1402 delivery plan v01 .pdf
HWB Assurance Framework	
Kent HWB BCF Mapping Exercise	**Summary included** HWB analysis template.xlsx

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VISION AND SCHEMES

a) Vision for health and care services
Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

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

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

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

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

The focus will be on supporting people to self-manage and coordinate their own care as much as possible, facilitated by integrated electronic records and care plans. GPs will lead community based multi-disciplinary teams, with access to outreach from specialists, mental health, dementia support as required to provide targeted, proactive care and support to those people identified as being of highest risk of hospital attendance or increasing use of care services. We will work in partnership with the voluntary and community sector and District Authorities recognising the contribution they make in ensuring we achieve the levels of transformation required.

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.

The use of the Better Care Fund will contribute to improving the outcomes identified within the HWB Strategy:

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

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

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

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

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

Integrated Commissioning:

- Together we will design and commission new systems-wide models of care that ensures the financial sustainability of health and social care services in Kent. These services will give people every opportunity to receive personalised care at, or closer to home to avoid hospital and care home admissions.

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

Integrated Provision:

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

As identified the Kent Health and Wellbeing Strategy has identified key performance measures, these are currently being updated and will include measures for integration. The Kent plan will also contribute to meeting the outcomes identified within the Health and Wellbeing Strategy.

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

As part of the Year of Care Programme Kent has undertaken a whole system analysis of the population which helps to identify improvements across the system. Public Health will work with key organisations to develop an information system that monitors and

evaluates the YOC programme, through its shadow testing phase in 14/15 and its anticipated implementation from 15/16 alongside national rollout. The same system will also be used to help evaluate integrated care models across different CCGs and understand their impact on the whole system.
Results of the whole system analysis indicate a ‘crisis curve’ utilisation of non-elective hospital admission activity and spend, over a 3 year period, in the high intensive users / frequent re-attenders who are concentrated mainly in the top 5% of the risk stratified population. The remaining 95% of the population did not appear to show similar ‘crisis curve’ activity. Illustrating the difference in activity attributed to ‘crisis’ in high risk patients gives us a better understanding how and when to target them using a proactive preventative integrated model of care. Risk stratification can be used to help GPs identify next year’s Band 1 patients before they enter ‘crisis’.

Details of results and analyses described at both CCG and Kent level profiles are available at www.kmpho.nhs.uk/jsna.

Description of planned changes
Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The schemes outlined below for 2014/15 and 2015/16 form part of the overall programme delivery plan for Kent as an Integrated Care and Support Pioneer (attached as supplementary information). The Pioneer programme has been developed as a phased approach across 3 overlapping waves, which take the whole system to the integrated commissioning of integrated health and social care provision. The key themes of delivery are underpinned by the Better Care Fund and are presented as:

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

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

Discussions have taken place across CCG areas with providers on the impact of implementing the schemes within the Better Care Fund plan. Further work is scheduled to take place across each care economy to develop the detailed actions required for delivery. Areas such as North Kent will be working with partner agencies The Kings Fund and Newton Europe to further refine implementation of the schemes within the Better Care Fund.

2014/15 Schemes	Description	HWB outcomes and national conditions supported by scheme
Enabling people to return to/or remain in the community - Assessment beds - Residential placements from hospital - Domiciliary care packages from hospital - Enablement - Crisis and carers response	Working together to improve pathways and ensure “own bed is best”. Discharge models increasing enablement. To develop care management capacity to prevent admissions and enable earlier discharge. To develop specialist discharge pathway tools (e.g. checklist) to ensure that new and innovative solutions are being considered. Increased assessment capacity outside acute wards, increased number of people discharged home.	• The quality of life for people with long term conditions is enhanced and they have access to good quality care and support. • 7 day services to support discharge and prevent unnecessary admissions. • Joint approach and coordinated care planning. • Protection of social care services.
Ease of Access to Services / Access to health and social care information - Enablement capacity - Case management and senior cover - Purchasing officers - Equipment	Continue to improve and enable ease of access to services through extended working hours across 7 days. Providing multi-disciplinary community teams – including GPs and mental health wrapped around the citizen. Citizens and health and social care professionals to have access real time to agreed health and social care information with NHS number as prime identifier, through a patient held record or electronic access card. Adult Social Care will continue the implementation of NHS numbers as the prime identifier within correspondence.	• 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. • 7 day services to support discharge and prevent unnecessary admissions. • Joint approach and coordinated care planning. • Protection of social care services • Effective prevention of ill health by people taking greater responsibility for their health and wellbeing.

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2014/15 Schemes	Description	HWB outcomes and national conditions supported by scheme
		• Better data sharing between health and social care.
Enabling Prevention and Self Care - Assistive Technology - Dementia services (cafes , peer support, web) - Carers - Befriending and personalisation - Autistic Spectrum Conditions - LD pathway to enablement and safeguarding	Expanded and co-ordinated community capacity to meet the citizen's priorities without necessarily having to utilise NHS and social care services and resources. The Kent Self-Management Steering Group is delivering an action plan as part of the Pioneer Programme which will include the development in 2014 of a methodology for self-care across Kent.	• Effective prevention of ill health by people taking greater responsibility for their health and wellbeing. • Protection of social care services.
Expand integrated commissioning of schemes that produce joint outcomes.	Initiatives such as Health and Social Care Co-ordinators improve outcomes across health and social care and help avoid admissions to hospital and residential care. Jointly commissioned services with private providers and the voluntary sector. Development and implementation of a joint accommodation strategy to support the needs of Kent.	• The quality of life for people with long term conditions is enhanced and they have access to good quality care and support. • Joint approach and coordinated care planning. • Protection of social care services
Falls prevention exercise classes – as part of an integrated falls pathway	Falls are the principal cause of hospitalisation in the elderly. Implementing a programme of exercise classes has been proven to significantly reduce the risk of falling through improvement of postural stability, muscle strength, balance and confidence. Postural stability classes can support the delivery of fitness, confidence and social interaction. Expansion of the West Kent scheme across East Kent, in partnership with Public Health, CCGs and District authorities.	• The quality of life for people with long term conditions is enhanced and they have access to good quality care and support. • Effective prevention of ill health by people taking greater responsibility for their health and wellbeing.

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2015/16 Schemes	Description	HWB outcomes and national conditions supported by the scheme
Integrated working through local models that deliver 7 day access:	West Kent: Enhanced rapid response service. Integrate LTC teams, with GPs coordinating care and involving mental health and dementia services. Integrated contacts and referrals, workforce implications and access to specialist input such as community geriatricians. Ensure provision of mental health and dementia is within all services. North Kent: Integrated Primary Care Teams, local referral unit, crisis response, integrated discharge team. Ensure provision of mental health and dementia is within all services East Kent: Integrated Teams and reablement, enhanced rapid response, enhanced primary care, neighbourhood care teams and care-coordination. Integrated urgent care centre. Ensure provision of mental health and dementia is within all services.	• The quality of life for people with long term conditions is enhanced and they have access to good quality care and support. • People with mental ill health issues are supported to live well. • People with dementia are assessed and treated earlier • Joint approach and coordinated care planning. • Better data sharing between health and social care. • 7 day services to support discharge and prevent unnecessary admissions. • Plans jointly agreed.
Enhanced support to residential and nursing homes	West Kent: Ensuring people have anticipatory care plans in place. Enable consultant access via technology. North Kent: Crisis response service, use of anticipatory care plans. East Kent: Anticipatory care plans, discharge plans and Community Geriatrician projects – to support care homes out of hours and at weekends. Peer support and medicines management programmes.	• The quality of life for people with long term conditions is enhanced and they have access to good quality care and support. • People with mental ill health issues are supported to live well. • People with dementia are assessed and treated earlier • Joint approach and coordinated care planning.
Develop models that support pro-active care	West Kent: Support the principle of unequal investment to close the health inequality gap by addressing specific needs in specific areas to improve health outcomes. Minimise use of physical resources	• Joint approach and coordinated care planning. • Plans jointly agreed.

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2015/16 Schemes	Description	HWB outcomes and national conditions supported by the scheme
	i.e. hospital buildings and maximise use of human resources i.e. skilled workforce with a multi-disciplinary health and social care approach. North Kent: Community Hospital re-design and estate configuration using evidence from the Oaks Group and Kings Fund. Development of skilled workforce with a multi-disciplinary health and social care approach. East Kent: Integrated approach to local housing and accommodation. Development of a community hub model. Development of skilled workforce with a multi-disciplinary health and social care approach.	
Self-Care/Self-Management	West Kent: Co-produce with patients, service users, public and voluntary and community sector improvements in self-care. Including care navigators, advanced assistive technology, patient held records and the development of Dementia Friendly Communities. North Kent: United approach to advice and information on community and public sector, investment in community capacity and the further development of Dementia Friendly Communities. East Kent: Falls prevention services, integrated personal budgets, care-coordinators and Health Trainers, use of the voluntary sector and development of Dementia Friendly Communities.	• Effective prevention of ill health by people taking greater responsibility for their health and wellbeing. • The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.
Section 256 Social Care to Benefit Health	Ensure existing services commissioned under 256 agreements are aligned to the objectives of transforming integrated working and continue to protect social care.	• The quality of life for people with long term conditions is enhanced and they have access to good quality care and support. • Effective prevention of ill

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2015/16 Schemes	Description	HWB outcomes and national conditions supported by the scheme
		health by people taking greater responsibility for their health and wellbeing. • 7 day services to support discharge and prevent unnecessary admissions. • Joint approach and coordinated care planning. • Protection of social care services.
Disabled Facilities Grant	Equipment and adaptations are a key enabler to maintaining independence we will work with Districts to consider future actions required in delivering DFG.	• The quality of life for people with long term conditions is enhanced and they have access to good quality care and support. • Effective prevention of ill health by people taking greater responsibility for their health and wellbeing. • 7 day services to support discharge and prevent unnecessary admissions.
ASC Capital Grants	Home support fund and equipment.	• The quality of life for people with long term conditions is enhanced and they have access to good quality care and support. • Effective prevention of ill health by people taking greater responsibility for their health and wellbeing. • 7 day services to support discharge and prevent unnecessary admissions • Protection of social care services.
Implementation of the Care Bill	Carers assessments and support services; Safeguarding Adults Boards; and national eligibility.	• The quality of life for people with long term conditions is enhanced and they have access to good quality care and support. • Effective prevention of ill health by people taking greater responsibility for their health and wellbeing. • 7 day services to support discharge and prevent unnecessary admissions Protection of social care services.

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2015/16 Schemes	Description	HWB outcomes and national conditions supported by the scheme
Carers support	Continue to develop carer specific support – including carers breaks.	• The quality of life for people with long term conditions is enhanced and they have access to good quality care and support. • Effective prevention of ill health by people taking greater responsibility for their health and wellbeing. • People with mental ill health issues are supported to live well. • People with dementia are assessed and treated earlier

c) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

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

In order to achieve the level of cost reduction required there will need to be significant reduction in the level of emergency admissions and A&E attenders in the acute care setting. By the end of 2015/16 the target level of avoided urgent care admissions ranges across CCGs from up to 5% of the level of today's emergency admissions, with a target end point of 15%.

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

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

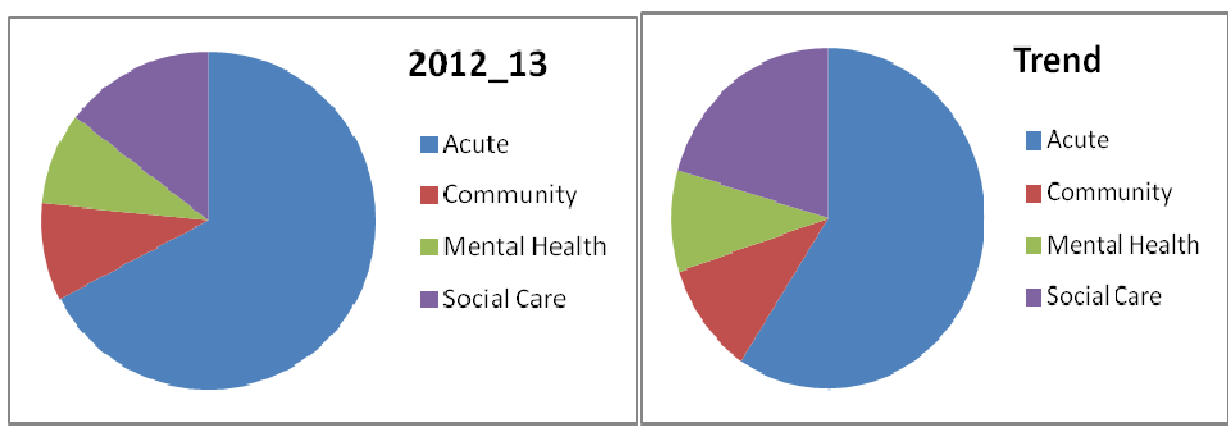
Detailed investment and benefit management plans will be designed throughout 2014/15 in line with CCG and Social Care commissioning plans. A summary of the local plans is:
West Kent: Mapping the Future sets out ambitious targets for reducing urgent care costs by £25m by 2018-19. Our plans for the forthcoming operating plan period up until the end of 2015-16 is to secure cost reductions totalling £10m. In order to drive out this level of cost reduction, there will need to be significant reduction in the level of emergency admissions and A&E attenders in the acute care setting. By the end of 2015-16 the target level of avoided urgent care admissions could represent up to 18% of the level of today's emergency admissions.

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

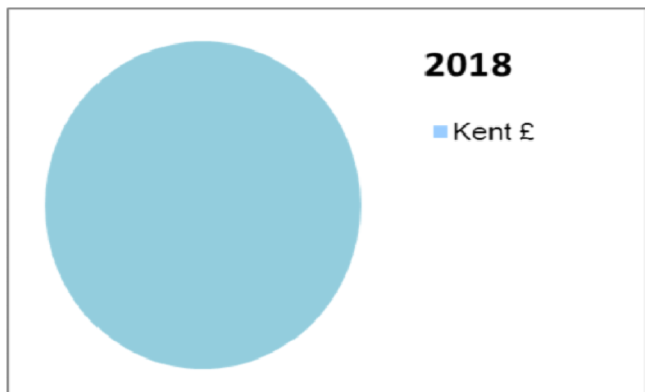
- For DGS CCG this results in reduction in cost of NEL admissions of £8m (4.1m in 2014/15, and 3.9m in 2015/16).
- For Swale CCG this results in reduction in cost of NEL admissions of £2.9m (1.5m in 2014/15, and 1.4m in 2015/16).

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

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



Appendix A Kent Submission v2



d) Governance
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

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

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

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

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

NATIONAL CONDITIONS

a) Protecting social care services
Please outline your agreed local definition of protecting adult social care services.

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

Significant numbers of people with complex needs, who live in their own homes, want to stay and be supported in their own homes. They do not require daily support from health but have needs that would change and deteriorate without social care contribution to their support. This includes support for loss of confidence and conditions that have changed

but do not require acute intervention from hospital or GP but do require enablement services from social care to regain their previous levels of independence. By providing effective enablement where a person has either been discharged from an acute setting or is under the care of their GP, admission or readmission can be prevented.

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

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

Please explain how local social care services will be protected within your plans.

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

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

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

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

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

West Kent

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

North Kent

Multiagency Executive Programme Boards are in place where programmes have been agreed and are monitored. This includes delivery of schemes to reduce emergency admissions and facilitate discharge of patients – including implementation of an integrated discharge team, based

within the local acute Trusts 7 days per week to reduce emergency admissions and facilitate discharge.

East Kent
All schemes within the local CCG plans require accessible 7 day a week service to support patients being discharged from hospital and prevent unnecessary admissions at weekends. In Thanet the Universal Care Team is the main structure for providing post hospital care for any reason and some pre-admission intervention in the community. In South Kent Coast the enhanced multidisciplinary Neighbourhood Care Team is the main structure for providing post hospital care for any reason and some pre-admission intervention in the community. Ashford and Canterbury will develop a detailed plan for a 7 day service during 2014/15 as part of capacity modelling for implementation in 2015/16.

Kent is also committed to effective reablement to ensure people remain at home or are facilitated to return home, supported across Kent by enhanced rapid response and urgent care services to further support admission avoidance and timely discharge. This includes a commitment to community responses within 4 hours to mirror the targets and pressures in the acute trusts.

c) Data sharing
Please confirm that you are 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.

Please confirm that you are committed to 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 confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise 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
Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

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

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

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

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

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

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

Appendix A Kent Submission v2

RISKS
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

Monitoring of risks and required contingencies will take place at a care economy level as outlined in the Governance section and via contract monitoring mechanisms.

Risk	Risk rating	Mitigating Actions
Shifting of resources will destabilise existing providers, particularly in the acute sector	**HIGH**	• The development of our plans for 2014/15 and 2015/16 will be conducted within the framework of our Kent Pioneer Programme. • This facilitates whole system discussions and further work on co-design of, and transition to future service models.
Workforce and Training – The right workforce with the right skills will be required to deliver integrated models of care. A shift in the model of care delivery will impact on training requirements. Additional risk is presented by age demographics of GPs and future resources impacted by retirement.	**HIGH**	• Workforce and training is a key objective of Kent's Integration Pioneer Programme. • A programme of work is structured to explore the requirements of future workforce and implement changes to meet these requirements.
Primary care not at the centre of care-coordination and unable to accept complex cases.	**HIGH**	• Engagement with clinical leads and primary care providers essential as part of implementation of the BCF and Pioneer programme.
The introduction of the Care Bill will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	**HIGH**	• The implementation of the Care Bill is part of the schemes within the BCF; further work is required to outline impact and mitigation required.
Cost reductions arising from a reduction in urgent care admission do not materialise	**HIGH**	• 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications. • Implementation supported by Year of Care as an early implementer site.

Cost reductions arising from a reduction in occupied bed days do not materialise	**HIGH**	• 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications. • Implementation supported by Year of Care as an early implementer site.
Cost reductions arising from a reduction in residential and care homes do not materialise	**HIGH**	• 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications. • Implementation supported by Year of Care as an early implementer site.
Reductions in delayed transfer of care are not achieved	**HIGH**	• 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications. • Implementation supported by Year of Care as an early implementer site.
Protection of social care is not achieved.	**HIGH**	• 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications. • Implementation supported by Year of Care as an early implementer site.

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Kent County Council			44824	44824
Dartford Gravesham and Swanley		4038	9759	14947
Swale		1779	4272	6556
West Kent		8310	16054	16054
Ashford		2136	4621	4621
Canterbury and Coastal		3789	7808	12077
South Kent Coast		4338	7923	13283
Thanet		2810	6143	9594
BCF Total		27200	101404	121956

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

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

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

Regular review through identified governance structures will be required to ensure whole system buy-in and there will be additional overview through contract monitoring and balance.

Contingency plan:	2015/16	Ongoing

Contingency figures are based on CCG level information and can be found within CCG level plans

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Enabling People to return to/or remain in the community	KCC	16527		See attached document outlining benefits realised from Adult Social Care Transformation					
Ease of access to services	KCC	1611							
Self Care & Prevention	KCC	3228							
Postural Stability	KCC	166							
Expand integrated commissioning of schemes that produce joint outcomes	KCC	531							
CCG area schemes that increase pace and scale of transformation	KCC	5136							
2015/16 Schemes									
Ashford Schemes	CCG					4621		Benefits for schemes are identified in CCG Area plans. Whole system benefits will be identified as via Year Of Care and further whole system analysis.	
Canterbury Schemes	CCG					12077			
North Kent Schemes	CCG					21503			
South Kent Coast Schemes	CCG					13283			
Thanet Schemes	CCG					9594			
West Kent Schemes	CCG					16054			
Section 256 Social Care to Benefit Health	KCC					27200			
Disabled Facilities Grant	District/KCC					7208			
ASC Capital Grants	KCC					3432			
Implementation of the Care Bill	KCC					3541			
Carers support	CCGs/KCC					3443			
Total		***27200***				***121956***			

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

The aims and objectives within Kent's BCF and Pioneer Programme will have a suite of measures that can be monitored and evaluated. This will be provided via the HWB assurance framework. Additional local metrics as detailed in CCG area plans will also be utilised. The performance metrics identified within the Better Care Fund will be implemented as follows:

Permanent admissions to residential and care homes: There will be a reduction in admissions based on rate of council-supported permanent admissions to residential and nursing care. This performance indicator will enable us to measure our success in preventing people from deteriorating to a level where they need residential or nursing care on a permanent basis. In order to achieve this, we will ensure that people are supported to live at home for as long as possible through provision of support through our integrated care centres, intermediate care, provision of enablement and telecare/ telehealth services. This will positively impact on people being discharged from hospital.

Kent currently performs well compared to the rates for England, the South-East and comparator local authorities on this performance indicator (2012/13 data). We expect to see 41 fewer permaner

Effectiveness of reablement – those 65+ still at home 91 days after discharge: Range to be between 82-88% and not show a reduction over 2 years. This performance indicator will enable us
Kent currently perform well compared to the rates for England, the South-East and comparator local authorities on this performance indicator (2012/13 data).

This metric will be measured using social care datasets and is available nationally.

Delayed transfers of care: Reduction in DTOC using total number of delayed transfers of care for each month.

Avoidable emergency admissions: There will be a 15% reduction in admissions.

Local Metrics:
Social Care Quality of Life: Whilst overall satisfaction with health and social care services is good, we aim to ensure that people's quality of life is improved with the support that they receive. We wou
Injuries due to falls in people aged 65 and over
Further local metrics may be used at CCG level, however as part of the Kent HWB dashboard improvements will be required in quality of life and reduction in injuries due to falls.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

Kent will be using the national metric for 2015/16

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

All performance indicators will be monitored to identify early warnings of risk and failures of service delivery. The Integrated Commissioning Groups, Whole System Boards will oversee this process and will report directly to both the local Health and Wellbeing Board and to the senior management teams of our commissioning and provider partners. This approach will encourage and enable multi-organisational management and responsibility.

Further assurance will be via the Kent HWB assurance framework and the Integration Pioneer Steering Group. Additional Year of Care will provide valuable insight in to the impact of schemes, the ongoing development of the detail of these schemes will be in partnership with providers.

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	782.67	N/A	737.21
	Numerator	2169		2043
	Denominator	277127		277127
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	84.04%	N/A	85%
	Numerator	1348		
	Denominator	1604		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month) *Kent Metric to be completed by 4 April based on CCG Area submissions*	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure) *Kent Metric to be completed by 4 April based on CCG Area submissions*	*Metric Value*			
	Numerator			
	Denominator			
		(TBC)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience *Kent will be using the national metric (under development) - in addition CCG Areas have indicated local patient experience measures.*			N/A	
		(insert time period)		*(insert time period)*
Social Care Quality of Life	*Metric Value*	18.8		19
	Numerator			
	Denominator			
		(April 2012 - March 2013)	*(insert time period)*	(April 2014 - March 2015)
Injuries due to falls in people aged 65 and over *Kent Metric to be completed by 4 April based on CCG Area submissions*	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	*(insert time period)*	*(insert time period)*

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Better Care Fund Plan Protection of Social Care – Summary of Benefits Delivered through KCC Adult Social Care Transformation Programme 2014/15 and 2015/16

Kent's Adult Social Care Transformation Programme is structured around three major workstreams:

- **Optimisation**
  Enhancing productivity through best use of resources, unblocking system and process barriers, reducing interfaces and matching staffing profile to activity throughout the whole system – including integrated provision where appropriate.

- **Care Pathway Transformation**
  Re-engineering the existing care pathway to ensure that demand is proactively managed through having the right services in the right place and that people entering into the system are able to receive the most appropriate service, which focuses on promoting their independence – including integrated pathways where appropriate.

- **Commissioning**
  Shaping the market to ensure outcome-focused service delivery models aligned with current and future user requirements, this includes integrated commissioning with partners and pooled budget arrangements. Achieving better value for money through strategic commissioning and better procurement.

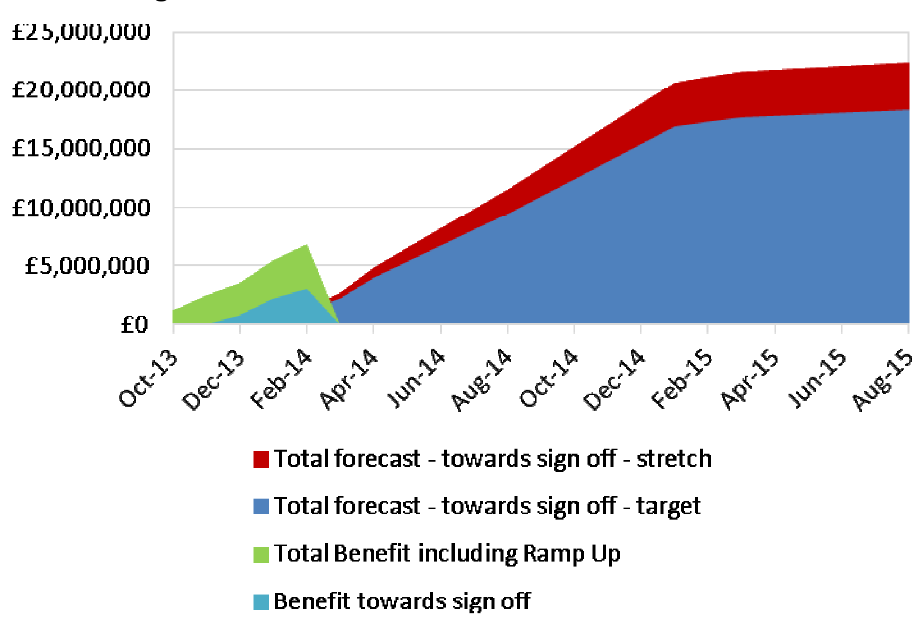
This document outlines some of the key benefits realised within Social Care Transformation and how they relate to associated schemes within the Better Care Fund to protect Adult Social Care.

Care Pathways

The Adult Social Care pathway, aligned to a focus on promoting independence, will be consciously refined to ensure that is doesn't 'suck' people into the system inappropriately, in such a way as to inadvertently increase an individual's dependency on direct care provision. Where possible the services within the pathway will support people to live independently in the community.

BCF Schemes: Ease of Access to Services / Access to health and social care information

Benefit Progress identified:



Better Care Fund Plan Protection of Social Care – Summary of Benefits Delivered through KCC Adult Social Care Transformation Programme 2014/15 and 2015/16

Telecare

Metric	Value
Total over baseline since start of project	**510**
Total programme benefit	**£1,397,155**
Date of "full rollout"	**1/3/2014**
Benefit since "full rollout"	**£0**
Projected saving at current activity level	**£3.63 million**

Enabling Prevention and Self Care

Enabling people to return to/or remain in the community

An increase in Assistive Technology Complex installations lowering the reliance on domiciliary care and delaying placement admission.

Residential Avoidance

Metric	Value
Total over baseline since start of project	**27**
Total programme benefit	**£151,512**
Date of "full rollout"	**1/12/2014**
Benefit since "full rollout"	**£110,421**
Projected saving at current activity level	**£662,000**

Enabling people to return to/or remain in the community

The principal objective of the pathway is to support people to live independently in the community.

Enablement will be a key element of the overarching care management strategy.

The aim of the enablement service is to stabilise the crisis, prevent immediate escalation, and initiate recovery wherever possible. This will not only reduce demand for residential placement, but also promote independence. The suite of possible 'enablement interventions' will include: the enablement service, the use of assistive technology, community services which promote interaction and support emotional well-being.

Better Care Fund Plan Protection of Social Care – Summary of Benefits Delivered through KCC Adult Social Care Transformation Programme 2014/15 and 2015/16

Promoting Independence Reviews

Metric	Value
Total programme benefit since start of project	**£924,770**
Date of "full rollout"	**1/3/2014**
Benefit since "full rollout"	**£0**
Projected saving at current activity level	**£2.74 million**

Enabling Prevention and Self Care

Enabling people to return to/or remain in the community

Promoting Independence Reviews has initiated a change of reviewing method, using the full suite of preventative interventions and third sector services to promote more independent outcomes for service users.

Demand Management Project

Metric	Value
Total over baseline since start of project	**IAG 187.5** **FT 130.3**
Total programme benefit	**£149,735**
Date of "full rollout"	**1/5/2014**
Benefit since "full rollout"	**£0**
Projected saving at current activity level	**£522,000**

Enabling people to return to/or remain in the community

Ease of Access to Services

Reengineering the care pathway to ensure the maximum number of people come through Enablement services when appropriate, seeking to stabilise the crisis, prevent immediate escalation, and initiate recovery wherever possible. This not only reduces demand for residential placement, but also promotes independence.

Alongside financial benefits of social care transformation productivity is also increasing, further work will be done to identify the benefits of this to the entire health and social care system.

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Ashford Clinical Commissioning Group

Draft Better Care Fund Plan
NHS Ashford Clinical Commissioning Group

No	Scheme	Description of Scheme	Outcome Measures	High Risks
1	**Integrated Health and Social Care Team** **"Cluster Team"**	We will continue to develop our integrated health and social care team to ensure that they will be available 24 hours a day seven days a week and will be contactable through a single access points. The "Cluster Team" will be focussed on both ends of the patient journey, through supporting patients, carers, social services and clinicians to avoid the need for patients to be admitted to hospitals, however where this is necessary the team will mobilise to ensure timely discharge of the patient. These teams will ensure wider integration with other community and primary care based services, including voluntary sector provided services, as well as hospital specialists working out in the community. The ultimate aim is to enable people to be cared for in their own homes or within their own community. The aim of team is to support people to self-manage and to be independent in their own homes. The model requires specialist input from across the social care, health and voluntary sectors to enable the management of care for more patients in the community for a range of specialisms including the care of the over 75s, this will include undertaking clinics and reviews of patients in or close to their own homes rather than in hospital. This would include actual and remote approaches supported through the use of technology, such as video conferencing with acute specialists.	• Reduced emergency admissions; • Reduced A&E attendances; • Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia; • Improve patient, carers' and relatives' experience; • Improve health and social outcomes; • Reduced length of stay across the health and social care	• Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability. • Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and

	SCHEME REQUIREMENTS: • Aligned to geographical areas the support will be accessible 24 hours a day seven days a week and will coordinate integrated management of patients through a multi-disciplinary approach with patient involvement at every stage of the process including the development and access of anticipatory care planning to ensure patient centred care and shared decision making; • Each Team will include input from the wider community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, and Social Case Managers as part of the multi-disciplinary approach; • The teams will support patients with complex needs to better manage their health to live independent lives in the community, including supporting and educating patients with their disease management by using technology, for as long as possible empowering them to take overall responsibility for managing their own health; • The integrated teams will provide continuity of care for patients who have been referred for support and care in the community, including within care homes. • To ensure continuity for patients with long term needs, the team will provide seamless coordination and delivery of End of Life care; • There will be a single point of access and single assessment to ensure responsive onward referral to either rapid response services or intermediate care services ensuring transfer to most appropriate care setting (including patients own home); • Specialist dementia nursing support, through the Admiral Nurses, will be integrated into the teams as part of an approach to maximising the knowledge of the team through the inclusion of specialists. • Each patient, identified through risk stratification, or as resident of a care home, will have a comprehensive anticipatory care plan to identify their individual needs and to identify possible pressure points so that approaches to the patients care can be identified in advance of the need arising. • We will ensure that patients are supported outside of the hospital	economy; • Improved transfers of care across health and social care; • Reduced long term placements in residential and nursing home beds; • Reduced need for long term supported care packages; • Increase patients returning to previous level of functionality in usual environment • Improving patients ability to self-manage	support integrated outcome measurement and monitoring. • Artificial barriers needs to be broken down (e.g. mental health nurses able to order ECG) • Governance structures within individual organisations may not currently support integrated care • Complex mechanisms for funding of long term care, either social or health, will reduce the impact of early discharge and admission avoidance.

No	Scheme	Description of Scheme	Outcome Measures	High Risks
		environment through "Befriending Services" to address and support the needs of vulnerable people. • Improved support for carers during periods of "crisis", including short breaks for carers. • Sharing of practice across professionals will improve the quality of care provided to patients and carers • We will implement a shared IT solution to allow health and social care professionals to access the shared care plan through our IT steering group.. • The aspiration is that, where possible, the team will be co-located. We suspect that this may prove to be the optimum model. • The voluntary sector is seen as having an important role in the delivery of this scheme.		
No	**Scheme**	**Description of Scheme**	**Outcome Measures**	**High Risks**
2	**Integrated Urgent Care Centre**	Extending Scheme 1 is the integration of urgent care services to ensure that patients receive the same standards of care, entering the same pathways, regardless of which point they access the Urgent Care system. It will achieve this by providing rapid access to key health economy services which include: • General Practitioners • Community Support Services • Social Services • Psychiatric Services • Secondary Care Consultants (including Geriatricians) The smooth flow of patients through the health and social care system is fundamental to meeting patients' expectations of urgent care services. It is	• Reduced A&E attendances; • Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia; • Improve patient, carers' and relatives' experience; • Reduced spend on medication;	• Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability; • Detailed modelling required to fully understand impact on acute capacity and

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		apparent that a significant proportion of urgent and emergency demand could more appropriately be classified as "primary care related" and undertaken by GPs or practice and community nursing. The model will require a change in how decisions are made with patients at the first point of accessing support. Principally, by front loading expertise, it is possible to significantly reduce the number of patients attending hospital and to improve care and treatment before they go to Hospital and seeing a senior decision maker on arrival. **SCHEME REQUIREMENTS:** Key principles for implementation of the Integrated Urgent Care Centre (IUCC), includes the ability to allow: • a clinician to clinician discussion via a 24/7 'Care Co-ordination' Centre; • enhanced GP out of hours service to replicate what is provided in hours; • enhanced input to review and treat patients within care homes, reducing the need to access acute hospital services; • robust decision making skills through the use of jointly developed 'decision support or assessment' tools; • consistently responsive and reliable service 24/7; • integration of the out of hours service with other care providers; • clear discharge processes from urgent care to planned or primary care, to maintain capacity within the system; and • proactive case management. The IUCC will provide both physical and virtual access 24/7, supporting patients who self-present, are brought in by Ambulance, referred by a GP &/or care professional, as well as responding to patients as a result of a clinical discussion via telephone. The IUCC will require immediate access to clinical support	• Reduced duplications across the health and social care system; • Reduce delays in provision of care • Reduce long term admissions to care homes	requirements of community capacity to inform transition over a defined period of time including investment and dis-investment requirements; • Large scale organisational change to ensure the whole health and social care system has shared vision and values to enable the delivery of required changes; • Governance structures within individual organisations may not currently support integrated care • Integrated performance monitoring of pathways needs to support the level of integration required;

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No	Scheme	Description of Scheme	Outcome Measures	High Risks
		services such as radiology and pathology to assist with assessment and decision making. It is intended that all providers will gain from a coordinated approach to Urgent Care providing patients with a single contact and intervention with all needs being assessed and met, without the onus being on the patient to know where and who to contact. The service is designed to provide a sustainable approach to Urgent Care across all disciplines and services allowing the IUCC to access and navigate the various components of service delivery. However, the patient will only see and experience those aspects of the service which provide the care, dependant on their needs, thereby ensuring that the service is patient centred, coordinated and efficient.		• IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring.
3	**Mental Health Services**	We recognise that like physical health related long term conditions, mental illness has a huge impact on the quality of life for the patients and their carer. The CCG will work with all partners to deliver improved mental health services for all age ranges to support: • Increased schemes to support health minds and early interventions • Crisis support within all pathway • Integrated models for all pathways to support patients within range of pathway • Systematised self-care/self-management through assistive technologies • Improved care navigation • The development of Dementia Friendly Communities and, • To facilitate access to other support provided by the voluntary sector. **SCHEME REQUIREMENTS:**	• Reduced emergency admissions; • Reduced A&E attendances; • Improve patient satisfaction and well-being; • Increase levels of patient self management of long term conditions;	• Extensive workforce reconfiguration in the community to ensure the workforce has the required skills and training to deliver all elements of the scheme; • Large scale organisational change to ensure the whole health and social care system has shared vision and values to

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No	Scheme	Description of Scheme	Outcome Measures	High Risks
		• Street triage services, aligned with Kent Police to ensure earlier assessment of a patient in crisis, thus avoiding the need for hospital admission • Develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by General Practice • We will ensure that patients are supported outside of the hospital environment through “Befriending Services” to address and support the needs of vulnerable people. • Improved support for carers during periods of “crisis”, including short breaks for carers. • Improvements to 24/7 Psychiatric liaison service provided within urgent care facilities • We will promote the use of integrated personal health budgets for patients with long term conditions and mental health needs to increase patient choice and control to meet their health and social care needs in different ways; • Pathways which are integrated across health and social care • Improved signposting and education will be available to patients through care coordinators and Health Trainers to ensure patients are given information about other opportunities to support them in the community, including the voluntary sector, and community pharmacies; • Develop a Health and Social Care information advice and guidance strategy to enable people to access services without support from the public sector if they choose to. • Introduction of an “all-age” earlier identification and intervention for problematic eating behaviours • Improved discharge pathways for patients with mental health related conditions	• Increase levels of patients with personal health budgets and integrated budgets; • Improve health outcomes by better use of prevention services.	enable the delivery of required changes. This includes ensuring the voluntary sector are aware of the direction of travel; • Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring. • Delay to discharge without flexible, lean and clear process relating to joint funding for care placement (e.g. Section 117)

4	**Support for Care Homes**	This model supports older people with a range of needs including physical disabilities and dementia will align specialists across multiple teams, including secondary care, to ensure patients in care homes have anticipatory care plans in place and those that are admitted to hospital have robust discharge plans in place before they are discharged in order to prevent re-admissions. **SCHEME REQUIREMENTS:** • The CCG and KCC will continue to support care homes through the Joint Geriatrician Project, extending this project further to support care homes out of hours and at the weekend. • Aligned to the integrated teams mentioned in Scheme 1, community based geriatricians will ensure appropriate community based services are in place to support patients as part of their discharge planning, from an acute episode of care. These discharge plans will be in place for every patient and known to all community based teams. The team will also undertake anticipatory care planning with the patients and their carers; • Access to integrated community teams to support ability to care for patients within their own home • Community Matron available to care homes 24/7 • Peer support through the Care Homes forum • Medicines management support • Joined up approach to quality overview and timely interaction where issues are identified • The consultant works in the community providing advice to GP in the treatment and support for patients and along with the wider team provides additional support, advice and guidance to care homes. • Access to specialist services such as Dementia Crisis will be available to support care homes; • Care homes will be given access to additional skills development to support improving quality of care and outcomes for the management of residents	• Reduced A&E attendances; • Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia; • Improve patient, carers' and relatives' experience; • Reduced duplications across the health and social care system; • Reduce unnecessary prescribing; • Improve patient satisfaction through personalised care planning.	• Workforce capacity to deliver the scheme is limited considering the large number of care home beds; • Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring. • Workforce in care homes needs support to increase skills to support more complex patients.

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		with long term conditions, compassionate care needs, mental health and wellbeing and management of End of Life care. • Primary care and the integrated team will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the care home • Sharing of practice across professionals will improve the quality of care provided to patients and carers		
No	**Scheme**	**Description of Scheme**	**Outcome Measures**	**High Risks**
5	**Health and Social Housing**	To improve the utilisation and appropriate use of existing housing options and increase the range if housing options available to people and to ensure it's used flexibly and enables more people to live independently in the community with the right level of support. This will also require responsive adaptations to enable people to manage their disability in a safe home environment. **SCHEME REQUIREMENTS:** • An integrated approach to local housing and accommodation provision, supported by a joint Health and Social care Accommodation Strategy, to enable more people to live safely in a home environment and other environments. • Responsive timely adaptations to housing; • Preventative pathways to enable patients and service users to remain in their homes safely; • Improved, rapid, access to specialist equipment to support people to remain in their own home. • Flexible housing schemes locally; • Increased provision of extra care housing locally; • More supported accommodation for those with learning disabilities and mental health needs. • The promotion and development of wheelchair accessible accommodation.	• Reduced A&E attendances; • Reduced hospital admissions and re-admissions; • Improve patient, carers' and relatives' experience; • Reduced duplications across the health and social care system; • Reduce unnecessary prescribing; • Improve patient satisfaction through personalised care	• Policy and legislation for housing and Disabled Facilities Grants need to support the level of integration required.

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			planning. • Reduced residential care admissions; • Reduced care packages;	
No	**Scheme**	**Description of Scheme**	**Outcome Measures**	**High Risks**
6	**Falls Prevention and Management**	Development of falls and fracture prevention services for older people to undertake screening and comprehensive assessment aimed at identifying and treating the underlying causes of falls, such as muscle weakness, cardiovascular problems, medication and housing issues. The overall aim of this schemes is to focus on objectives 2 and 3 of the Kent Falls Strategy, and improve the quality of life for Kent residents (particularly over 65yrs of age): • Objective 2 - respond to a first fracture and prevent the second – through fracture liaison services in acute and primary care settings • Objective 3 - early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries **SCHEME REQUIREMENTS:** The strategy recommends following interventions, which if undertaken in a systematic way will prove beneficial at a population level. These include: 1. Screening of adults who are at a higher risk of falls 2. Integrated multi-disciplinary assessment for the secondary prevention of falls and fractures	• Reduction in falls and secondary falls; • Reduction in hip fractures; • Improve patient experience and levels of self management; • Reduced emergency admissions; • Reduced A&E attendances.	• Different skills and training required across multiple professionals and organisations; • Integrated performance monitoring of pathways needs to support the level of integration required as will be challenging to monitor improvements linked to falls prevention; • IT systems need to enable shared care plans between

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		3. Use of standardised Multifactorial Falls Assessment and Evaluation tool across Kent 4. Availability of community based postural stability exercise classes 5. Follow on community support for on-going maintenance closer to home **Development of a local specialist falls and fracture prevention service** • This service will work closely with the Cluster Teams, Rapid Response and Intermediate Care and will undertake proactive and responsive screening and multi factorial assessments to identify causes of falls and make arrangements for preventative approaches. **Local integrated falls prevention pathways** • Level of current services across locally will be more integrated to include the increased level of input from geriatrician for integrated management and integration with other professionals e.g., pharmacists, chiropodists, podiatrists, opticians and audiologists; • Develop an Integrated Falls Response Service; • Improve availability and awareness of therapeutic exercise programmes (postural stability classes) via community classes, domiciliary based and within care homes.		organisations and support integrated outcome measurement and monitoring.
No	**Scheme**	**Description of Scheme**	**Outcome Measures**	**High Risks**
7	**"Community Hub"**	The fundamental, underlying, principle which reaches across the CCG Strategic Commissioning Plan is to ensure that care is delivered as close to where patients live as possible. The consequence of this is that patients will be able to access a variety of services in a variety of locations –including their own home, their pharmacy, the optometrist, their GP surgery, community hospitals as well as district hospitals.	• Reduced emergency admissions; • Reduced A&E attendances; • Reduced hospital	• Large scale organisational change to ensure the whole health and social care system has shared vision and values to enable the delivery of

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		Ultimately we anticipate that the outcome of this longer term approach will mean larger practices offering more services, including Social Care, and acting as the central hub for a wider variety of services and with improved access for traditional GP services. **SCHEME REQUIREMENTS:** **SCHEME REQUIREMENTS:** • Core set of community based health **and** social care services, with tailored community based services • General Practice as the most frequent point of contact for patients and carers; • Improved GP access - in terms of time waiting for an appointment and telephone access • More services provided locally, within a community setting e.g. at or via the GP surgery • More locally based day services for carers and patients • Improved communication with patients and carers. This could reduce patients' and carers' concerns regarding treatment and disputes regarding decisions about health care provision and support • Improved communication between health care professionals and across health and social care • Better information, whether it is about services that are available (accessibility, timings, contacts) in different formats including easy read • Reduced cost of void space to the CCGs in future • Improved community bed utilisation • Voluntary and social services integrated into community-based contracts • Integrated contracts for defined geographical locations • Increased emphasis on early interventions and health and wellbeing	admissions and re-admissions for patients with chronic long term conditions including Dementia; • Improve patient, carers' and relatives' experience; • Improve health and social outcomes; • Reduced length of stay across the health and social care economy; • Improved transfers of care across health and social care; • Reduced long term placements in residential and nursing home beds; • Reduced need for long term supported care packages;	required changes. This includes ensuring the voluntary sector are aware of the direction of travel; • Different skills and training required across multiple professionals and organisations; • Integrated performance monitoring of pathways needs to support the level of integration required as will be challenging to monitor improvements linked to falls prevention; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring.

			• Increase patients returning to previous level of functionality in usual environment • Improving patients ability to self-manage	

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Better Care Fund planning template – Part 1

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Kent County Council**
Clinical Commissioning Groups	**NHS Ashford CCG**
Boundary Differences	**The CCG is co-terminus with Ashford Borough Council**
Date agreed at Health and Well-Being Board:	
Date submitted:	
Minimum required value of BCF pooled budget: 2014/15	
2015/16	
Total agreed value of pooled budget: 2014/15	
2015/16	

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**NHS Ashford CCG**
By	Bill Millar
Position	Chief Operating Officer
Date	01/03/14
Signed on behalf of the Council	**Kent County Council**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Health and Wellbeing Board	Kent Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Roger Gough
Date	<date>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

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

The current work on the Health and Social Care Integration Programme takes place through HASCIP Steering Groups which are groups of commissioners and providers from health, social care and the voluntary and community sector.

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

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

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

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

In addition to these arrangements, the BCF plan has been developed through a series of "business as usual" strategic groups with senior representation from all service provider organisations, including:

- Whole Systems Board
- Integrated Commissioning Group
- Urgent Care/Long Term Conditions Board
- Planned Care/Long Term Conditions Board

As well as senior representation, membership also includes frontline staff from medical, nursing, mental health backgrounds, other health and social care professionals, and colleagues from Public Health.

During February and March 2014, and into the new financial year, further engagement activities are scheduled on a local area basis to ensure all providers are aware and engaged with the contents of the plan.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

The blueprint for Kent becoming an Integrated Care and Support Pioneer is based on detailed engagement with patients, service users and the public. Kent Healthwatch is assisting in

outlining the evaluation of objectives and outcomes against I Statements.

On a local level there is sustained involvement with the public through patient participation groups and the local health and social care integration implementation groups. As part of the operational integration programme regular surveys on integrated are undertaken with patients by providers and the CCG.

Kent is committed to meaningful engagement and co-production with the public and wider stakeholders and as a Pioneer will use ICASE (www.icase.org.uk) as a mechanism to provide updates on our progress within integration and the implementation of the Better Care fund.

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

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

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

e) 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
Canterbury and Coastal Health Profile	To be inserted
Kent Health and Wellbeing Strategy	To be inserted
Kent Integrated Care and Support Programme Plan	To be inserted
NHS Canterbury and Coastal CCG Plan on a Page	To be inserted
NHS Canterbury and Coastal CCG Strategic Commissioning Plan	To be inserted
Canterbury and Coastal Health and Wellbeing Board Organogram	To be inserted

VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The fundamental, underlying, principle which reaches across all of the following domains is that the CCG is keen to ensure that care is be delivered as close to where patients live as possible. The consequence of this is that patients will be able to access a variety of services in a variety of locations –including their own home, their pharmacy, the optometrist, their GP surgery, community hospitals as well as district hospitals. We recognise that collectively planning improved care and support services requires significant transformation of existing methods of service delivery.

The vision for the Canterbury & Coastal locality is that through integrated working with partners we can deliver services which are fully integrated and support the following:

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

For the past two years, the health and social care community has been working collectively towards creating an integrated system of care that seeks to wrap care and support around the needs of the individual, their family and carers and helps to deliver on this wider vision

Our programme of work acknowledges that patients and carers should expect a high quality, compassionate, safe and personal service based around their needs, present and future. They should be enabled to take ownership of their health and social care and with that accept responsibility for their health behaviour and use of health and social care services.

Our ambition over the next five years is that through continuous evaluation and learning from elsewhere, our residents will be able to access further community facilities of this nature. Our approach recognises that whilst services are currently delivered by different organisations, organisational boundaries in the future will continue to be more permeable and flexible with

staff working to support and care for people as part of interdisciplinary endeavour. Services must be based around the needs of people, not around organisations.

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

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

The focus will be on supporting people to self-manage and coordinate their own care as much as possible, facilitated by integrated electronic records and care plans. GPs will lead community based multi-disciplinary teams, with access to outreach from specialists, mental health, dementia support as required to provide targeted, proactive care and support to those people identified as being of highest risk of hospital attendance or increasing use of care services. We will work in partnership with the voluntary and community sector and District Authorities recognising the contribution they make in ensuring we achieve the levels of transformation required.

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

The use of the Better Care Fund will contribute to improving the outcomes identified within the HWB Strategy:

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

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?

- What measures of health gain will you apply to your population?

We will use the Better Care Fund to:

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

- Reduce unnecessary activity within secondary care by ensuring the right services are available and accessible, within the community, for people when required.

- Get the best possible outcomes within the resources we have available.

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

Integrated Commissioning:

- Together we will design and commission new systems and models of care that ensures the financial sustainability of health and social care services in Kent. These services will give people every opportunity to receive personalised care at, or closer to home to avoid hospital and care home admissions.

- We will use an integrated commissioning approach to buy integrated health and social care services where this makes sense.

- The Health and Wellbeing Board will be an established systems leader, supported by clinical co-design and strong links to innovation, evaluation and research networks. Integrated Commissioning will be achieving the shift from spend and activity in acute and residential care to community services, underpinned by JSNA, Year of Care financial model and risk stratification. We will have a locally agreed tariff system across health and social care commissioning.

Integrated Provision:

- A proactive model of 24/7 community based care, with fully integrated multi-disciplinary teams across acute and community services with primary care playing a key co-ordination role. The community / primary / secondary care interfaces will become integrated.

- We will have a workforce fit for purpose to deliver integrated health and social care services. To have this, we need to start planning now and deliver training right across health, social care and voluntary sectors. We will also need to ensure that we link in with

our partners within education

- An IT integration platform will enable clinicians and others involved in someone's care, including the person themselves, to view and input information so that care records are joined up and seamless. We will have overcome information governance issues. Patient held records and shared care plans will be commonplace.

- We will systematise self-care/self-management through assistive technologies, care navigation, the development of Dementia Friendly Communities and other support provided by the voluntary sector.

- New kinds of services that bridge current silos of working where health and social care staff can "follow" the citizen, providing the right care in the right place.

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

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The CCG has developed a 5 year Commissioning Plan which incorporates evidence for change using the JSNA, patient feedback and evidence from the existing partners.

The specific schemes relating to the BCF are detailed in the embedded document:

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

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

Detailed investment and benefit management plans will be designed throughout 2014/15 in line

with CCG and Social Care commissioning plans.

In order to achieve the level of cost reduction required there will need to be significant reduction in the level of emergency admissions and A&E attenders in the acute care setting. Increasing community capacity should act not only to promote the integration agenda, but also to support the delivery of these key performance targets.

Savings in the health and social care sector need to be generated by shifting activity into the community, and making the entire sector more focussed on prevention. We are also mindful that hospital based care must be sustainable and it is crucial that as less money and activity is delivered in the acute sector as a result of the BCF initiatives, costs in that sector either reduce or are refocused on specialist activity.

If costs in the acute sector are to be shed, in practical terms, this means reduced staff in the acute sector. This is within the context of a shift to 24 hours, 7 days a week working and so innovative work with staff to develop pioneering solutions is crucial. As a consequence of moving to a more prevention focussed agenda, workforce redesign is a priority. As acute activity starts to fall off, and community activity rises, re-training the workforce will become increasingly important and workforce development to meet changing needs is part of our wider transformation programme. Roles that were once only available in the hospital will still be required, but in a different setting. In the longer term, the BCF will need to have a scheme focussed on workforce and training to ensure we have the correctly qualified staff working in the right places and with the right patients to create the integrated health and social care system patients, service users and their families deserve.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Kent's governance for delivering as an Integrated Care and Support Pioneer is set out in the attached governance, the responsibility and management of the Better Care Fund will sit within this.

Existing governance structures through the local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group provides advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within the HWB and on the Integrated Pioneer Steering Group.

As part of the governance arrangements there will be monitoring of the financial flows associated with implementation of the Better Care Fund. Through the integrated commissioning groups the leadership of the CCGs and providers will have a clear and shared visibility and accountability in relation to BCF.

2) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

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

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

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

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

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

Please explain how local social care services will be protected within your plans.

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

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

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

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

As part of our Kent Pioneer programme we are committed to not only providing seven-day health and social care services but also furthering this to a proactive model of 24/7 community based care.

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

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

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

A detailed plan for a 7 day service will be developed during 2014/15 as part of our capacity modelling for implementation in 2015/16

c) Data sharing

Please confirm that you are 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.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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

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

The BCF will be used to help further this work and enable real time data sharing across health and social care and with the public.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise 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

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

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

- All people in care homes to have agreed care plans including EOL understood by the patient and the relatives where appropriate. This scheme for Canterbury is already counted under QUIPP.
- Patients and health and social care professionals to have access real time to agreed health and social care information.
- Consultants (in long term conditions) to increasingly no longer have caseload but outreach to support primary care to deliver high quality complex care.

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

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

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

RISKS

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

Risk	Risk rating	Mitigating Actions
The savings and efficiencies needed to	Very High	The proposals within the

fund whole system change that meets people's health and social care needs may not be delivered through the work planned.		Better Care Fund submission have been costed and likely efficiencies estimated. There is very little evidence base with few examples of full implementation of schemes. Progress post implementation will be closely monitored but likely impact will be based on a culmination of interventions.
In order for the hospital sector to release efficiencies, it will need to close beds as activity drops.	Very High	
Work carried out under the Better Care Fund will need to be managed and monitored. Resources have not yet been identified to undertake this essential function. NHS facing 10% real terms budget cut in administration in 2015/16	High	Resources are being discussed and will be allocated from both health and social care.
Shifting resources to fund new schemes may destabilise current services and providers, particularly in the acute sector.	High	Proposals been jointly developed, including service providers. This has enabled a holistic consideration of the benefits of each proposal
Work outlined may not adequately ensure the Protection of Adult Social Care services.	High	
Operational pressures and the current high volume of business change will restrict the ability of our workforce to deliver the projects needed to make the vision of care outlined a reality.	High	Proposals include investment in infrastructure and development to support overall organisational development.
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / home care activity by 2015/16, impacting the overall funding available to support care services and future schemes	High	Proposals have been developed using a wide range of available data. 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed Business Cases and service specifications
The introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, will result in	High	

a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.		
Workforce Education establishments will be required to review current training schemes to support ability to transfer care	High	
The CCG and KCC may suffer reputational damage if we fail to deliver the outcomes detailed..	Medium	Proposals have been developed through a rigorous process of consultation and engagement, review and scrutiny.
Community and social settings may be unable to pick up increased demand as care moves away from acute settings.	Medium	Savings generated through work under the Better Care Fund will be used to increase capacity in community and social settings.
The lack of detailed baseline data and the need to rely on current assumptions may mean that financial targets are unachievable.	Medium	Proposals are based in all available information and will be refined as work progresses.

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	NHS England Funds	Actual contribution (15/16)
Local Authority #1					
Ashford CCG		1379	*2443*	*2137*	*7321*
Local Authority #2					
etc					
BCF Total					

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		2015/16		Ongoing
Outcome 1	Planned savings (if targets fully achieved)			
	Maximum support needed for other services (if targets not achieved)			
Outcome 2	Planned savings (if targets fully achieved)			
	Maximum support needed for other services (if targets not achieved)			

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Ashford - Integrated Health & Social Care		300				1721			
Ashford - IUCC		300				1700			
Ashford - Mental Health Service		100				500			
Ashford - Support for care homes		100				500			
Ashford - Health and Social Housing		100				500			
Ashford - Falls		100				500			
Ashford - Community Hub		380				1900			

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*		N/A	
	Numerator			
	Denominator			
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*		N/A	
	Numerator			
	Denominator			
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*			
	Numerator			
	Denominator			
		(TBC)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]			N/A	
		(insert time period)		*(insert time period)*
[local measure - please give full description]	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	*(insert time period)*	*(insert time period)*

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Better Care Fund planning template – Part 1

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Kent County Council**
Clinical Commissioning Groups	**NHS Canterbury & Coastal CCG**
Boundary Differences	**There are some boundary differences between the CCG and local District authorities.** **Whilst the CCG wholly covers Canterbury City Council's areas, the CCG also covers parts of Swale Borough Council, Dover District Council and Ashford Borough Council.** **In developing the plan discussions with these areas has taken place to ensure consistency of outcomes.**
Date agreed at Health and Well-Being Board:	
Date submitted:	
Minimum required value of BCF pooled budget: 2014/15	
2015/16	
Total agreed value of pooled budget: 2014/15	
2015/16	

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**NHS Canterbury & Coastal CCG**
By	Bill Millar
Position	Chief Operating Officer
Date	01/03/14
Signed on behalf of the Council	**Kent County Council**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Health and Wellbeing Board	Kent Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Roger Gough
Date	<date>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

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

The current work on the Health and Social Care Integration Programme takes place through HASCIP Steering Groups which are groups of commissioners and providers from health, social care and the voluntary and community sector.

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

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

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

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

In addition to these arrangements, the BCF plan has been developed through a series of "business as usual" strategic groups with senior representation from all service provider organisations, including:

- Whole Systems Board
- Integrated Commissioning Group
- Urgent Care/Long Term Conditions Board
- Planned Care/Long Term Conditions Board

As well as senior representation, membership also includes frontline staff from medical, nursing, mental health backgrounds, other health and social care professionals, and colleagues from Public Health.

During February and March 2014, and into the new financial year, further engagement activities are scheduled on a local area basis to ensure all providers are aware and engaged with the

contents of the plan.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

The blueprint for Kent becoming an Integrated Care and Support Pioneer is based on detailed engagement with patients, service users and the public. Kent Healthwatch is assisting in outlining the evaluation of objectives and outcomes against I Statements.

On a local level there is sustained involvement with the public through patient participation groups and the local health and social care integration implementation groups. As part of the operational integration programme regular surveys on integrated are undertaken with patients by providers and the CCG.

Kent is committed to meaningful engagement and co-production with the public and wider stakeholders and as a Pioneer will use ICASE (www.icase.org.uk) as a mechanism to provide updates on our progress within integration and the implementation of the Better Care fund.

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

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

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

e) 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
Canterbury and Coastal Health Profile	To be inserted
Kent Health and Wellbeing Strategy	To be inserted
Kent Integrated Care and Support Programme Plan	To be inserted
NHS Canterbury and Coastal CCG Plan on a Page	To be inserted
NHS Canterbury and Coastal CCG Strategic	To be inserted

Commissioning Plan	
Canterbury and Coastal Health and Wellbeing Board Organogram	To be inserted

VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The fundamental, underlying, principle which reaches across all of the following domains is that the CCG is keen to ensure that care is be delivered as close to where patients live as possible. The consequence of this is that patients will be able to access a variety of services in a variety of locations –including their own home, their pharmacy, the optometrist, their GP surgery, community hospitals as well as district hospitals. We recognise that collectively planning improved care and support services requires significant transformation of existing methods of service delivery.

The vision for the Canterbury & Coastal locality is that through integrated working with partners we can deliver services which are fully integrated and support the following:

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

For the past two years, the health and social care community has been working collectively towards creating an integrated system of care that seeks to wrap care and support around the needs of the individual, their family and carers and helps to deliver on this wider vision

Our programme of work acknowledges that patients and carers should expect a high quality, compassionate, safe and personal service based around their needs, present and future. They should be enabled to take ownership of their health and social care and with that accept responsibility for their health behaviour and use of health and social care services.

Our ambition over the next five years is that through continuous evaluation and learning from elsewhere, our residents will be able to access further community facilities of this nature. Our approach recognises that whilst services are currently delivered by different organisations, organisational boundaries in the future will continue to be more permeable and flexible with

staff working to support and care for people as part of interdisciplinary endeavour. Services must be based around the needs of people, not around organisations.

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

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

The focus will be on supporting people to self-manage and coordinate their own care as much as possible, facilitated by integrated electronic records and care plans. GPs will lead community based multi-disciplinary teams, with access to outreach from specialists, mental health, dementia support as required to provide targeted, proactive care and support to those people identified as being of highest risk of hospital attendance or increasing use of care services. We will work in partnership with the voluntary and community sector and District Authorities recognising the contribution they make in ensuring we achieve the levels of transformation required.

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

The use of the Better Care Fund will contribute to improving the outcomes identified within the HWB Strategy:

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

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?

- What measures of health gain will you apply to your population?

We will use the Better Care Fund to:

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

- Reduce unnecessary activity within secondary care by ensuring the right services are available and accessible, within the community, for people when required.

- Get the best possible outcomes within the resources we have available.

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

Integrated Commissioning:

- Together we will design and commission new systems and models of care that ensures the financial sustainability of health and social care services in Kent. These services will give people every opportunity to receive personalised care at, or closer to home to avoid hospital and care home admissions.

- We will use an integrated commissioning approach to buy integrated health and social care services where this makes sense.

- The Health and Wellbeing Board will be an established systems leader, supported by clinical co-design and strong links to innovation, evaluation and research networks. Integrated Commissioning will be achieving the shift from spend and activity in acute and residential care to community services, underpinned by JSNA, Year of Care financial model and risk stratification. We will have a locally agreed tariff system across health and social care commissioning.

Integrated Provision:

- A proactive model of 24/7 community based care, with fully integrated multi-disciplinary teams across acute and community services with primary care playing a key co-ordination role. The community / primary / secondary care interfaces will become integrated.

- We will have a workforce fit for purpose to deliver integrated health and social care services. To have this, we need to start planning now and deliver training right across health, social care and voluntary sectors. We will also need to ensure that we link in with

our partners within education

- An IT integration platform will enable clinicians and others involved in someone's care, including the person themselves, to view and input information so that care records are joined up and seamless. We will have overcome information governance issues. Patient held records and shared care plans will be commonplace.

- We will systematise self-care/self-management through assistive technologies, care navigation, the development of Dementia Friendly Communities and other support provided by the voluntary sector.

- New kinds of services that bridge current silos of working where health and social care staff can "follow" the citizen, providing the right care in the right place.

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

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The CCG has developed a 5 year Commissioning Plan which incorporates evidence for change using the JSNA, patient feedback and evidence from the existing partners.

The specific schemes relating to the BCF are detailed in the embedded document:

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

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

Detailed investment and benefit management plans will be designed throughout 2014/15 in line

with CCG and Social Care commissioning plans.

In order to achieve the level of cost reduction required there will need to be significant reduction in the level of emergency admissions and A&E attenders in the acute care setting. Increasing community capacity should act not only to promote the integration agenda, but also to support the delivery of these key performance targets.

Savings in the health and social care sector need to be generated by shifting activity into the community, and making the entire sector more focussed on prevention. We are also mindful that hospital based care must be sustainable and it is crucial that as less money and activity is delivered in the acute sector as a result of the BCF initiatives, costs in that sector either reduce or are refocused on specialist activity.

If costs in the acute sector are to be shed, in practical terms, this means reduced staff in the acute sector. This is within the context of a shift to 24 hours, 7 days a week working and so innovative work with staff to develop pioneering solutions is crucial. As a consequence of moving to a more prevention focussed agenda, workforce redesign is a priority. As acute activity starts to fall off, and community activity rises, re-training the workforce will become increasingly important and workforce development to meet changing needs is part of our wider transformation programme. Roles that were once only available in the hospital will still be required, but in a different setting. In the longer term, the BCF will need to have a scheme focussed on workforce and training to ensure we have the correctly qualified staff working in the right places and with the right patients to create the integrated health and social care system patients, service users and their families deserve.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Kent's governance for delivering as an Integrated Care and Support Pioneer is set out in the attached governance, the responsibility and management of the Better Care Fund will sit within this.

Existing governance structures through the local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group provides advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within the HWB and on the Integrated Pioneer Steering Group.

As part of the governance arrangements there will be monitoring of the financial flows associated with implementation of the Better Care Fund. Through the integrated commissioning groups the leadership of the CCGs and providers will have a clear and shared visibility and accountability in relation to BCF.

2) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

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

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

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

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

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

Please explain how local social care services will be protected within your plans.

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

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

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

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

As part of our Kent Pioneer programme we are committed to not only providing seven-day health and social care services but also furthering this to a proactive model of 24/7 community based care.

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

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

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

A detailed plan for a 7 day service will be developed during 2014/15 as part of our capacity modelling for implementation in 2015/16

c) Data sharing

Please confirm that you are 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.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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

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

The BCF will be used to help further this work and enable real time data sharing across health and social care and with the public.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise 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

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

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

- All people in care homes to have agreed care plans including EOL understood by the patient and the relatives where appropriate. This scheme for Canterbury is already counted under QUIPP.
- Patients and health and social care professionals to have access real time to agreed health and social care information.
- Consultants (in long term conditions) to increasingly no longer have caseload but outreach to support primary care to deliver high quality complex care.

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

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

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

RISKS

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

Risk	Risk rating	Mitigating Actions
The savings and efficiencies needed to	Very High	The proposals within the

fund whole system change that meets people's health and social care needs may not be delivered through the work planned.		Better Care Fund submission have been costed and likely efficiencies estimated. There is very little evidence base with few examples of full implementation of schemes. Progress post implementation will be closely monitored but likely impact will be based on a culmination of interventions.
In order for the hospital sector to release efficiencies, it will need to close beds as activity drops.	Very High	
Work carried out under the Better Care Fund will need to be managed and monitored. Resources have not yet been identified to undertake this essential function. NHS facing 10% real terms budget cut in administration in 2015/16	High	Resources are being discussed and will be allocated from both health and social care.
Shifting resources to fund new schemes may destabilise current services and providers, particularly in the acute sector.	High	Proposals been jointly developed, including service providers. This has enabled a holistic consideration of the benefits of each proposal
Work outlined may not adequately ensure the Protection of Adult Social Care services.	High	
Operational pressures and the current high volume of business change will restrict the ability of our workforce to deliver the projects needed to make the vision of care outlined a reality.	High	Proposals include investment in infrastructure and development to support overall organisational development.
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / home care activity by 2015/16, impacting the overall funding available to support care services and future schemes	High	Proposals have been developed using a wide range of available data. 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed Business Cases and service specifications
The introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, will result in	High	

a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.		
Workforce Education establishments will be required to review current training schemes to support ability to transfer care	High	
The CCG and KCC may suffer reputational damage if we fail to deliver the outcomes detailed..	Medium	Proposals have been developed through a rigorous process of consultation and engagement, review and scrutiny.
Community and social settings may be unable to pick up increased demand as care moves away from acute settings.	Medium	Savings generated through work under the Better Care Fund will be used to increase capacity in community and social settings.
The lack of detailed baseline data and the need to rely on current assumptions may mean that financial targets are unachievable.	Medium	Proposals are based in all available information and will be refined as work progresses.

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Draft Better Care Fund Plan
NHS Canterbury and Coastal Clinical Commissioning Group

No	Scheme	Description of Scheme	Outcome Measures	High Risks
1	**Integrated Health and Social Care Team** **"Neighbourhood Care Team"**	We will continue to develop our integrated health and social care team to ensure that they will be available 24 hours a day seven days a week and will be contactable through a single access points. The team will be focussed on both ends of the patient journey, through supporting patients, carers, social services and clinicians to avoid the need for patients to be admitted to hospitals, however where this is necessary the team will mobilise to ensure timely discharge of the patient. These teams will ensure wider integration with other community and primary care based services, including voluntary sector provided services, as well as hospital specialists working out in the community. The ultimate aim is to enable people to be cared for in their own homes or within their own community. The aim of team is to support people to self-manage and to be independent in their own homes. The model requires specialist input from across the social care, health and voluntary sectors to enable the management of care for more patients in the community for a range of specialisms including the care of the over 75s, this will include undertaking clinics and reviews of patients in or close to their own homes rather than in hospital. This could include actual and remote approaches supported through the use of technology, such as video conferencing with acute specialists.	• Reduced emergency admissions; • Reduced A&E attendances; • Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia; • Improve patient, carers' and relatives' experience; • Improve health and social outcomes; • Reduced length of stay across the health	• Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability. • Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between

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		SCHEME REQUIREMENTS: • Aligned to geographical areas the support will be accessible 24 hours a day seven days a week and will coordinate integrated management of patients through a multi-disciplinary approach with patient involvement at every stage of the process including the development and access of anticipatory care planning to ensure patient centred care and shared decision making; • Each Team will include input from the wider community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, and Social Case Managers as part of the multi-disciplinary approach; • The teams will support patients with complex needs to better manage their health to live independent lives in the community, including supporting and educating patients with their disease management by using technology, for as long as possible empowering them to take overall responsibility for managing their own health; • The integrated teams will provide continuity of care for patients who have been referred for support and care in the community, including within care homes. • To ensure continuity for patients with long term needs, the team will provide seamless coordination and delivery of End of Life care; • There will be a single point of access, the Health and Social Care Co-Ordinator, and single assessment to ensure responsive onward referral to either rapid response services or intermediate care services ensuring transfer to most appropriate care setting (including patients own home); • Specialist dementia nursing support, through the Admiral Nurses, will be integrated into the teams as part of an approach to maximising the knowledge of the team through the inclusion of specialists. • Each patient, identified through risk stratification, or as resident of a care home, will have a comprehensive anticipatory care plan to identify their individual needs and to identify possible pressure points so that approaches	and social care economy; • Improved transfers of care across health and social care; • Reduced long term placements in residential and nursing home beds; • Reduced need for long term supported care packages; • Increase patients returning to previous level of functionality in usual environment • Improving patients ability to self-manage	organisations and support integrated outcome measurement and monitoring. • Artificial barriers needs to be broken down (e.g. mental health nurses able to order ECG) • Governance structures within individual organisations may not currently support integrated care • Complex mechanisms for funding of long term care, either social or health, will reduce the impact of early discharge and admission avoidance.

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No	Scheme	Description of Scheme	Outcome Measures	High Risks
		to the patients care can be identified in advance of the need arising. • We will ensure that patients are supported outside of the hospital environment through "Befriending Services" to address and support the needs of vulnerable people. • Improved support for carers during periods of "crisis", including short breaks for carers. • Sharing of practice across professionals will improve the quality of care provided to patients and carers • We will implement a shared IT solution to allow health and social care professionals to access the shared care plan. • The aspiration is that, where possible, the team will be co-located. We suspect that this may prove to be the optimum model. • The voluntary sector is seen as having an important role in the delivery of this scheme.		
2	**Integrated Urgent Care Centre**	Extending Scheme 1 is the integration of urgent care services to ensure that patients receive the same standards of care, entering the same pathways, regardless of which point they access the Urgent Care system. It will achieve this by providing rapid access to key health economy services which include: • General Practitioners • Community Support Services • Social Services • Psychiatric Services • Secondary Care Consultants (including Geriatricians)	• Reduced A&E attendances; • Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia; • Improve patient, carers' and relatives'	• Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability;

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		The smooth flow of patients through the health and social care system is fundamental to meeting patients' expectations of urgent care services. It is apparent that a significant proportion of urgent and emergency demand could more appropriately be classified as "primary care related" and undertaken by GPs or practice and community nursing. The model will require a change in how decisions are made with patients at the first point of accessing support. Principally, by front loading expertise, it is possible to significantly reduce the number of patients attending hospital and to improve care and treatment before they go to Hospital and seeing a senior decision maker on arrival. **SCHEME REQUIREMENTS:** Key principles for implementation of the Integrated Urgent Care Centre (IUCC), includes the ability to allow: • a clinician to clinician discussion via a 24/7 'Care Co-ordination' Centre; • enhanced GP out of hours service to replicate what is provided in hours; • enhanced input to review and treat patients within care homes, reducing the need to access acute hospital services; • robust decision making skills through the use of jointly developed 'decision support or assessment' tools; • consistently responsive and reliable service 24/7; • integration of the out of hours service with other care providers; • clear discharge processes from urgent care to planned or primary care, to maintain capacity within the system; and	experience; • Reduced spend on medication; • Reduced duplications across the health and social care system; • Reduce delays in provision of care • Reduce long term admissions to care homes	• Detailed modelling required to fully understand impact on acute capacity and requirements of community capacity to inform transition over a defined period of time including investment and dis-investment requirements; • Large scale organisational change to ensure the whole health and social care system has shared vision and values to enable the delivery of required changes; • Governance structures within individual organisations may not currently support integrated care • Integrated

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		• proactive case management. The IUCC will provide both physical and virtual access 24/7, supporting patients who self-present, are brought in by Ambulance, referred by a GP &/or care professional, as well as responding to patients as a result of a clinical discussion via telephone. The IUCC will require immediate access to clinical support services such as radiology and pathology to assist with assessment and decision making. It is intended that all providers will gain from a coordinated approach to Urgent Care providing patients with a single contact and intervention with all needs being assessed and met, without the onus being on the patient to know where and who to contact. The service is designed to provide a sustainable approach to Urgent Care across all disciplines and services allowing the IUCC to access and navigate the various components of service delivery. However, the patient will only see and experience those aspects of the service which provide the care, dependant on their needs, thereby ensuring that the service is patient centred, coordinated and efficient.		performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring.
No	**Scheme**	**Description of Scheme**	**Outcome Measures**	**High Risks**
3	**Mental Health Services**	We recognise that like physical health related long term conditions, mental illness has a huge impact on the quality of life for the patients and their carer. The CCG will work with all partners to deliver improved mental health services for all age ranges to support: • Increased schemes to support health minds and early interventions • Crisis support within all pathway • Integrated models for all pathways to support patients within range of pathway	• Reduced emergency admissions; • Reduced A&E attendances; • Improve patient satisfaction and well-	• Extensive workforce reconfiguration in the community to ensure the workforce has the required skills and training to deliver all elements of the scheme;

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		• Systematised self-care/self-management through assistive technologies • Improved care navigation • The development of Dementia Friendly Communities and, • To facilitate access to other support provided by the voluntary sector. **SCHEME REQUIREMENTS:** • Street triage services, aligned with Kent Police to ensure earlier assessment of a patient in crisis, thus avoiding the need for hospital admission • Develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by General Practice • We will ensure that patients are supported outside of the hospital environment through "Befriending Services" to address and support the needs of vulnerable people. • Improved support for carers during periods of "crisis", including short breaks for carers. • Improvements to Psychiatric liaison service provided within urgent care facilities • We will promote the use of integrated personal health budgets for patients with long term conditions and mental health needs to increase patient choice and control to meet their health and social care needs in different ways; • Pathways which are integrated across health and social care • Primary care and the integrated team will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the community; • Improved signposting and education will be available to patients through care coordinators and Health Trainers to ensure patients are given information about other opportunities to support them in the community, including the voluntary sector, and community pharmacies;	being; • Increase levels of patient self management of long term conditions; • Increase levels of patients with personal health budgets and integrated budgets; • Improve health outcomes by better use of prevention services.	• Large scale organisational change to ensure the whole health and social care system has shared vision and values to enable the delivery of required changes. This includes ensuring the voluntary sector are aware of the direction of travel; • Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring.

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No	Scheme	Description of Scheme	Outcome Measures	High Risks
		• Develop a Health and Social Care information advice and guidance strategy to enable people to access services without support from the public sector if they choose to. • Introduction of an "all-age" earlier identification and intervention for problematic eating behaviours • Improved discharge pathways for patients with mental health related conditions		Delay to discharge without flexible, lean and clear process relating to joint funding for care placement (e.g. Section 117)
4	**Support for Care Homes**	This model supports older people with a range of needs including physical disabilities and dementia will align specialists across multiple teams, including secondary care, to ensure patients in care homes have anticipatory care plans in place and those that are admitted to hospital have robust discharge plans in place before they are discharged in order to prevent re-admissions. **SCHEME REQUIREMENTS:** • The CCG and KCC will continue to support care homes through the Joint Geriatrician Project, extending this project further to support care homes out of hours and at the weekend. • Aligned to the integrated teams mentioned in Scheme 1, community based geriatricians will ensure appropriate community based services are in place to support patients as part of their discharge planning, from an acute episode of care. These discharge plans will be in place for every patient and known to all community based teams. The team will also undertake anticipatory care planning with the patients and their carers; • Access to integrated community teams to support ability to care for patients within their own home	• Reduced A&E attendances; • Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia; • Improve patient, carers' and relatives' experience; • Reduced duplications across the health and social care system;	• Workforce capacity to deliver the scheme is limited considering the large number of care home beds; • Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and support integrated

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No	Scheme	Description of Scheme	Outcome Measures	High Risks
		• Increased community geriatrician and GP support for the care setting • Medicines management support • Joined up approach to quality overview and timely interaction where issues are identified • The consultant works in the community providing advice to GP in the treatment and support for patients and along with the wider team provides additional support, advice and guidance to care homes. • Access to specialist services such as Dementia Crisis will be available to support care homes; • Care homes will be given access to additional skills development to support improving quality of care and outcomes for the management of residents with long term conditions, compassionate care needs, mental health and wellbeing and management of End of Life care. • Primary care and the integrated team will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the care home • Sharing of practice across professionals will improve the quality of care provided to patients and carers	• Reduce unnecessary prescribing; • Improve patient satisfaction through personalised care planning.	outcome measurement and monitoring. • Workforce in care homes needs support to increase skills to support more complex patients.
No	**Scheme**	**Description of Scheme**	**Outcome Measures**	**High Risks**
5	**Health and Social Housing**	To improve the utilisation and appropriate use of existing housing options and increase the range if housing options available to people and to ensure it's used flexibly and enables more people to live independently in the community with the right level of support. This will also require responsive adaptations to enable people to manage their disability in a safe home environment. **SCHEME REQUIREMENTS:**	• Reduced A&E attendances; • Reduced hospital admissions and re-admissions;	• Policy and legislation for housing and Disabled Facilities Grants need to support the level of integration required.

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No	Scheme	Description of Scheme	Outcome Measures	High Risks
		• An integrated approach to local housing and accommodation provision, supported by a joint Health and Social care Accommodation Strategy, to enable more people to live safely in a home environment and other environments. • Responsive timely adaptations to housing; • Preventative pathways to enable patients and service users to remain in their homes safely; • Flexible housing schemes locally; • Increased provision of extra care housing locally; • More supported accommodation for those with learning disabilities and mental health needs.	• Improve patient, carers' and relatives' experience; • Reduced duplications across the health and social care system; • Reduce unnecessary prescribing; • Improve patient satisfaction through personalised care planning. • Reduced residential care admissions; • Reduced care packages;	
No	**Scheme**	**Description of Scheme**	**Outcome Measures**	**High Risks**
6	**Falls Prevention and Management**	Development of falls and fracture prevention services for older people to undertake screening and comprehensive assessment aimed at identifying and treating the underlying causes of falls, such as muscle weakness, cardiovascular problems, medication and housing issues. The overall aim of this schemes is to focus on objectives 2 and 3 of the Kent Falls Strategy, and improve the quality of life for Kent residents (particularly	• Reduction in falls and secondary falls; • Reduction in hip fractures;	• Different skills and training required across multiple professionals and organisations;

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		over 65yrs of age): • Objective 2 - respond to a first fracture and prevent the second – through fracture liaison services in acute and primary care settings • Objective 3 - early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries **SCHEME REQUIREMENTS:** The strategy recommends following interventions, which if undertaken in a systematic way will prove beneficial at a population level. These include: 1. Screening of adults who are at a higher risk of falls 2. Integrated multi-disciplinary assessment for the secondary prevention of falls and fractures 3. Use of standardised Multifactorial Falls Assessment and Evaluation tool across Kent 4. Availability of community based postural stability exercise classes 5. Follow on community support for on-going maintenance closer to home **Development of a local specialist falls and fracture prevention service** • This service will work closely with the Neighbourhood Care Teams, Rapid Response and Intermediate Care and will undertake proactive and responsive screening and multi factorial assessments to identify causes of falls and make arrangements for preventative approaches. **Local integrated falls prevention pathways** • Level of current services across locally will be more integrated to include the increased level of input from geriatrician for integrated management and integration with other professionals e.g., pharmacists, chiropodists, podiatrists, opticians and audiologists;	• Improve patient experience and levels of self management; • Reduced emergency admissions; • Reduced A&E attendances.	• Integrated performance monitoring of pathways needs to support the level of integration required as will be challenging to monitor improvements linked to falls prevention; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring.

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No	Scheme	Description of Scheme	Outcome Measures	High Risks
		• Develop an Integrated Ambulance Falls Response Service; • Improve availability and awareness of therapeutic exercise programmes (postural stability classes) via community classes, domiciliary based and within care homes.		
No	**Scheme**	**Description of Scheme**	**Outcome Measures**	**High Risks**
7	**"Community Hub"**	The fundamental, underlying, principle which reaches across all of the following domains is that the CCG are keen to ensure that care is be delivered as close to where patients live as possible. The consequence of this is that patients will be able to access a variety of services in a variety of locations –including their own home, their pharmacy, the optometrist, their GP surgery, community hospitals as well as district hospitals. Ultimately we anticipate that the outcome of this longer term approach will mean larger practices offering more services, including Social Care, and acting as the central hub for a wider variety of services and with improved access for traditional GP services. **SCHEME REQUIREMENTS:** • Core set of community based health **<u>and</u>** social care services, with tailored community based services • General Practice as the most frequent point of contact for patients and carers; • Improved GP access - in terms of time waiting for an appointment and telephone access • More services provided locally, within a community setting e.g. at or via the GP surgery • More locally based day services for carers and patients	• Reduced emergency admissions; • Reduced A&E attendances; • Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia; • Improve patient, carers' and relatives' experience; • Improve health and social outcomes; • Reduced length of	• Large scale organisational change to ensure the whole health and social care system has shared vision and values to enable the delivery of required changes. This includes ensuring the voluntary sector are aware of the direction of travel; • Different skills and training required across multiple professionals and organisations; • Integrated performance monitoring of

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		• Improved communication with patients and carers. This could reduce patients' and carers' concerns regarding treatment and disputes regarding decisions about health care provision and support • Improved communication between health care professionals and across health and social care • Better information, whether it is about services that are available (accessibility, timings, contacts) in different formats including easy read • Reduced cost of void space to the CCGs in future • Improved community bed utilisation • Voluntary and social services integrated into community-based contracts • Integrated contracts for defined geographical locations • Increased emphasis on early interventions and health and wellbeing	stay across the health and social care economy; • Improved transfers of care across health and social care; • Reduced long term placements in residential and nursing home beds; • Reduced need for long term supported care packages; • Increase patients returning to previous level of functionality in usual environment • Improving patients ability to self-manage	pathways needs to support the level of integration required as will be challenging to monitor improvements linked to falls prevention; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring.

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Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	NHS England Funds	Actual contribution (15/16)
Local Authority #1					
Canterbury CCG		2,481	*3727*	*3789*	*12564*
Local Authority #2					
etc					
BCF Total					

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		**2015/16**		**Ongoing**
Outcome 1	Planned savings (if targets fully achieved)			
	Maximum support needed for other services (if targets not achieved)			
Outcome 2	Planned savings (if targets fully achieved)			
	Maximum support needed for other services (if targets not achieved)			

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Canterbury - Integrated Health & Social Care		542				2900			
Canterbury - IUCC		540				2900			
Canterbury - Mental Health Service		200				1100			
Canterbury - Support for care homes		200				1100			
Canterbury - Health and Social Housing		200				1100			
Canterbury - Falls		200				1100			
Canterbury - Community Hub		600				2364			
Total		2482				12564			

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*		N/A	
	Numerator			
	Denominator			
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*		N/A	
	Numerator			
	Denominator			
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*			
	Numerator			
	Denominator			
		(TBC)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]			N/A	
		(insert time period)		*(insert time period)*
[local measure - please give full description]	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	*(insert time period)*	*(insert time period)*

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South Kent Coast
Clinical Commissioning Group

High Level Better Care Fund Plan
NHS South Kent Coast Clinical Commissioning Group

No	Scheme	Description of Scheme	Outcome Measures	High Risks
1	**INTEGRATED TEAMS, RAPID RESPONSE & REABLEMENT**	Integrated teams available 24 hours a day seven days a week will be contactable through single access points. Patients will know who they should contact within these teams whenever they need advice and support. The teams will undertake single assessments and coordinate onward referrals and comprehensive care planning and will provide enhanced rapid response to patients at high risk of hospital admission providing intermediate care and rehabilitation in the community. The teams will integrate with the hospital discharge planning and referral processes seven days a week and will coordinate post-discharge support into the community linking with the community based Neighbourhood Care Teams, primary care and the voluntary sector. **SCHEME REQUIREMENTS:** **Integrated Intermediate Care Pathway & flexible use of community based beds** • Integrated pathway to coordinate referral management, admissions avoidance and care coordination across health and social care, supported by single access points; • Integrated assessments to ensure responsive onward referral to either rapid response services or intermediate care services ensuring transfer to most appropriate care setting (including patients own home); • Intermediate care provision to be provided at patients own home wherever possible by professional carers or by a multidisciplinary team of therapists and nurses;	• Reduced emergency admissions; • Reduced A&E attendances; • Reduced hospital admissions and re-admissions for patients with chronic long term conditions and Dementia; • Improve patient experience; • Improve health outcomes; • Reduced length of stay; • Improved transfers of care; • Reduced long term	• Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability. • Flexibility of community based beds requires constant monitoring to ensure system copes with changing demand; • Integrated performance monitoring of pathways needs to support the level of integration required;

		• Community hospital beds only to be used for comprehensive assessments , for patients needing 24/7 nursing care and for carer respite; • Community based beds (in any local setting) will provide 60% step down from hospital and 40% step up to support timely hospital discharge and prevent avoidable hospital admissions and re-admissions. These beds will be used flexibly to effectively respond to changes in demand. **Enhanced Rapid Response – supporting acute discharge/preventing readmission** • Enhanced Rapid Response teams supporting admissions avoidance as part of intermediate care provision as well as respond directly to A&E referrals; • The teams will be integrated with Emergency Care Practitioners to ensure enhanced skills are available and supporting the ability to keep sub-acute patients at home; • The teams will include medicine management support as well as medical leadership and input from hospital consultants to enable continuous support at home; • The teams will integrate with the Dementia Crisis Service which can receive referrals 24/7 providing support 24/7 to patients with Dementia and carers of people with Dementia to prevent hospital or care home admissions; • The teams will integrate with the Mental Health Crisis Service which provides support 24/7. **Integrated rehabilitation & Non Weight Bearing Pathway** • Integrated approach to support timely hospital discharge, rehabilitation and intermediate care for patients including non-weight bearing patients; • Proactive case management approach to support timely transfer of patients from acute beds into the community and preventing admissions into acute from the community; • Integrated step up and step down beds supported by a dedicated multi-disciplinary team, including therapists, social care and primary care input, to ensure timely patient flows.	placements in residential and nursing home beds; • Reduced need for long term supported care packages; • Increase patients returning to previous level of functionality in usual environment	• IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring.

South Kent Coast
Clinical Commissioning Group

No	Scheme	Description of Scheme	Outcome Measures	High Risks
2	**ENHANCE NEIGHBOURHOOD CARE TEAMS AND CARE COORDINATION**	This model builds a team around the patient who focus holistically on the patients overall health and well-being and pro-actively manages their needs. These teams will be further enhanced to ensure wider integration with other community and primary care based services as well as hospital specialists working out in the community and mental health teams to ensure people can be cared for locally and in their own homes wherever possible and using technology for virtual ward rounds or consultations and remote guidance for GPs rather than patients attending hospital. The teams will be aligned to every GP practice, will undertake Multi-disciplinary Team meetings and will include designated care coordinators for all patients. **SCHEME REQUIREMENTS:** **Risk Profiling to enable proactive care of patients who are at both high and low risk of hospital admission to deliver more coordinated patient care in the community** • Aligned to every GP practice the Neighbourhood Care Teams will be accessible 24 hours a day seven days a week and will coordinate integrated proactive care management of patients through a multi-disciplinary approach with patient involvement at every stage of the process including the development and access of anticipatory care planning to ensure patient centred care and shared decision making; • The Neighbourhood Care Teams function as integrated teams and provide continuity of care for patients who have been referred for support and care in the community, including within care homes, and form the main structure in providing post hospital discharge care and some pre-admission interventions as well as seamless coordination and delivery of end of life care; • The Neighbourhood Care Teams will form the main structure in providing post hospital discharge care and some pre-admission	• Reduced emergency admissions; • Reduced A&E attendances; • Improve patient experience; • Increase levels of patient self management of long term conditions; • Improve health outcomes; • Reduced spend on drugs; • Reduced duplications across the health and social care system; • Reduce the needs for long term placements in residential and nursing homes.	• Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability; • Detailed modelling required to fully understand impact on acute capacity and requirements of community capacity to inform transition over a defined period of time including investment and dis-investment requirements; • Large scale organisational change to ensure the whole health and social care system has shared vision and values to enable the delivery of required changes;

	interventions and will be integrated with pathways to assess a patients home environment; • Access into and out of the Neighbourhood Care Teams will be coordinated through a clinically supported single access points. Patients who require assistance by more than one professional will receive coordinated integrated assessments. This single point of access will be integrated with social services and will be linked with secondary care via a flagging system to report when patients known to the teams have been admitted into secondary care; • Each Neighbourhood Care Team will include input from the wider community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, and Social Case Managers as part of the multi-disciplinary approach; • The teams will support patients with complex needs to better manage their health to live independent lives in the community, including supporting and educating patients with their disease management by using technology, for as long as possible empowering them to take overall responsibility for managing their own health; • The Neighbourhood Care Team will be able to access the relevant care package required to support the person for the time required. **Specialists to integrate into community based generalist roles** • The enhanced Neighbourhood Care Team model requires specialist input from the acute trust in the community to enable the integrated assessment and management of care for more patients in the community for a range of specialisms (respiratory, diabetes, heart failure and COPD) including the care of the over 75s, this will include undertaking clinics and reviews of patients in or close to their own homes rather than in hospital. This could include actual and remote approaches supported through the use of technology, such as video conferencing with acute specialists.		• Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring.

South Kent Coast
Clinical Commissioning Group

No	Scheme	Description of Scheme	Outcome Measures	High Risks
3	**ENHANCE PRIMARY CARE**	Integrated community models of care centred on GP practices requires significant change in primary care working patterns. Different models need to be developed to ensure the right levels of support and capacity is available within general practice and to support the development of sustainable local communities. This will include a hub of practices in every community to improve access to a full range of local health and social care services to support the move from a medical focused model of care and shifting towards a health and well-being focus. **SCHEME REQUIREMENTS:** **Develop primary care based services with improved access and integrated with other community and specialist services** • GPs to undertake proactive case management of patients including regular medication reviews, proactive working with patients to avoid admissions. This will require closer working with social services working with at risk patients to avoid crisis, and better use of carer support services. This could also include virtual ward rounds of at risk patients following hospital discharge; • GP practices to be clustered in hubs and configured in a way that enables different access opportunities for patients to include open access and access to other practices in the hub to improve responsiveness of service provision; • Develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by primary care. This will be co-produced in tandem with public engagement. This will require stronger integration with the Neighbourhood Care Teams and the Intermediate Care Teams and ensuring that all community pathways signpost people as appropriate to the voluntary sector; • Integrated primary care provision will have greater support from specialist hospital teams and stronger links with rapid response services to enable	• Reduced emergency admissions; • Reduced A&E attendances; • Improve patient satisfaction and well-being; • Increase levels of patient self management of long term conditions; • Increase levels of patients with personal health budgets and integrated budgets; • Improve health outcomes by better use of prevention services.	• Extensive workforce reconfiguration in the community to ensure the workforce has the required skills and training to deliver all elements of the scheme; • Large scale organisational change to ensure the whole health and social care system has shared vision and values to enable the delivery of required changes. This includes ensuring the voluntary sector are aware of the direction of travel; • Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and

		patients to remain out of hospital; • GP practices to link with the support to care homes pathways to provide more intensive support. **Primary care service will support and empower patients and carers to self manage their conditions** • Professionals in primary care will promote the use of integrated personal health budgets for patients with long term conditions and mental health needs to increase patient choice and control to meet their health and social care needs in different ways; • Primary care and the Neighbourhood Care Teams will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the community; • The Neighbourhood Care Teams will educate patients about preventative services such as weight management, alcohol services and community mental health prevention services as part of the multidisciplinary assessment; • Patients will be supported by the Neighbourhood Care Teams and primary care to inform and take ownership of their care plans and anticipatory care plans this includes electronic sharing of care records and plans with the patient and between health and social care professionals; • Improved signposting and education will be available to patients through care coordinators and Health Trainers to ensure patients are given information about other opportunities to support them in the community, including the voluntary sector, and community pharmacies. GPs will signpost patients with early signs of mental health to the right services; • Develop a Health and Social Care information advice and guidance strategy to enable people to access services without support from the public sector if they choose to.		support integrated outcome measurement and monitoring.

South Kent Coast
Clinical Commissioning Group

No	Scheme	Description of Scheme	Outcome Measures	High Risks
4	**ENHANCE SUPPORT TO CARE HOMES**	This model supports older people with a range of needs including physical disabilities and dementia will align specialists across multiple teams, including secondary care, to ensure patients in care homes have anticipatory care plans in place and those that are admitted to hospital have robust discharge plans in place before they are discharged in order to prevent re-admissions. **SCHEME REQUIREMENTS:** **An integrated local community based Consultant Geriatrician and specialist nursing team providing support to care homes** • The integrated team can be referred to directly and is aligned to the Neighbourhood Care Teams and the Integrated Intermediate Care teams to undertake reviews all care home discharges from hospital and A&E and ensure appropriate community based services are in place to support patients as part of their discharge planning. These discharge plans will be in place for every patient and known to all community based teams. The team will also undertake anticipatory care planning with the patients and their carers; • The consultant works in the community providing advice to GP in the treatment and support for patients and along with the wider team provides additional support, advice and guidance to care homes. • Access to specialist services such as Dementia Crisis will be available to support care homes; • Care homes will be given access to additional skills development to support improving quality of care and outcomes for the management of residents with long term conditions, compassionate care needs, mental health and wellbeing and management of End of Life care.	• Reduced emergency admissions; • Reduced A&E attendances; • Reduce unnecessary prescribing; • Improve patient satisfaction through personalised care planning.	• Workforce capacity to deliver the scheme is limited considering the large number of care home beds (approximately 3,000) in South Kent Coast; • Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring. • Workforce in care homes needs support to increase skills to support more complex patients.

South Kent Coast
Clinical Commissioning Group

No	Scheme	Description of Scheme	Outcome Measures	High Risks
5	**INTEGRTAED HEALTH AND SOCIAL HOUSING APPROACH**	To develop and improve the utilisation and appropriate use of existing housing options and increase the range if housing options available to people and to ensure it's used flexibly and enables more people to live independently in the community with the right level of support. This will also require responsive adaptations to enable people to manage their condition in a safe home environment. **SCHEME REQUIREMENTS:** **An integrated approach to local housing and accommodation provision, supported by a joint Health and Social care Accommodation Strategy, to enable more people to live safely in a home environment and other environments and to enable people to be discharged from hospital in a timely manner into the appropriate environment.** • Current bed based facilities (both step up and step down) to be flexible and broadened to use housing schemes; • Promote developments of wheelchair accessible housing to support the reduction of costly adaptations; • Responsive timely adaptations to housing; • Preventative pathways to enable patients and service users to return to, following admissions to hospital or care homes, or remain in their homes safely including full holistic home safety checks; • Flexible housing schemes locally; • Increased provision of extra care housing locally, including a facility to support patient rehabilitation or carer respite for short periods of time with clear criteria and processes for accessing such facilities; • Different types of supported accommodation for those with learning disabilities and mental health needs.	• Reduction in emergency hospital admissions; • Reduced A&E attendances; • Reduced residential care admissions; • Reduced care packages; • Increased personalisation; • Reduced delayed transfers of care; • Increased patient experience as more people maintain level of independence in their own home.	• Policy and legislation for housing and Disabled Facilities Grants need to support the level of integration required.

South Kent Coast
Clinical Commissioning Group

No	Scheme	Description of Scheme	Outcome Measures	High Risks
6	**FALLS MANAGEMENT AND PREVENTION**	Development of falls and fracture prevention services for older people to undertake screening and comprehensive assessment aimed at identifying and treating the underlying causes of falls, such as muscle weakness, cardiovascular problems, medication and housing issues. **SCHEME REQUIREMENTS:** **Development of a local specialist falls and fracture prevention service** • This service will work closely with the Neighbourhood Care Teams, Rapid Response and Intermediate Care and will undertake proactive and responsive screening and multi factorial assessments to identify causes of falls and make arrangements for preventative approaches. **Local integrated falls prevention pathways** • Level of current services across locally will be more integrated to include the increased level of input from geriatrician for integrated management and integration with other professionals e.g., pharmacists, chiropodists, podiatrists, opticians and audiologists; • Develop an Integrated Ambulance Falls Response Service; • Improve availability and awareness of therapeutic exercise programmes (postural stability classes) via community classes, domiciliary based and within care homes.	• Reduction in falls and secondary falls; • Reduction in hip fractures; • Improve patient experience and levels of self management; • Reduced emergency admissions; • Reduced A&E attendances.	• Different skills and training required across multiple professionals and organisations; • Integrated performance monitoring of pathways needs to support the level of integration required as will be challenging to monitor improvements linked to falls prevention; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring.

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Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Kent County Council**
Clinical Commissioning Groups	**NHS South Kent Coast CCG**
Boundary Differences	
Date agreed at Health and Well-Being Board:	**12 February (1st draft)**
Date submitted:	**13 March**
Minimum required value of ITF pooled budget: 2014/15	**£3,884,000**
2015/16	**£13,283,000**
Total agreed value of pooled budget: 2014/15	**£3,884,000**
2015/16	**£13,283,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS South Kent Coast CCG
By	Hazel Carpenter
Position	Accountable Officer
Date	3 February 2014

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

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

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

The South Kent Coast Integrated Commissioning Group has overseen the development of the Better Care Plan and has included representation from local providers to help shape the plan and the schemes within it during January and February. Details of each scheme has been shared and discussed with representatives from the local acute trust, community trust and the mental health trust through the discussions at the Integrated Commissioning Group.

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

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it.

The Better Care Plan includes schemes already included in the CCGs operational plans for 2014/15. For these elements a range of local CCG engagement activities have been undertaken throughout 2013/14 in preparation for the 2014 plans. These include;

- Public Events – including focus groups to develop and integrated Intermediate Care pathway;
- Membership Council(s) – including the development of the Integrated Community Nursing model and Neighbourhood Care Teams;
- Locality Meetings – to test plans on GP membership
- Health Reference Groups - to test plans on patient group

For elements of the Better Care Plan that are an enhancement or addition to the 2014/15 operational plans on-going engagement activities will be undertaken to ensure our clinically led plans are tested on the patients and service users the plans impact upon.

e) 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
High level description of each scheme	BCF Schemes summary and outcome
High level timetable of plans	SKC Better Care Fund Programme Plan HIGH

2) VISION AND SCHEMES

a) Vision for health and care services
Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Vision
The South Kent Coast vision for integrated health and social care is for patients to always be at the heart of their care and support, receiving coordinated services without organisational barriers that are easy to access 24/7, of high quality and that maximises their ability to live independently and safely in their community and in their own homes wherever possible. We will ensure service users and their carers can navigate the services they need and that their health and well-being needs are always met by the right service in the right location.

We will achieve this by building integrated health and social care teams around every patient. These teams, linked to every GP practice, will undertake integrated health and social care assessments and coordinated care planning to pro-actively manage patient's conditions and needs in the community helping people to stay out of hospital or to recover more quickly after a hospital stay.

Our plans for the Better Care Fund will be achieved by a number of schemes aimed at services working together to provide better support for people with long term conditions, older people and people with disabilities at home to maintain independence and earlier treatment in the community to prevent people needing emergency care in hospital or care homes and education and empowering people to make decisions about their own health and well-being. We will deliver this by:

- Building on and enhancing some of the local projects already implemented or planned and;
- Introducing other schemes to ensure faster evolution of what we are already setting out to achieve.

Changes to service configuration
As set out in the CCGs five year strategy the overall vision to ensure the best health and care for our community will result in changes to current service configuration. Achieving the CCGs vision will require building sufficient capacity in the community, including the workforce, whilst reducing capacity in acute hospitals in order to deliver the following:

- Out of hospital services to be integrated and wrapped around the most vulnerable to enable them to remain in their own home for as long as possible. Patients will be supported by a package of care focussed on their personal health and wellbeing ambitions;

- Acute hospital services will be specialist facilities whether for physical or mental health needs and will be highly expert to ensure high quality. Hospitals will act as hubs for clinicians to work out from and utilise their skills as part of broader teams as close to the patient as possible.

Patient and service user outcomes
By working in new and innovative ways we aim to achieve the following:
- Focus on prevention and targeted interventions to support peoples overall health and well-being;
- Ensure services respond rapidly and more effectively to patient's needs, especially at times of crisis;
- Support carers and empower individuals to do more for themselves;
- Improve the overall patient experience of the delivery of care.

b) Aims and objectives
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:
- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Aims and objectives of an integrated system
With a high elderly population in South Kent Coast and increasing numbers of people who have one or more long-term condition we aim to focus the Better Care Fund on prevention, reducing the demand and making the most efficient and effective use of health and social care resources.
Our plans for the Better Care Fund support the delivery of the CCGs five year strategy which has a strong focus on the management of long term conditions and the subsequent impact long term conditions has on the local health systems. The plan will also support the delivery of the five year East Kent Strategic Plan (2014-2019).

Given the extent of integration set out in our plans there are considerable changes to the current ways of working and the existing workforce across multiple organisations. This will require us to undertake work to re-shape the supply of the market to enable delivery of our plans over time; this may take the form of an Integrated Care Organisation.
South Kent Coast CCG has developed an Integrated Commissioning Strategy in partnership with the local authority and both Dover and Shepway District Councils. This Strategy identified four shared aims which are working together toward:

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

contribute to their local communities and;
- To ensure that the best possible care is provided at the end of people's lives.

Measuring improved outcomes

By delivering the above aims to will achieve the following outcomes:
- Reduced hospital admissions;
- Reduced length of stay in hospital;
- Timely access to local health and social care services;
- Improved access to information which allows people to make decision about their own lives;
- Thriving and self-reliant communities;
- Reduction in duplication;
- People will have access to local quality housing that meets their needs;
- People will be able to get around and access facilities in their local communities;
- People will have more choice and control over the health and social care services they use;
- After people are discharged from hospital they will return home to a safe and accessible environment as quickly as possible;
- Carers will have access to good quality information and advice;
- Carers will be supported to access services to support them in that role;
- Carers will be supported to stay mentally and physically well and treated with dignity;
- Improve end of life care for people living in residential, nursing and extra care housing;
- More people die in the place of their choice having received the care appropriate to their needs;
- Improved end of life care for people with dementia and long term conditions.
- Ensure services respond rapidly and more effectively;
- Support carers and empower individuals to do more for themselves;
- Improve the patient experience of the delivery of care

The above measures will be monitored using an integrated performance dashboard for the Better Care Fund, this will be developed and piloted during 2014/15.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:
- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

To achieve greater transformation to the integration of local services the current identified local priority schemes for the Better Care Fund are listed below:

- **<u>Integrated Teams and Reablement</u>**

Integrated teams available 24 hours a day seven days a week will be contactable through single access points. Patients will know who they should contact within these teams whenever they need advice and support. The teams will undertake single assessments and coordinate onward referrals and comprehensive care planning and will provide

enhanced rapid response to patients at high risk of hospital admission providing intermediate care and rehabilitation in the community. The teams will integrate with the hospital discharge planning and referral processes seven days a week and coordinate post-discharge support into the community linking with the community based Neighbourhood Care Teams, primary care and the voluntary sector.

SCHEME REQUIREMENTS

Integrated Intermediate Care Pathway & flexible use of community based beds

- Integrated pathway to coordinate referral management, admissions avoidance and care coordination across health and social care, supported by single access points;
- Integrated assessments to ensure responsive onward referral to either rapid response services or intermediate care services ensuring transfer to most appropriate care setting (including patients own home);
- Intermediate care provision to be provided at patients own home wherever possible by professional carers or by a multidisciplinary team of therapists and nurses;
- Community hospital beds only to be used for comprehensive assessments, for patients needing 24/7 nursing rehabilitative care and for carer respite;
- Community based beds (in any local setting) will provide 60% step down from hospital and 40% step up to support timely hospital discharge and prevent avoidable hospital admissions and re-admissions. These beds will be used flexibly to effectively respond to changes in demand.

Enhanced Rapid Response – supporting acute discharge/preventing readmission

- Enhanced Rapid Response teams supporting admissions avoidance as part of intermediate care provision as well as respond directly to A&E referrals;
- The teams will be integrated with Emergency Care Practitioners to ensure enhanced skills are available and supporting the ability to keep sub-acute patients at home;
- The teams will include medicine management support as well as medical leadership and input from hospital consultants to enable continuous support at home;
- The teams will integrate with the Dementia Crisis Service which can receive referrals 24/7 providing support 24/7 to patients with Dementia and carers of people with Dementia to prevent hospital or care home admissions.

Integrated rehabilitation & Non Weight Bearing Pathway

- Integrated approach to support timely hospital discharge, rehabilitation and intermediate care for patients including non-weight bearing patients;
- Proactive case management approach to support timely transfer of patients from acute beds into the community and preventing admissions into acute from the community;
- Integrated step up and step down beds supported by a dedicated multi-disciplinary team, including therapists, social care and primary care input, to ensure timely patient flows.

- **Enhance Neighbourhood Care Teams and Care Coordination**

This model builds a team around the patient who focus holistically on the patients overall

health and well-being and pro-actively manages their needs. These teams will be further enhanced to ensure wider integration with other community and primary care based services as well as hospital specialists working out in the community and mental health teams to ensure people can be cared for locally and in their own homes wherever possible and using technology for virtual ward rounds or consultations and remote guidance for GPs rather than patients attending hospital. The teams will be aligned to every GP practice, will undertake Multi-disciplinary Team meetings and will include designated care coordinators for all patients.

SCHEME REQUIREMENTS:

Risk Profiling to enable Proactive Care of patients who are at both high and low risk of hospital admission to deliver more coordinated patient care in the community (see section d below for further details of the South Kent Coast Pro-Active Care Programme)

- Aligned to every GP practice the Neighbourhood Care Teams will be accessible 24 hours a day seven days a week and will coordinate integrated proactive care management of patients through a multi-disciplinary approach with patient involvement at every stage of the process including the development and access of anticipatory care planning to ensure patient centred care and shared decision making;
- The Neighbourhood Care Teams function as integrated teams and provide continuity of care for patients who have been referred for support in the community and form the main structure in providing post hospital discharge care and some pre-admission interventions as well as seamless coordination and delivery of End of Life care;
- The Neighbourhood Care Teams will form the main structure in providing post hospital discharge care and some pre-admission interventions and will be integrated with pathways to asses a patients home environment;
- Access into and out of the Neighbourhood Care Teams will be coordinated through clinically supported single access points. Patients who require assistance by more than one professional will receive coordinated integrated assessments. This single point of access will be integrated with social services and will be linked with secondary care via a flagging system to report when patients known to the teams have been admitted into secondary care;
- Each Neighbourhood Care Team will include input from the wider community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, and Social Care Managers as part of the multi-disciplinary approach;
- The teams will support patients with complex needs to better manage their health to live independent lives in the community, including supporting and educating patients with their disease management by using technology, for as long as possible empowering them to take overall responsibility for managing their own health;
- The Neighbourhood Care Team will be able to access the relevant care package required to support the person for the time required.

Specialists to integrate into community based generalist roles

- The enhanced Neighbourhood Care Team model requires specialist input from acute in the community to enable the management of care for more patients in the community for a range of specialisms (respiratory, diabetes, heart failure and COPD) including the care of the over 75s, this will include undertaking clinics and

reviews of patients in or close to their own homes rather than in hospital. This could include actual and remote approaches supported through the use of technology, such as video conferencing with acute specialists.

- **<u>Enhance Primary Care</u>**

Integrated community models of care centred on GP practices requires significant change in primary care working patterns. Different models need to be developed to ensure the right levels of support and capacity is available within general practice and to support the development of sustainable local communities. This will include a hub of practices in every community to improve access to a full range of local health and social care services to support the move from a medical focused model of care and shifting towards a health and well-being focus.

SCHEME REQUIREMENTS:

Develop primary care based services with improved access and integrated with other community and specialist services

- GPs to undertake proactive case management of patients including regular medication reviews, proactive working with patients to avoid admissions. This will require closer working with social services working with at risk patients to avoid crisis and better use of carer support services. This could also include virtual ward rounds of at risk patients following hospital discharge;
- GP practices to be clustered in hubs and configured in a way that enables different access opportunities for patients to include open access and access to other practices in the hub to improve responsiveness of service provision;
- Develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by primary care. This will require stronger integration with the Neighbourhood Care Teams as well as stronger links with and signposting to the voluntary sector;
- Integrated primary care provision will have greater support from specialist hospital teams to ensure on-going medical care for patients after hospital discharge by creating shared on-going care plans to avoid hospitals readmissions and stronger links with rapid response services to enable patients to remain out of hospital;
- GP practices to link with the support to care homes pathways to provide more intensive support

Primary care service will support and empower patients and carers to self manage their conditions

- Professionals in primary care will promote the use of integrated personal health budgets for patients with long term conditions and mental health needs to increase patient choice and control to meet their health and social care needs in different ways;
- Primary care and the Neighbourhood Care Teams will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the community;
- The Neighbourhood Care Teams will educate patients about preventative services such as weight management and alcohol services as part of the multidisciplinary assessment;
- Patients will be supported by the Neighbourhood Care Teams and primary care to inform and take ownership of their care plans this includes electronic sharing of

care records with the patient and between health and social care professionals;

- Improved signposting and education and access to signposting and education will be available to patients through care coordinators and Health Trainers to ensure patients are given information about other opportunities to support them in the community, including the voluntary sector, and community pharmacies. GPs will signpost patients with early signs of mental health to the right services
- Develop a Health and social care information advice and guidance strategy to enable people to access services without support from the public sector if they choose to.

- **Enhance support to Care Homes**

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

SCHEME REQUIREMENTS:

An integrated local community based Consultant Geriatrician and specialist nursing team providing support to care homes

- The integrated team can be referred to directly and is aligned to the Neighbourhood Care Teams and the Integrated Intermediate Care teams to undertake reviews all care home discharges from hospital and A&E and ensure appropriate community based services are in place to support patients as part of their discharge planning. These discharge plans will be in place for every patient and known to all community based teams. The team will also undertake anticipatory care planning with the patients and their carers;
- The consultant works in the community providing advice to GP in the treatment and support for patients and along with the wider team provides additional support, advice and guidance to care homes;
- Access to specialist services such as Dementia Crisis will be available to support care homes.

- **Integrated Health and Social Housing approaches**

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

SCHEME REQUIREMENTS:

An integrated approach to local housing and accommodation provision to enable, supported by a joint Health and Social Care Accommodation Strategy, to enable more people to live safely in a home and other environments and to enable people to be discharged from hospital in a timely manner into the appropriate environment.

- Current bed based facilities (step up and step down) to be flexible and broadened to use housing schemes;
- Promote developments of wheelchair accessible housing to support the reduction

of costly adaptations;
- Responsive timely adaptations to housing;
- Preventative pathways to enable patients and service users to return to (following hospital and care home admissions) and remain in their homes safely including full holistic home safety checks;
- Flexible housing schemes locally;
- Increased provision of extra care housing locally, including a facility to support patient rehabilitation or carer respite for short periods of time with clear criteria and processes for accessing such facilities;
- Different types of supported accommodation for those with learning disabilities and mental health needs.

- **Falls prevention**

Development of falls and fracture prevention services for older people to undertake screening and comprehensive assessment aimed at identifying and treating the underlying causes of falls, such as muscle weakness, cardiovascular problems, medication and housing issues.

SCHEME REQUIREMENTS:

Development of a local specialist falls and fracture prevention service
- This service will work closely with the Neighbourhood Care Teams, Rapid Response and Intermediate Care and will undertake proactive and responsive screening and multi factorial assessments to identify causes of falls and make arrangements for preventative approaches.

Local integrated falls prevention pathways
- Level of current services across locally will be more integrated to include the increased level of input from geriatrician for integrated management and integration with other professionals e.g., pharmacists, chiropodists, podiatrists, opticians and audiologists;
- Develop an Integrated Ambulance Falls Response Service;
- Improve availability and awareness of therapeutic exercise programmes (postural stability classes) via community classes and domiciliary based.

Success factors and timeframes for delivery
Each of the above schemes has a range of outcome measures to demonstrate success. The key measurements of success are as follows:

- Reduced A&E attendances;
- Reduced hospital admissions and re-admissions for patients with chronic long term conditions and Dementia;
- Reduced length of stay;
- Improved transfers of care;
- Reduced long term placements in residential and nursing home beds;
- Reduced need for long term supported care packages;
- Increase patients returning to previous level of functionality in usual environment;
- Increase levels of patient self management of long term conditions;
- Reduction in falls and secondary falls;
- Reduction in hip fractures;

- Improve patient satisfaction and well-being;
- Increase levels of patients with personal health budgets and integrated budgets;
- Improve health outcomes by better use of prevention services;
- Reduce unnecessary prescribing.

To ensure delivery of the above schemes in 2015/16 a programme plan setting out details of the key milestones is in development and will be refined during 2014/15 to ensure clarity of when the changes come into effect and the implications of these changes as well as the expected outcomes. The programme plan will also include contingencies if the plans are not delivered.

Alignment with local JSNA and local commissioning plans
The schemes outlined in this plan which have been developed in partnership with social care commissioners. The schemes, along with the CCGs overall commissioning plans, will support addressing the pressing needs identified through the local Joint Strategic Needs Assessment, particularly around the care of people with long term conditions and for those families and individuals supporting them. These health priorities are as follows:

- Being ready to respond to the impact of our aging population;
- Tackling increasing inequalities;
- Improving access to primary care services;
- Managing patients mental health (including Dementia);
- Increasing access to care closer to home;
- Tackle patients' long term conditions;
- Tackle unnecessary and unfair variations in care;
- Improve management and identification of diabetes;
- Pro-active general practice (smoking, weight, alcohol, health checks etc.);
- Work closely with partners to tackle patients and carer wellbeing.

d) Implications for the acute sector
Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The plans align with the delivery of the CCGs strategy, as outlined in section 2a above. The majority of the NHS savings will be realised by the reduced emergency attendances and admissions and a reduction in length of stays within the acute setting and therefore there will be a reduced investment in secondary care.

The plans will not have a negative impact on the CCGs constitutional targets as set out in the Everyone Counts: Planning for Patients 2014/15-2018/19. The plans should enable the delivery of some of these targets, in particular the A&E waiting times and the proportion of older people at home 91 days after discharge from hospital into Reablement/rehabilitation services.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The local Better Care plans will be implemented and monitored using a commissioning project management framework. The delivery of the schemes will be supported by the local Integrated Commissioning Group which will report progress to the local Health and Well Being Board. Delivery of the plans will ultimately be the responsibility of the CCGs Governing Board.

All defined milestones and outcomes of the plan will be monitored at a CCG's Governing Body committee level via the Performance and Delivery Committee and reported for assurance purposes to the Governing Body. The Better Care Fund schemes and metrics will be included within the body of the Integrated Quality and Performance Report which is a standing agenda item on the Performance and Delivery Committee.

The committee feeds into the CCG's risk register and any risk to delivery or expected outcomes will be included via output from the committee. Whilst many of the metrics are nationally defined and officially reported annually, proxy measures will be used to monitor them in year, including the Levels of Ambition Tool, Atlas of Variation and SUS data.

3) NATIONAL CONDITIONS

a) Protecting social care services
Please outline your agreed local definition of protecting adult social care services.

The Better Care Fund plans set out a vision for a fully integrated health and social care system. The delivery of these plans will not have an adverse impact the care on the adult social care services and therefore patients and service users eligible for social care services will continue to receive the care they need.

Please explain how local social care services will be protected within your plans.

By managing to reable people back to a level of care that means they can manage in the community this will reduce the impact on social care freeing up capacity for the increased demand on services. Development of a Self Care Strategy will support the prevention agenda which will benefit all organisations as will the development of a joint information advice and guidance strategy which signposts people to the right place.

b) 7 day services to support discharge
Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

The Kent Joint Health and Wellbeing Strategy sets out a number of outcomes aimed at providing seven day health and social care services across the local health economy, for example:

- Ensure all agencies who are working with people most at risk of admission to hospital and long term care have access to anticipatory and advanced care plans and 24/7 crisis response services in order to provide the support needed;
- Ensure all people with a significant mental health concern, or their carers, can access a local crisis response service at any time and an urgent response within 24 hours.

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

In South Kent Coast the enhanced multidisciplinary Neighbourhood Care Team is the main structure for providing post hospital care for any reason and some pre-admission intervention in the community.

c) Data sharing
Please confirm that you are 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. **NHS** At present all NHS organisations must ensure that a minimum of 95 per cent of all active patient records have an NHS number. The NHS Information Standards Board mandates the use of the NHS number on both general practice and secondary care organisations. The NHS standard contract states: "Subject to and in accordance with guidance the provider must ensure that the service user health record includes the service user's verified NHS number. The provider must use the NHS Number as the primary identifier in all clinical correspondence (paper or electronic). The provider must be able to use the NHS Number to identify all activity relating to a service user." **Social Care** A 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. The NHS number is predominately used to facilitate the matching of data sets for Year of Care and Risk Stratification, not for correspondence or to undertake client checks, the numbers are too low. We would use name: address and date of birth as the key identifiers at present. Further work will be required to ensure NHS number is used across all correspondence. KCC achieved approx. 80% matching of records to NHS numbers when we started, improvement to this percentage would need significant additional resource. 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).

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Not applicable.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

South Kent Coast CCG, along with all other East Kent CCGs, is committed to using the Medical Interoperability Gateway (MIG) as its preferred solution to interoperability. This is provided by a joint venture between EMIS and INPS Vision, in a company called Healthcare Gateway. Not only will this be within the CCG's Information Technology Strategy, ensuring all new systems utilise this technology, contracts with providers will

also require a commitment of their agreement to utilise the MIG. Data sharing (with GPs as the data controllers) have been developed as have governance protocols for the viewing of patient identifiable data and patient consent. In the main consent will be requested at the point of treatment, but protocols are in place for patients who are physically unable to give consent i.e. unconscious.

The project first stage is the integrated use with EKHUFT's A&E and pharmacy departments, stages 2 and 3 will widen this to other providers, as well as allow viewing of provider data at the GP practice site.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Please see previous response for Governance arrangements around data sharing with regards to the MIG.

d) Joint assessment and accountable lead professional
Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

In South Kent Coast the accountable lead professional for people at high risk of hospital admission is their GP. Risk stratification is undertaken by practices and shared with community nursing teams to identify those patients most at risk. These patients are recommended for Proactive Care to ensure coordination of all their health and social care needs to prevent hospital admissions. If the patients are under the care of the community nursing or intermediate care teams they are informed on how to contact a member of these teams 24/7 if they need to. All patients at high risk or hospital admission and put forward for Proactive Care have a joint care plan in place.

Risk Profiling (Pro-Active Care)
South Kent Coast CCG has been running a programme called Pro-Active Care which almost all practices are participating in. Pro-Active Care is a 12 week intervention by a multi-disciplinary health and social care team for risk stratified patients with multiple co-morbidities. The aim is to improve patient's self-management, their quality of life, medicines compliance and reduce A&E and associated hospital admissions.

Through risk stratification Pro-Active Care targets the patients at highest risk of hospital admission and then works its way through the lower risk patients. This is something that, over a year on, the first practices to run pro-active care are now starting to achieve after having seen all of their highest risk long term condition patients. In turn this means that the amount of clinical time and intervention decreases with lower risk patients and there is an expectation that such intervention will go some way to preventing these lower risk patients from deteriorating as fast thus prolonging their health and quality of life over the long term.

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

4) RISKS
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

Risk	Risk rating	Mitigating Actions
Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability.	High	Each responsible organisation to develop a detailed workforce plan to support delivery of each scheme.
Different skills and training required across multiple professionals and organisations.	High	Training and skills requirements for each scheme to be linked to workforce plan to support the delivery.
Governance of the plans and the delivery of a fully integrated health and social care system should be clinically led and clearly defined.	High	The plans will be governed jointly by the CCG and the local authority using joint metrics. The CCG will report delivery of the plans through existing assurance frameworks.
Communication – need to ensure robust communication with the public and across organisations to ensure people know how to access services within the integrated system to ensure services are used appropriately	High	Robust communication plan to be developed to support delivery of each scheme.
IT systems across services not integrated and therefore do not enable shared care plans between organisations and support integrated outcome measurement and monitoring.	High	Integrated system to support sharing of care plans to be developed as a priority. Integrated performance monitoring and reporting to be enhanced to take into account all schemes.
Transition of service capacity changes to be planned and implemented in stages to prevent destabilising the system.	High	Detailed modelling required to fully understand impact on acute capacity and requirements of community capacity to inform transition over a defined period of time including investment and dis-investment requirements.
The investment required into primary care for the full benefits of the plan falls outside the remit of the pooled budget and sits with NHS England.	High	To be discussed with NHS England.
Cultural change – significant shift in how	High	Ensure whole health and

systems need to work in the future requirement large culture change		social care system has shared vision and values to enable the delivery of required changes. Communication with organisations, staff and service users to be included in communication plan.
Regulatory and legislative environment – current arrangements not always looking at how the overall system works	High	Provide feedback to NHS England on this issue via the Kent Pioneer Programme.

South Kent Coast CCG
Better Care Fund - Programme Plan (High Level)

SKC Better Care Fund Plan - High level timetable

				Development Year 2014/15				Better Care Fund Delivery 2015/16			
No.	**Tasks**	**Lead/s**	**RAG status**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
1	**Programme Governance/Monitoring**										
1.1	Develop project briefs and plans to set out details of all schemes including milestones	ZM									
1.2	Finalise performance dashboard (activity and finance) to include all scheme metrics	TBC									
1.3	Agree details of section 256 monies for the 14/15 schemes and how they support 15/16 transformational changes	CCG/KCC									
1.4	Agree reporting process with Integrated Commissioning Group & local HWBB	ICG									
1.5	Agree timetable for reporting progress of plans through CCG assurance framework	ZM									
1.6	Agree communication plans and ongoing engagement activities for shemes (patients/members/providers/other stakeho	ZM									
1.7	Reports to Local HWBB	ZM									
1.8	Reports to CCG Clinical Cabinet & Performance & Delivery Committees	ZM									
1.9	*Others (tbc)*										
2	**Integrated Teams, Rapid Response & Reablement (supported by local Intermediate Care group)**										
2.1	Agree amendments to existing ICT service specification and communicate with stakeholders	ZM/KCHT									
2.2	Agree trajectory for achieving 60%:40% split for step down/step up community hospital beds	ZM/KCHT									
2.3	Further work to defined enhancement of rapid response	CCG/KCHT/KCC									
2.4	Complete modelling of activty to determine therapist input required 7 days a week	KCHT/CCG									
2.5	Commence pilot of an integrated intermediate care performance dashboard	CCG/KCC/KCHT									
2.6	Review evaluation of non-weight bearing / interim beds project and confirm model of care & investment for model	CCG									
2.7	Implement integrated rehabilitation & non-weight bearing pathway (with additional beds if agreed)	CCG									
2.8	Implement changes to ICT to achieve next stage of integration	KCHT									
2.9	Integrate ICT single point of access with social services & ICT for all areas	KCHT/KCC									
2. 10	Agree details of an integrated hospital discharge team and how it links to community pathways	KCHT/EKHUFT/CCG									
2. 11	Step up (40%) beds available in community hospital supported by revised criteria	KCHT									
2. 12	Implement enhanced rapid response (1st stage)	KCHT									
2. 13	Implement enhanced rapid response (2nd stage)	KCHT									
2. 14	*Additional developments for 2014/15 tbc*										
2. 15	*Additional changes for 2015/16 tbc*										
3	**Enhance Neighbourhood Care Teams & Care Coordination (supported by Proactive Care & Primary Care Groups)**										
3.1	Agree further enhancement of NCTs	CCG									
3.2	Integrate NCT single point of access with social services & ICT	KCHT/KCC									
3.3	Integrate NCT pathways with secondary care including the development of integrated discharge teams	KCHT/CCG									
3.4	*Additional developments for 2014/15 tbc*										
3.5	*Additional changes for 2015/16 tbc*										
4	**Enhance Primary Care (supported by Primary Care Development group)**										
4.1	Agree pathway for proactive management of high risk patients and how MDTs fit with new schemes	ZM									
4.2	Start implementing schemes to support over 75s (to be listed seperately once agreed)	CCG									
4.3	Agree additional opportunities for enhancing primary care	CCG									
4.4	*Additional developments for 2014/15 tbc*										
4.5	*Additional changes for 2015/16 tbc*										
5	**Enhance Support to Care Homes (supported by local Care Homes group)**										
5.1	Recruit additional resource to CNS Older People team to enhance existing pathway and implement changes	KCHT									
5.2	Agree outcomes for scheme jointly with stakeholders	JDK									
5.3	Implement revised service specification to formally reflect changes to existing contract	JDK									
5.4	Develop stakeholder engagement plans	CCG									

South Kent Coast CCG
Better Care Fund - Programme Plan (High Level)

5.5	Integrate CNS for older people to consultant team, NCT, single point of access & ICT	KCHT									
5.6	Agree care homes discharge pathway from acute (linked to integrated discharge teams)	CCG/EKHUFT/KCHT									
5.7	Develop an outline for a skills programme to increase care home quality of care and outcomes (agree pilot homes)	CCG									
5.8	Commence a pilot of the agreed skills programme in at least 5 homes	CCG									
5.9	Agree integrated anticipatory care plan/patient management plan to be used at point of hospital discharge	CCG/EKHUFT/KCHT									
5. 10	Further engagement to confirm ongoing developments	CCG									
5. 11	*Additional developments for 2014/15 tbc*										
5. 12	*Additional changes for 2015/16 tbc*										
6	**Integrated Health & Social Housing Approach (supported by Integrated Commissioning Group)**										
6.1	Agree local priorities following consultation on Accommodation Strategy	KCC/CCG									
6.2	Commence reviews of jointly funded existing facilities (details tbc)	KCC/CCG									
6.3	Assess and gaps in existing home safety check processes and agree future requirements	KCC/CCG									
6.4	Implement extra care housing scheme at Deal	KCC									
6.5	*Additional developments for 2014/15 tbc*										
6.6	*Additional changes for 2015/16 tbc*										
7	**Falls Management & Prevention (supported by local Falls group)**										
7.1	Agree changes to local falls pathway and develop action plan	CCG									
7.2	Communicate pathway with stakeholders	CCG									
7.3	Develop details of pilot for postural stability classes in care homes	CCG/Public Health									
7.4	Develop details of local integrated ambulance falls response service	CCG/KCC									
7.5	Undertake care homes postural stability clasess pilot	CCG/Public Health									
7.6	Implement integrated falls pathway across	CCG									
7.7	Implement locall integrated ambulance falls response service	CCG/KCC									
7.8	Implement local specialised falls and fracture prevention service	CCG									
7.9	*Additional developments for 2014/15 tbc*										
7. 10	*Additional changes for 2015/16 tbc*										

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
South Kent Coast		3,884,000	13,283,000	13,283,000
BCF Total		3,884,000	13,283,000	13,283,000

Section 256 monies

Require further details from KCC to show how the 2014/15 s256 monies align to the schemes in the local plan and how the monies will support transformational step change in 2015/16

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		2015/16	Ongoing
Admissions to residential and care homes	Planned savings (if targets fully achieved)	468,000	468,000
	Maximum support needed for other services (if targets not achieved)	468,000	468,000
Effectiveness of reablement	Planned savings (if targets fully achieved)	42,000	42,000
	Maximum support needed for other services (if targets not achieved)	42,000	42,000
	Planned savings (if targets fully achieved)	0	0

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Metrics
Permanent admissions of older people to residential and care homes - reduced number of those 65+ admitted to care homes
Effectiveness of Reablement - those 65+ still as home 91 days after discharge, ranging from 88.10-90%
Delayed Transfers of Care - reduction in total number of delayed transfers of care each month
Avoidable Emergency Admissions - reduction in admissions to be reported via the Levels of Ambition Atlas as provided by NHS England
Proportion of people feeling supported to manage their condition (local metric) - to be measured from the GP Survey every six months

Local Outcomes
Reduced A&E attendances
Reduced hospital admissions for patients with chronic long term conditions and dementia
Reduced re-admissions for patients with chronic long term conditions and dementia
Reduced Length of Stay
Reduced long term placements in residential and nursing packages
Reduce the need for long term support packages
Increase patients returning to previous level of functionality in usual environment
Increase levels of patient self management of long term conditions
Reduction in falls and secondary falls
Improve patient satisfaction and well being
Increase levels of patients with personal health budgets and integrated budgets
Improve health outcomes by better use of prevention services
Reduce unnecessary prescribing

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

Local patient / service user experience metric: Average EQ-5D score for people reporting having one or more long-term condition - to be reported via the Levels of Ambition Atlas as provided by NHS England

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

An integrated performance dashboard to be developed and made available monthly. This will be monitored through the CCGs existing assurance framework and made available to the local Health and well being Board and its Integrated Commissioning sub committee.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	156.2	N/A	154
	Numerator	358		346
	Denominator	43636		44552
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	88.10%	N/A	90%
	Numerator	1401		1431
	Denominator	1590		1590
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	38.5		36.4
	Numerator	13		11
	Denominator	200382		202306
		(April 2012 - March 2013)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	1774.9	N/A	1759.7
	Numerator	not supplied		
	Denominator	not supplied		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Patient / service user experience: Average EQ-5D score for people reporting having one or more long-term condition		72.4	N/A	72.6
		(April 2012 - March 2013)		(April 2014 - March 2015)
(Local Metric) Proportion of People feeling supported to manage their condition. Expressed as a percentage and reflects the number of 'Yes, definitely', and 'Yes to some extent', response in the GP patient survey as a proportion of the total answers.	*Metric Value*	64.8%	N/A	70.0%
	Numerator	1176		1271
	Denominator	1815		1815
		(July 2013 to September 2013)		(January 2015 to March 2015

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Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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.

DRAFT

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Kent County Council**
Clinical Commissioning Groups	**NHS Thanet CCG**
Boundary Differences	
Date agreed at Health and Well-Being Board:	**12 February (1st draft)**
Date submitted:	**3 February (1st Draft for 12 Feb Kent HWB)**
Minimum required value of ITF pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Thanet Clinical Commissioning Group
By	Hazel Carpenter
Position	Accountable Officer
Date	3rd February 2014

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

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

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Thanet CCG has already begun the work of transformational system change in collaboration with its major providers in both health and social care. This has resulted in an East Kent strategic plan that sets out the vision for a desired health and care system in 2018/19. This includes outcomes for people; a clear financial sustainability model; improvement interventions to achieve the desired outcomes and system along with the governance that will oversee the delivery of the plans and the key values and principles required to underpin the system wide working to deliver the vision.

The four East Kent CCGs, on establishment, recognised the need to work together at a strategic level thus establishing the East Kent Federation and associated Whole System Board and related infrastructure. The Whole System Board agreed to take forward a collaborative approach to the development and delivery of a strategic plan establishing the necessary local service change to enable the local health and social care to ***best meet the needs of local people, delivering the right experience and outcomes in a way that is sustainable into the future.***

There is high-level multi-agency agreement in the direction of travel set out in the national vision. For services to integrate wrapping around the most vulnerable to enable them to remain in their own home for as long as possible supported by a package of care and support focused on their personal health and wellbeing ambitions. This will lead to a broader and potentially more innovative delivery of health and care out of hospital.

The local Thanet Integrated Commissioning Group (ICG) has been central to the development of the Integration agenda and specifically the Better Care Fund Plan. Its membership includes representation from CCG Commissioners, Local Authorities, service providers and stakeholders working to help shape the range of schemes and proposals. Work is also underway with our major providers to explore transformational system wide change through integration opportunities.

The East Kent Federation vision has been developed and shared at the East Kent Whole Systems Board whose membership includes local providers. Our local plans have been informed and are aligned to this vision.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

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A number of Thanet commissioning schemes included in its operational plans for 2014 are included in the Better Care Fund Plan. These were developed through the CCGs stakeholder engagement activities led by its Communication and Engagement Committee and outlined in its local community and engagement strategy. These include:

- A number of Public and Voluntary Sector Events under the banner of 'A call to action'
- Engagement with service users via Thanet Health Network
- A number of engagement events with individual Practice Patient Groups
- Locality Meetings – GP planning

Further patient, service user and public engagement activities will be developed through 2014 as part of the work of the Integrated Commissioning Group and will, with engagement with all stakeholders form a system wide/multi-agency perspective. This will inform further development of the Better Care Plan into 2015/16

e) 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**
Developing the East Kent Strategic Plan 2014-19 – East Kent Federation	
Thanet Clinical Commissioning Group Strategic – *Working towards a healthier Thanet 2013-2018*	

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2) VISION AND SCHEMES

a) Vision for health and care services
Please describe the vision for health and social care services for this community for 2018/19.

Thanet CCG is committed to transforming the health of people living and working in Thanet, we will work with local people, communities and our partners to deliver high quality services that are patient centred, safe and innovative. We want all of our local communities to be ambitious about their own health and to challenge the best possible care in the best possible environments with our resources.

Our vision is to provide care that crosses organisational boundaries and best serves the needs of the population we serve. This is outlined both in our strategic planning and our developing work on integration. Our ambition is to achieve a health economy that is both fit for purpose and sustainable for the future.

This vision will take forward a localised strategy in acknowledgement that in order to deliver much larger system change it will be necessary to work across an East Kent footprint. 2014-15 will be the start of this process and an East Kent wide strategy will be developed. The integration agenda will be at the centre of this work and the Better Care Fund will be an enabler of many of these initiatives

To achieve this vision we will:

- Develop services collaboratively across all service partners
- Ensure services are clinical led (supported by professional management)
- Ensure service development is informed by patients describing how services can be integrated around them to meet their needs
- Informed by public debate on a sustainable NHS service model within the wider community
- Ensure that the individual is at the centre of their care. Delivering the right care, at the right time, by the right person
- Support individuals in maximizing their own independence to take more responsibility for their own health and wellbeing
- Support people in service delivery in their own homes and communities
- Reduce acute hospital pressure by ensuring that appropriate services are available in the community
- Achieve the best possible outcome within the available resource and services
- Develop and provide integrated services where this is the optimum service delivery model of care

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This vision will be achieved by providing integrated services through integrated teams that are wholly designed around patient needs. It will achieve differences in provision and improvements to patient and service users by:

- Reduced treatment of patients in hospital where it is appropriate to provide care within the community, particularly for the frail elderly
- Ensure GPs can act as the lead responsible clinician in the management of the most needy patients ensuring optimum care at the right time by the most appropriate intervention
- Better use of each “Health Pound” on behalf of those patients and service users
- Hospital Consultants working across the hospital-primary care “divide” to;
    - Manage the care of individual patients
    - Train Primary and Community Care (out of hospital) clinicians in best practice
    - Provide advice to individual clinicians about the management of their patients

It is inherent within these plans that patients, service users and carers can navigate quickly and easily through the services they need, being offered by the right service provision, at the right time, in the right location.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Our overall aims and objectives have been developed and published in our overarching five year Strategic Plan, which itself draws on joint work of the East Kent Federation of CCGs. The following highlights the elements of these plans that are supported by an integrated approach and in particular are applicable to the Better Care Fund:

1. Securing years of life for the people with treatable mental and physical health conditions

2. Improving the health related quality of life for people with one or more long term conditions, including mental health conditions

3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital

4. Increasing the proportion of older people spend living independently at home following discharge form hospital
5. Increasing the number of people having positive experience of hospital care
6. Increasing the number of people with mental and physical health conditions having positive experience of care outside hospital, in general practice and in the community
7. Reduction in funding for hospital care for services that can be more effectively provided in a community setting

We are already delivering a number of these service changes and improvements across the health and social care system. These are outlined in section c).

c) Description of planned changes
Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Alignment with local JSNA and local commissioning plans

The following schemes have been aligned with the CCGs top health priorities derived from the local Joint Strategic Needs Assessment. In addition, they will be further developed as part of the CCG strategic commissioning intentions and in negotiation with major providers, local authorities and key stakeholders. We will work with the Thanet Integrated Commissioning Group, the already established multi-agency forum, in planning the Integration agenda and specifically the Better Care proposals and activity.

Integration – Thanet Current Schemes 2014/15

Delayed Transfers of Care

- Purchase of step up step down beds (GP step up bed project)
- Loan store

Emergency Admissions

- Additional Emergency Care Practitioners (GPs in A&E)

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- Mental Health provision in Emergency Departments
- Multi Disciplinary Team (MDT) in reach to care homes
- Improved pathways for Counselling Services
- Universal Care Teams/Cluster Team Development

Effectiveness of Reablement

- Community Services Review including intermediate care and community hospital beds

Admissions to Residential & Nursing Homes

- Step up and step down beds (GP Step up bed project)
- Multi Disciplinary Team (MDT) in reach to care homes
- Carers – Rapid Response
- Continuing Healthcare, funded nursing care and out of hospital area placements review
- Additional capacity in care home as step up bed pilot
- Westbrook - review current provision to ensure efficient use of bed base

Patient & Service User Experience

- Ensure an increase in patients reporting a positive experience of care as reported through the friends and family test

Children Services

- Adoption
- Looked after children

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- Post sexual abuse

Admission Avoidance

- Falls service Intermediate care
- Care navigators
- Social enterprise scheme to support dementia
- Personal health budgets
- 7 day working in locality teams
- Social transport

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Integration – Thanet Current and Proposed Better Care Fund Schemes 2015/16

Proposed service areas that are identified as local priority schemes for the Better Care

Fund through 2014 and into 2015/16 are shown below:

1. Integrated Teams and Reablement

The team will be available 24 hours a day and seven days a week, contactable through a single access point. The team will provide a rapid response to patients at high risk of hospital admission and coordinate intermediate care and support in the community, including the use of community beds. The team will also develop a robust integrated discharge process and coordinate post-discharge support in the community. Patients will know who to contact in the team whenever they need advice or support.

Scheme Requirements:

a. **Admission avoidance**

- Integrated pathway to coordinate referral management, admissions avoidance and care coordination across health and social care, supported by single access points
- Integrated assessments to ensure responsive onward referral to either rapid response services or intermediate care services ensuring transfer to most appropriate care setting (including patients own home);
- Intermediate care provision to be provided at patients own home wherever possible by professional carers or by a multidisciplinary team of therapists and nurses;
- The team will additionally enable response to patients in A&E within 2-4 hours of referral and initiate admission avoidance intervention.
- The team will integrate with paramedic practitioners to support care homes to assess, diagnose and treat patients as an alternative to non-elective admission via A&E.

Outcomes

- *Reduced hospital admissions*
- *Fully integrated team responding appropriately to the patient's needs*

Metrics

- *Single access point into the team known to all patients with long term conditions*
- *Measurement of ability to obtain timely support*
- *% of care provision undertaken at patient's own home*
- *Response to known patients presenting to A&E within 2-4 hours of referral*
- *% patients with long term conditions known to the team*
- *% of admissions avoided from A&E*

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b. Integrated rapid response team to support acute discharge and prevent readmission

- Enhanced Rapid Response teams supporting admissions avoidance as part of intermediate care provision as well as respond directly to A&E referrals
- The team will develop a robust integrated discharge referral service to support the patient in the first 5-7 days post discharge, by integrating with the hospital discharge planning processes and coordinating post-discharge support in the community. Medicines use will also be assessed in the first 5-7 days post discharge as this is a major cause of readmission.
- The teams will include medicine management support as well as medical leadership and input from hospital consultants to enable continuous support at home.
- The teams will integrate with the Dementia Crisis Service which can receive referrals 24/7 providing support 24/7 to patients with Dementia and carers of people with Dementia to prevent hospital or care home admissions

Outcomes

- *Reduced hospital readmissions*
- *Fully integrated team responding appropriately to the patient's needs*
- *Robust planned discharge process*

Metrics

- *% of eligible patients receiving support 5-7 days post discharge*
- *% of eligible patients receiving a medicines review 5-7 days post discharge*
- *% of readmissions of patients seen by the team*
- *Measure of response times*
- *% admissions & readmissions of patients with dementia*
- *Patient satisfaction*
- *Workforce measurements*

c. Flexible use of community beds and Westbrook House

- Care home beds (previously GP step-up beds) to be used as step-up beds for patients requiring a short-term intervention that would prevent them being admitted to secondary care. These beds will be used flexibly to effectively respond to changes in demand and may also be used as step-down beds to enable maximum occupancy.
- Westbrook house will be further developed as an enhanced step down facility to support patients for 6-8 weeks post discharge so that they can be returned, where possible, to their own bed and avoid social care placement or re-admission. The Westbrook House team will be supported by a dedicated multi-disciplinary team, including therapists, social care and primary care input, to ensure timely patient flows.

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Outcomes
- *Reduced hospital admissions*
- *Reduced hospital readmissions*
- *Avoidance of long term social care placements*

Metrics
- *% occupancy of step-up beds*
- *% occupancy of Westbrook House (Victoria Unit)*
- *% of readmissions of patients seen by the team*
- *% patients returning to their own home*
- *Measure of response times*
- *Patient satisfaction*

d. Falls prevention

Development of falls and fracture prevention services for older people to undertake screening and comprehensive assessment aimed at identifying and treating the underlying causes of falls, such as muscle weakness, cardiovascular problems, medication and housing issues.

SCHEME REQUIREMENTS:

Development of a local specialist falls and fracture prevention service
- This service will work closely with the Neighbourhood Care Teams, Rapid Response and Intermediate Care and will undertake proactive and responsive screening and multi factorial assessments to identify causes of falls and make arrangements for preventative approaches.

Local integrated falls prevention pathways
- Level of current services across locally will be more integrated to include the increased level of input from geriatrician for integrated management and integration with other professionals e.g., pharmacists, chiropodists, podiatrists, opticians and audiologists;
- Develop an Integrated Ambulance Falls Response Service;
- Improve availability and awareness of therapeutic exercise programmes (postural stability classes) via community classes and domiciliary based.

2. <u>Enhance Integrated Community Teams and Care Coordination</u>

This model builds community care teams wrapped around the patient at the centre to support and pro-actively manage their needs. The teams will be further enhanced to ensure integrated working between GP practice, community and social care with specialist input from hospital, mental health and community services as required in order to keep people in their own homes. The teams will be aligned to every GP practice, will

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undertake Multi-disciplinary Team meetings and will include designated care coordinators for all patients.

Scheme Requirements:

a. **Risk Profiling to enable proactive care of patients who are at both high and low risk of hospital admission to deliver more coordinated patient care in the community**
   - Aligned to every GP practice the Community Integrated Care Teams will be available 24 hours a day seven days a week and will coordinate integrated proactive care management of patients through a multi-disciplinary approach with patient involvement at every stage of the process including the development and access of anticipatory care planning to ensure patient centred care and shared decision making;
   - The Community Integrated Care Teams function as integrated teams and provide continuity of care for patients who have been referred for support in the community and form the main structure in providing post hospital discharge care and some pre-admission interventions as well as seamless coordination and delivery of End of Life care;
   - Access into and out of the Care Teams will be coordinated through a clinically supported single access points. Patients who require assistance by more than one professional will receive coordinated integrated assessments;
   - Each Care Team will include input from the wider community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, and Social Care Managers as part of the multi-disciplinary approach;
   - The community services nursing model will ensure continuity of care by training the core team as “universal nurses” who will manage the majority of individual patient nursing needs, ensuring that specialist input is appropriate and timely
   - The teams will support patients with complex needs to better manage their health to live independent lives in the community, including supporting and educating patients with their disease management by using technology, for as long as possible empowering them to take overall responsibility for managing their own health;

Outcomes
- *Reduced hospital admissions*
- *Reduced hospital readmissions*
- *Avoidance of social care placements*

Metrics
- *% patients with a named care-coordinator*
- *GP practice and patient satisfaction*
- *% of admissions of patients seen by the team*

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- *% patients needing coordinated integrated assessments*
- *Measure of response times and availability*
- *% patients using assistive technology*

b. Specialists to integrate into community based generalist roles

- The enhanced Community Integrated Care Team model requires specialist input from acute in the community to enable the management of care for more patients in the community for a range of specialisms including the care of the over 75s, this will include undertaking clinics and reviews of patients in or close to their own homes rather than in hospital. This could include actual and remote approaches supported through the use of technology.

Outcomes

- *Appropriate use of specialists out of hospital*
- *Reduced hospital admissions*
- *Avoidance of social care placements*

Metrics

- *Time spent on specialist caseload*
- *Training to universal team from specialists*
- *% of patients able to access hospital care in the community*
- *% of admissions of patients seen by the team*
- *% patients using assistive technology*

3. <u>Enhanced Primary Care</u>

Integrated community models of care centred on GP practices requires significant change in primary care working patterns. Different models need to be developed to ensure the right levels of support and capacity is available within general practice. This will include a hub of practices in every community to improve access to a full range of local health and social care services to support the move from a medical focused model of care and shifting towards a health and well-being focus.

Scheme Requirements:

a. Develop primary care based services with improved access and integrated with other community and specialist services

- GP practices to be clustered in hubs and configured in a way that enables different access opportunities for patients to include open access and access to other practices in the hub to improve responsiveness of service provision;
- Develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by primary care. This will

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require stronger integration with the integrated community care teams as well as stronger links with and signposting to the voluntary sector;

- Integrated primary care provision will have greater support from specialist hospital teams and stronger links with rapid response services to enable patients to remain out of hospital.

Outcomes

- *Improved ability for patients able to access primary and out of hospital care*
- *Improved responsiveness of service provision*
- *More patients seen by the right person in the right place*
- *Reduced hospital admissions*

Metrics

- *Access to primary care*
- *Patient satisfaction*
- *% of patients able to access hospital care in the community*

b. Primary care service will support and empower patients and carers to self-manage their conditions

- Professionals in primary care will promote the use of integrated personal health budgets for patients with long term conditions and mental health needs to increase patient choice and control to meet their health and social care needs in different ways;
- Primary care and the Integrated Care Teams will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the community;
- The Integrated Care Teams will educate patients about preventative services such as weight management and alcohol services as part of the multidisciplinary assessment;
- Patients will be supported by the Integrated Care Teams and primary care to inform and take ownership of their care plans this includes electronic sharing of care records with the patient and between health and social care professionals;
- Improved signposting and education will be available to patients through care coordinators and Health Trainers to ensure patients are given information about other opportunities to support them in the community, including the voluntary sector, and community pharmacies.

Outcomes

- *Patients informed and empowered*
- *Improved health outcomes*
- *Reduced hospital admissions*
- *Avoidance of social care placements*

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Metrics

- *% patients with a self-care plan*
- *% patients sharing electronic records*
- *Measurement of ease of all health and social care professionals to access patient records*
- *GP % eligible patients with a personal health budget*
- *practice and patient satisfaction*
- *% of patients using the voluntary sector*
- *Measure of response times and availability*
- *% patients using assistive technology*

4. Enhanced Support to Care Homes

Scheme Requirements:

In particular, we want to introduction of enhanced primary care support to care homes by aligning each home to a single practice, with clear requirements for the practice to assess and review residents and to ensure care management plans (anticipatory plans) are in place.

We intend to commission high quality End of Life Care (focus on Advance Care Planning) for patients whether they live in their own homes or in care homes.

Outcomes

- *Reduced hospital admissions from care homes*
- *Reduced hospital attendances for care home residents*
- *Reduced use of emergency services (SECAmb and IC24) by care homes*
- *Care homes feel better supported by general practice*
- *Improved skills and confidence of care home staff particularly around End of Life Care*
- *Increase in percentage of people dying in their preferred place*
- *Increased use of Share My Care (or any other agreed mechanism for sharing appropriate patient information), particularly for End of Life patients*

Metrics

- *Care home residents registered with an aligned practice (aiming for 80% by 6 months).*
- *Assessments of new residents*
- *GP visits to care homes (with purpose and number of residents seen/reviewed)*
- *Virtual consultations*
- *Care management plans completed for all residents who have at least one long term condition or who are frail*
- *Advanced care plans completed and kept up to date for all residents and patients thought to be in the final year of life*
- *Multidisciplinary meetings held*

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- *Numbers of:*
  - *hospital admissions from care homes*
  - *attendances at A&E from care homes*
  - *emergency ambulance call-outs*
  - *calls to Out of Hours service*

5. **Mental Health**

Scheme Requirements:

Improving the integration, service quality and outcomes for people with mental ill-health, based on recovery principles and to ensure health and social care needs and care package are regularly reviewed. This will include booking annual medication review and that patients get access to the right mental health service, in a timely manner. To increase the current capacity of the Primary Care Mental Health Specialists Pilot in Thanet to improve the identification and management of adult mental health conditions in primary care, including where this is secondary to a physical long term health condition.

Outcomes

- *Care received in primary/community setting*

Metrics

- *Reduced number of patients cared for in a secondary care setting through a shift to primary care management*

6. **Dementia**

Scheme Requirements:

Thanet CCG aims to improve the rates of diagnosis of dementia to 67% by March 2015. It is intended to establish a memory assessment service (KMPT) which will have close links to primary care, social care and other support services. Support for carers is a priority; all carers will be offered a carer's assessment.

Outcomes

- *Improved diagnosis rates*

Metrics

- *Referral rates to the memory assessment service*
- *Diagnosis rates*
- *Carer's assessments carried out and support packages agreed*

7. **End of Life Care**

Scheme Requirements:

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A major opportunity to address some of the key issues for EOLC is through adoption of the new Long Term Conditions Agenda that incorporates the themes of risk-stratification, integrated teams and self-care. The vision is for a unified data hub that integrates activity across all health and social care and a fully functional system which will enable early identification for those at risk of death, enable more accurate EOLC planning across a population and ensure health and social care are better coordinated and integrated with each other. End of Life Care (EOLC) should support people to remain independent where possible, allowing the final stages of life to be as comfortable as possible. The preferred location of death should be discussed with family and carers, with the choice being adhered to wherever possible. Many people do not wish to die in hospital and would prefer to die at home, but often this does not happen. Two-thirds of people would prefer to die at home, but in practice only about one-third of individuals actually do.

Outcomes

- *To enable end of life care in patients own home*

Metrics

- *To reduce the number of secondary care admissions for patients receiving end of life care*

Success factors and Outcome Measures

A number of outcomes measures have been determined for each of the schemes. These will be further fine-tuned in developing the CCG strategic commissioning intentions and in negation with major providers and key stakeholders.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The plans align with the delivery of Thanet CCGs 5 year strategy, as outlined. The majority of the NHS savings will be realised by the reduced emergency attendances and admissions and a reduction in length of stays within the acute setting and therefore there will be a reduced investment in secondary care.

The plans will not have a negative impact on the CCGs constitutional targets as set out in the Everyone Counts: Planning for Patients 2014/15-2018/19. The plans will support the delivery of some of these targets, in particular the A&E waiting times and the proportion of older people at home 91 days after discharge from hospital into Reablement/rehabilitation services.

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e) Governance
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Better Care Fund Management

The management, monitoring and delivery of the schemes will be supported by the Thanet Integrated Commissioning Group which will report progress to the Thanet Health and Well Being Board.

Measuring Delivery

The Better Care Fund schemes and metrics will be included within the body of the Integrated Quality and Performance Report which is a standing agenda item on the Operational Leadership Team. The Operational Leadership Team feeds into the CCG's risk register and any risk to delivery or expected outcomes will be included via output from the committee.

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3) NATIONAL CONDITIONS

a) Protecting social care services
Please outline your agreed local definition of protecting adult social care services.

The Better Care Fund plans set out a vision for a fully integrated health and social care system. The delivery of these plans will not have an adverse impact the care on the adult social care services and therefore patients and service users eligible for social care services will continue to receive the care they need.

Please explain how local social care services will be protected within your plans.

By managing to reable people back to a level of care that means they can manage in the community this will reduce the impact on social care freeing up capacity for the increased demand on services.

Development of a Self Care Strategy will support the prevention agenda which will benefit all organisations as will the development of a joint information advice and guidance strategy which signposts people to the right place.

b) 7 day services to support discharge
Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

The Kent Joint Health and Wellbeing Strategy sets out a number of outcomes aimed at providing seven day health and social care services across the local health economy, for example:

- Ensure all agencies who are working with people most at risk of admission to hospital and long term care have access to anticipatory and advanced care plans and 24/7 crisis response services in order to provide the support needed;
- Ensure all people with a significant mental health concern, or their carers, can access a local crisis response service at any time and an urgent response within 24 hours.

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

In Thanet the Universal Care Team is the main structure for providing post hospital care for any reason and some pre-admission intervention in the community.

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c) Data sharing
Please confirm that you are 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.

NHS
At present all NHS organisations must ensure that a minimum of 95 per cent of all active patient records have an NHS number. The NHS Information Standards Board mandates the use of the NHS number on both general practice and secondary care organisations.

The NHS standard contract states:
"Subject to and in accordance with guidance the provider must ensure that the service user health record includes the service user's verified NHS number. The provider must use the NHS Number as the primary identifier in all clinical correspondence (paper or electronic). The provider must be able to use the NHS Number to identify all activity relating to a service user."

Social Care
A 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.
The NHS number is predominately used to facilitate the matching of data sets for Year of Care and Risk Stratification, not for correspondence or to undertake client checks, the numbers are too low. We would use name: address and date of birth as the key identifiers at present. Further work will be required to ensure NHS number is used across all correspondence.
KCC achieved approx. 80% matching of records to NHS numbers when we started, improvement to this percentage would need significant additional resource.
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).

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

N/A

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Thanet, along with all other East Kent CCGs, is committed to using the Medical Interoperability Gateway (MIG) as its preferred solution to interoperability. This is provided by a joint venture between EMIS and INPS Vision, in a company called Healthcare Gateway. Not only will this be within the CCG's Information Technology Strategy, ensuring all new systems utilise this technology, contracts with providers will also require a commitment of their agreement to utilise the MIG. Data sharing (with GPs

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as the data controllers) have been developed as have governance protocols for the viewing of patient identifiable data and patient consent. In the main consent will be requested at the point of treatment, but protocols are in place for patients who are physically unable to give consent i.e. unconscious.

The project first stage is the integrated use with EKHUFT's A&E and pharmacy departments, stages 2 and 3 will widen this to other providers, as well as allow viewing of provider data at the GP practice site.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Please see previous response for Governance arrangements around data sharing with regards to the MIG.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Risk Profiling

Thanet CCG has been running a Risk Stratification Tool which almost all practices are participating in. This involves multi-disciplinary integrated team meetings for risk stratified patients with multiple co-morbidities. The aim is to improve patient's self-management, their quality of life, medicines compliance and reduce A&E and associated hospital admissions.

Through risk stratification the patients at highest risk of hospital admission and then works its way through the lower risk patients. This means that the amount of clinical time and intervention decreases with lower risk patients and there is an expectation that such intervention will go some way to preventing these lower risk patients from deteriorating as fast thus prolonging their health and quality of life over the long term.

Risk Stratification is delivered by a multi-disciplinary health and social care team undertaking joint assessments, clinically led by a GP, and jointly agreeing anticipatory care plans for every patients going through the programme. The GP remains the accountable professional for their patients.

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4) RISKS
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

Risk	Risk rating	Mitigating Actions
Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability.	High	Each responsible organisation to develop a detailed workforce plan to support delivery of each scheme.
Different skills and training required across multiple professionals and organisations.	High	Training and skills requirements for each scheme to be linked to workforce plan to support the delivery.
Governance of the plans and the delivery of a fully integrated health and social care system should be clinically led and clearly defined.	High	CCG Primary Care Strategy to set out an agreed approach, which could include an Integrated Care Organisation, for overall governance of the plans.
Communication – need to ensure robust communication with the public and across organisations to ensure people know how to access services within the integrated system to ensure services are used appropriately	High	Robust communication plan to be developed to support delivery of each scheme.
IT systems across services not integrated and therefore do not enable shared care plans between organisations and support integrated outcome measurement and monitoring.	High	Integrated system to support sharing of care plans to be developed as a priority. Integrated performance monitoring and reporting to be enhanced to take into account all schemes.
Transition of service capacity changes to be planned and implemented in stages to prevent destabilising the system.	High	Detailed modelling required to fully understand impact on acute capacity and requirements of community capacity to inform transition over a defined period of time including investment and dis-investment requirements.
The investment required into primary care for the full benefits of the plan falls outside the remit of the pooled budget and sits with NHS England.	High	To be discussed with NHS England.
Cultural change – significant shift in how	High	Ensure whole health and

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systems need to work in the future requirement large culture change		social care system has shared vision and values to enable the delivery of required changes. Communication with organisations, staff and service users to be included in communication plan.
Regulatory and legislative environment – current arrangements not always looking at how the overall system works	High	Provide feedback to NHS England on this issue via the Kent Pioneer Programme.

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Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Thanet CCG	Various	**9,595,941**	**9,595,941**	**9,595,941**
Kent County Council	Various	**2,810,000**	**2,810,000**	**2,810,000**
BCF Total		**12,405,941**	**12,405,941**	**12,405,941**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Performance indicators will be monitored to identify early warnings of risk and service non-delivery. The Integrated Commissioning Group (ICG) will oversee this process and will report directly to the Thanet Health and Well Being Board and to the system organisations senior management teams. This approach will provide multi-organisational management and responsibility.

Contingency plan:		2015/16	Ongoing
Outcome 1 Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Planned savings (if targets fully achieved)	525,000	525,000
	Maximum support needed for other services (if targets not achieved)	1,052,000	1,052,000
Outcome 2 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Planned savings (if targets fully achieved)	unable to quantify	
	Maximum support needed for other services (if targets not achieved)	unable to quantify	
Outcome 3 Delayed transfers of care from hospital per 100,000 population (average per	Planned savings (if targets fully achieved)	unable to quantify	

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
THANET CCG									
Delayed Transfer of Care	Various	1,013,000				1,013,000			
Avoidance of Emergency Admissions & Enhanced Integrated Community Teams & Care Coordination	Various	3,290,000		- 500,000		3,290,000		- 500,000	
Effectiveness of Reablement	Various	706,000				706,000			
Admissions to Residential Nursing Homes & Enhanced Support to Care Homes	Various	2,981,000		- 100,000		2,981,000		- 100,000	
Childrens Services	Various	262,500				262,500			
Admission Avoidance (inc Dementia)	Various	300,000		- 58,000		300,000		- 58,000	
GP Over 75s £5 Per Head Contribution & Enhanced Primary Care	GPs	700,000				700,000			
Volunteer Orgs	Various	87,441				87,441			
Mental Health	Various	255,000		- 125,000		255,000			
KENT COUNTY COUNCIL 256 Work Streams.									
Enabling People to return to/or remain in the community	Various	1,647,000				1,647,000			
Ease of access to services	Various	171,000				171,000			
Self Care & Prevention	Various	335,000				335,000			
Postural Stability	Various	18,000				18,000			
Supporting Implementation of Integration	Various	33,000				33,000			
Expand integrated commissioning of schemes that produce joint outcomes	Various	63,000				63,000			
Share of £200m national pot	Various	544,000				544,000			
TOTAL		**12,405,941**	-	**- 783,000**	-	**12,405,941**	-	**- 658,000**	-

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

1. Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

Our aim is to achieve an 11% reduction in admissions. This will be achieved through our integrated reablement/rehabilitation schemes which will combine both health and Local Authority services to offer more proactive approaches to developing and promoting independence in the community. We will improve reablement services into all provision, e.g. domiciliary care, nursing and residential homes. Our locality integrated teams will target those people most at risk through robust risk stratification and analysis of pooled information across health and social care ensuring that individuals receive coordinated care services.

2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Our aim is to achieve an increase of 4.5% above current baseline. We will be extending the reach of our reablement services and focussing on more complex patients in the community. The main schemes focussing on this metric will be through our integrated reablement/rehabilitation services.

3. Delayed transfers of care from hospital per 100,000 population (average per month)

Our aim is to reduce the average number of delayed transfers by 10% This will be achieved through improving discharge processes within the hospital, eg. our investment in the intermediate care team which operates 7 days per week.

4. Avoidable emergency admissions

We aim is to reduce our number of avoidable emergency admissions by 5% This will be achieved through a series of programmes which will include primary care schemes to manage the care of over 75's, GP step up beds used to avoi

5. Reduction in falls and secondary falls

Our aim is to reduce the number of falls per year by 6% (allowing for population increase). This will be achieved through the development of falls and fracture prevention services for older people to undertake screening and comprehen

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

6. (Local Metric) Proportion of People feeling supported to manage their condition. Expressed as a percentage and reflects the number of 'Yes, definitely', and 'Yes to some extent',

The outcome will be achieved through improved cooperation between GP Practices, Community and Social Care teams. The continued development of multidisciplinary team working, the improved use of Risk Analysis tools and community information systems will support this initiative. The Enhanced Primary Care and Integrated Community Teams and Care Coordination schemes are designed to underpin this process.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

The performance plans were set by reviewing historical trends and benchmarking our performance nationally and with local comparators. We have consulted with Heads of Service whose services impact on performance in all the areas and have also mapped the schemes in our local plan against the key factors impacting on the indicators.
We intend to apply rigorous and appropriate assurance processes to all the metrics. We will continue to use both national and local data which inform the metrics. As well as the nationally published data we will have access to local figures and information produced by our commissioning support organisation. This is further under-pinned by the development of state-of-the-art Community Information System by our local Community Trust, The CIS not only will provide data and information regarding the daily management of patients, but will also allow this data to be shared with GPs and Social Care partners. The day to day exchange of information and data will help to support significantly improved outcomes such as patients remaining in their own homes, avoiding inappropriate admissions and enabling enhanced care at home.
Specific actions include the achievement of more timely discharges from hospital using a detailed whole system review of our emergency care system that was undertaken last year. This review was carried out by external experts (ECIS
All performance indicators will be monitored to identify early warnings of risk and failures of service delivery. The Integrated Commissioning Group will oversee this process and will report directly to both the local Health and Wellbeing B

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

N/A

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	901	N/A	804
	Numerator (number of admissions)	274		251
	Denominator (population aged 65+)	30422		31222
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	84.76%	N/A	87.36%
	Numerator (of the discharges, those still at home at 91 days)	684		705
	Denominator (all discharges - including those that werent still at home)	807		807
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	6.04	N/A	5.41
	Numerator (number of DTOC)	102		92
	Denominator (total population)	140614		141809
		(April 2012 - March 2013)		(April 2014 - March 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	2003.5	N/A	1903.5
	Numerator	not supplied		
	Denominator	not supplied		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Patient / service user experience: Average EQ-5D score for people reporting havijng one or more long-trm condition		70	N/A	70.2
		(April 2012 - March 2013)		(April 2014 - March 2015)
(Local Metric) Proportion of People feeling supported to manage their their condition. Expressed as a percentage and reflects the number of 'Yes, definitiely', and 'Yes to some extent', response in the GP patient survey as a proportion of the total answers.	*Metric Value*	59.8%	N/A	65.0%
	Numerator	772		840
	Denominator	1292		1292
		(July 2013 to September 2013)		(January 2015 to March 2015
Reduction in falls and secondary falls (ICD S7200, S7201, S721, S7210 and R29.6 for ages 65+)		263	N/A	240

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Better Care Fund

Vision Document

North Kent

This document reflects the vision and input from the following Health and Social Care Commissioners, Healthcare Providers and County and Local Authorities:

Swale CCG

Dartford, Gravesham and Swanley CCG

Kent Community Healthcare NHS Trust

Dartford and Gravesham NHS Trust

Medway NHS Foundation Trust

Medway Community Healthcare NHS Trust

South East Coast Ambulance NHS Trust

Kent and Medway NHS and Social Care Partnership Trust

Kent County Council

Dartford Borough Council

Gravesham Borough Council

Sevenoaks District Council

Swale Borough Council

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Document Control:

Version	Date	Comments	Lead
1.0	10/1/14	Preparation of document for review	Debbie Stock / Patricia Davies
2.0	11/1/14	Updated following comments	Debbie Stock
3.0	14/1/14	Updated following comments	Debbie Stock
4.0	21st January 2014	Updated following provider event on 16th January	Debbie Stock
5.0	3rd February 2014	Update following feedback and North Kent stakeholders meeting	Debbie Stock
6.0	February 2014	Update following comments received	Debbie Stock
7.0	February 2014	Update following comments received	Debbie Stock
7.1	24th February 2014	Inclusion of prescribing comments	Debbie Stock
8.0	5th March 2014	Inclusion of governance structure, comments from joint commissioning group and other stakeholders	Karen Barkway
9.0	11th March 2014	Review and update of finance elements	Debbie Stock/ Bill Jones

Review and Approval History:

Board	Reviewed	Approved
DGS CCG Governing Body		
Swale CCG Governing Body		
Executive Programme Board (DGS)		
DGS Health and Wellbeing Board		
Swale Health and Wellbeing Board		
Kent Health and Wellbeing Board		

Associated Documents:

- North Kent Better Care Fund Planning Template 1
- North Kent Better Care Fund Template 2 – finance and outcomes
- Kent Better Care Fund submission (including planning templates 1 and 2)
- Swale, and DGS CCGs Operating Plans 2014-16 and Strategies 2014 to 2019
- Community Services Patient Engagement Deep Dive

1. Introduction

1.1. The CCGs believe 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, and by doing so, ease the pressure on the system more generally, enabling it to provide better services to the whole population of North Kent. In the current financial climate, this is also likely to be a unique opportunity to re-think how significant chunks of money are spent. This is not new money and the system is required to provide more care at higher quality for less resource.

1.2. Fundamentally, we believe that the Better Care Fund should be used for genuine transformation of the health and social care system in North Kent, not to plug a gap in the social care or health budgets brought about by increasing demand and reducing budgets. This transformation is not just about reducing admissions to hospital, but rather about changing the whole system so that it is focused on supporting people wherever possible with person-centred and professionally-led primary / community / mental health / social care, with the goal of living as independently as possible. This aligns with the principles set out by Government, NHS England and LGA, is consistent with the priorities set out in Kent's Health and Wellbeing Strategy, the Kent Integration Pioneer Plan and builds upon public engagement feedback from recent events held in Swale and Dartford, Gravesham and Swanley CCG areas. It is also well-supported by evidence that clinical and service integration delivers better outcomes for people, particularly if groups of patients or service users are clearly identified and services for them are joined up around their needs[1]

1.3. We know nationally that the numbers of GPs and community nurses are declining. The numbers of practitioners approaching retirement nationally is 22%. Within North Kent this is higher with 33% of GPs, for example, approaching retirement within Swale in the next 5 years. The configuration of teams will, therefore, be linked to the North Kent primary care strategies for swale and Dartford, Gravesham and Swanley CCGs (which will be informed by the national strategy for Primary care) and the local North Kent community service redesign work which will define the community nursing and wider community health and social care model.

1.4. In addition to the changes within the local workforce, the Joint Strategic Needs Assessment (review at January 2014), and local modelling confirms a number of key issues across North Kent 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).
- 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

[1] See 'Clinical and service integration' Curry, N and Ham, C; King's Fund 2010; available from http://www.kingsfund.org.uk/sites/files/kf/Clinical-and-service-integration-Natasha-Curry-Chris-Ham-22-November-2010.pdf

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. 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

Key recommendations from the JSNA refresh are addressed within the following document, 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.
- 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.

2. Our Vision for 2018/19 – what this will mean for the people we serve

2.1. Our vision for whole system integrated care is based on what people have told us is most important to them (details available within the CCG Community Services Engagement Deep Dive document). Through patient and service user workshops, interviews and surveys across Dartford Gravesham Swanley and Swale we know that what people want is choice and control, and for their care to be planned with people working together to help them reach their goals of living longer and living well. They want their care to be delivered by people and organisations that show dignity, compassion and respect at all times.

2.2. We recognise that realising this 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. 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 in the acute sector, to ensure that this happens at scale and at pace.

2.3. 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 communities.

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

2.5. 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

3. Building On Success – Current Integration Schemes in North Kent

The plans within this document aim to build on and develop further integration schemes already in place locally. This includes:

- The Local Referral Units, which provide a single point of access within each of the CCGs for community health and social care teams (described further under section 5.1)
- Development of a single assessment form in progress
- Implementation of an Integrated Discharge Team during 2013, which is described further in section 5.1.

4. Our vision - What this will mean for our health and social care services

4.1. Effects on services

We think it is important to be clear about what this will mean, especially because this is not new investment in the system, but a re-organisation of existing funding and services. There is likely to be an increase in the support available in the community through an investment in self-care and

early intervention, and by managing demand in this way, a decrease in the need for more intensive social care support or health support at acute level, with corresponding changes in acute services. We will be working towards single health and social care assessments that will require a much closer level of integration between primary health (GPs, community Pharmacists), community health (e.g. district nursing, physiotherapy), mental health (e.g. primary care mental health workers, dementia nurses), social care (support to live independently) voluntary sector support, 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.

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 social care

This is easy to say and hard to do. Recognising that the way that change is done is as important as the change that is aimed at, the next four principles set out 'rules' we are proposing to govern what we do to achieve this vision.

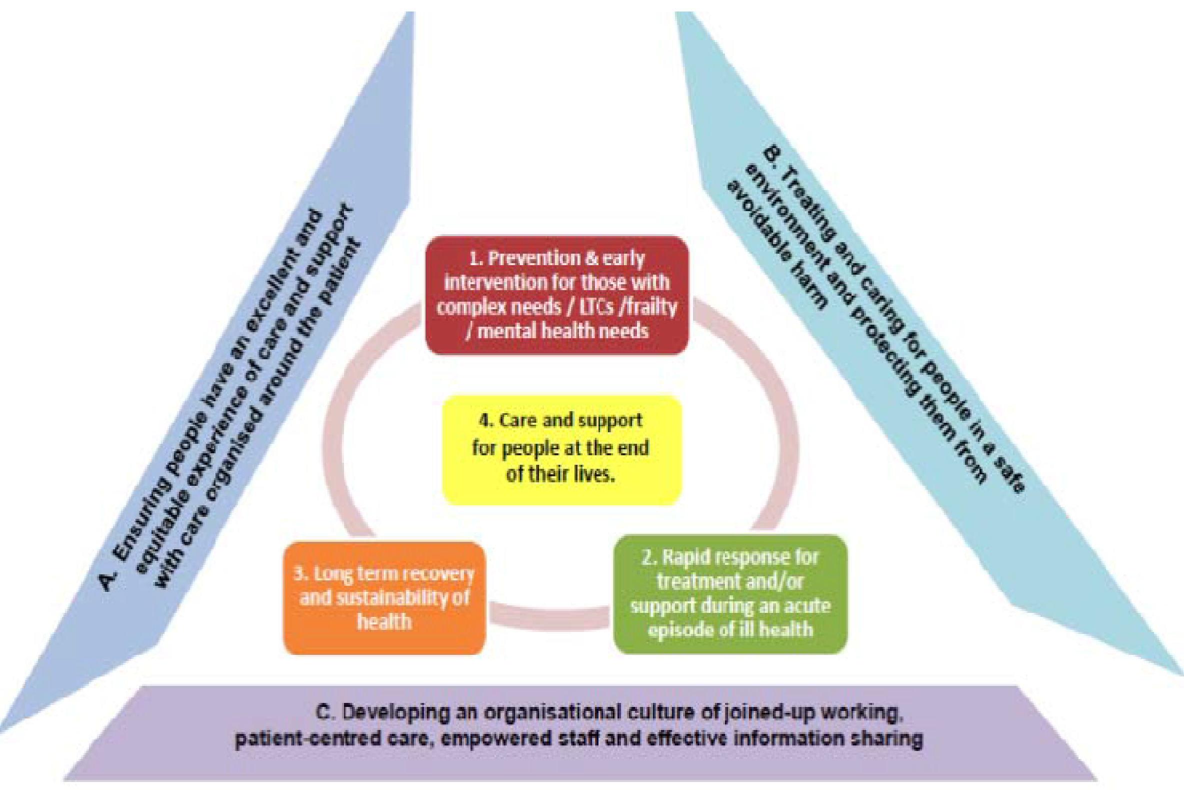
The following summarises the key impact on healthcare providers:

Acute Trusts and Ambulance Trust	Reduction of bed pressures, via • Reduction in non-elective admissions by 15% over two years , at o Dartford and Gravesham NHS Trust – o Medway NHS Foundation Trust - • Reduction in length of stay o Dartford and Gravesham NHS Trust – o Medway NHS Foundation Trust – NB – contracts currently in negotiation.
Community health providers including mental health	Increase in community activity – to be defined.

4.2. Measuring success

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 and Social Care. 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

4.2.1. NHS Outcomes Framework Domains



We will also use other measures that show us whether the system is effective, such as delayed transfers of care, the effectiveness of short-term recovery-focused services like re-ablement, and patient and user experience of services. We will therefore seek to deliver services that have a positive impact as measured by these measures.

4.3. This strategy 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.

4.4. Open, Honest and evidence-based

It is recognised that the basis of the funding for the Better Care Fund is money that is already committed to health and social care services of many different types. Some services will need to change to support the aim set out above, others will need stability. Discussions should be open, honest and evidence-based in order to make sure we use the money in the best way.

4.5. Early intervention and supporting independence

The plans set out in the Better Care Fund should align with existing or developing strategies, such as the CCGs, Kent County Council and Local Authority Strategic Plans, including the Kent Health and Well-being Strategy, Integration Pioneer plan and Health Inequality plans. A key principle of all of these strategies is that people experience the best outcomes when they are able to live independently at home, and supporting them to do so will be a theme throughout all proposals in the Integration Plan. There will be other important themes, including coherence and integration of services, the importance of identifying vulnerability and acting to prevent deterioration, ensuring professional judgment is valued and free to be flexible, and that services are person-centred.

4.6. Support for everyone

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 are continued 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.

5. A Proposed Model

5.1. We are proposing to develop the model 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. We understand the need for pace and the financial climate dictates that the system needs to change in the short, medium as well as the 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. We will build on our current plans with providers, KCC and North Kent District Councils, to deliver the critical transformational changes required to deliver the key priorities identified by our public and patients. These will include;

5.1.1. **A united approach to advice and information on community and public sector services.** This will include developing robust and reliable sources of advice and support for older people before they become frail or need to access the statutory system; and providing universal information and advice about services from all partner agencies, which should be quick to access, clear, friendly and personalised. This will include developing access to transport for vulnerable people who need it to prevent social isolation and access to medical appointments. We will ensure that Patients can See their pharmacist more often and have more opportunities to discuss their health and wellbeing and early detection of serious illness. Be signposted to community services and facilities

aimed at helping to address some of the underlying determinants of health. This includes links with existing services such as:

- **Postural Stability**

Falls and fractures are a significant public health issue particularly amongst older people with estimates that one in three people aged over sixty five will fall each year and one in two people aged over eighty. It is estimated that falls account for between 10% and 25% of ambulance callouts at £115 per call-out. Postural Stability group exercise programmes improve the balance, strength, gait/mobility and confidence of frail, ambulant older adults at risk of falling. KCC currently commission community based postural stability classes through a variety of public and voluntary sector providers as an integral part of an emerging Falls Framework and care pathway but provision has been fragmented. Significant work is underway with KCC Social care to tender a new integrated enhanced model during 2014/15.

- **Winter Warmth**

Excess Winter Mortality (EWMs) are the 'extra' deaths that occur in the winter months compared to the rest of the year. The causes of death are complex and interlinked with cold weather, fuel poverty, poor housing and health inequalities, as well as infectious diseases such as flu and noro-virus, and the extent of snow and ice. Many, but not all are likely to be preventable.

KCC and Local Borough Councils, commission and provide a range of interventions to support at risk groups including funding low level interventions through Home Improvement Agencies, supporting Eco provision for at risk households, training frontline service providers and grant funding for a volunteer led homeless shelter.

5.1.2. Coordinated and intelligence-led early identification and early intervention. Implementing community record and information sharing between the range of organisations supporting individuals at risk of requiring more support in the future. Ensuring that the workforce are able to feed back as much intelligence as possible as to the needs of the service users they are supporting and how service delivery and deployment of available resources can be improved.

5.1.3. Integrated Primary Care Teams - 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 main stream 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 collaborate in networks focused on populations between 9,000 and 15,000 within given geographies, with community, social care, mental health and specialist services, organised to work effectively with these networks. 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 a long-term condition should expect Pharmacists and GP's working in partnership to ensure the best possible care, with linked IT systems Pharmacists to help them to manage their medicines needs on an ongoing basis. With Support available from pharmacists and their teams to enable self-management of patients conditions so that they can stay well in and out of hospital. This will include early detection of problems or deterioration in their condition through routine monitoring. Pharmacists will be able to consult with them in a range of settings appropriate and convenient to them. For example pharmacy consulting rooms, GP practices, home visits,

We expect the core team that will function around the GP network to be as follows:

- Generalist District Nursing Service (see specification attached). This will include District Nursing sisters who will act as case holders and managers working with and delegating work to their team of registered staff nurses, health care assistance / re-ablement workers, using peripatetic skills across therapy, nursing and social care.
- Named Social Care Workers who together with district nurses will take responsibility for case management (inclusive of enablement and re-ablement services)
- Named community Pharmacy of patients choice
- Primary Care Mental Health Practitioner (see job specification attached)
- Primary Care Dementia Practitioner (see job specification attached)
- Primary Care Health Visitor linked to vulnerable adults using public health skills (NHS England responsibility)
- Health Trainers, Health prevention workers and Health and Social Care navigators
- We would expect District Nurses to provide end of life care but access hospice and palliative care specialists (on discussion with GP and the MDT as required)

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.

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 diabetiologists supporting risk stratification and maintenance management as required. Assistive technology, telecare and telemedicine will be more effectively used to support patients to be independent.

5.1.4. **Investment in community capacity as described above, to enable people to meet their needs with support in their local community.** The integrated primary care teams will be based around the General Practice networks and focused on the needs of patients. They will deliver robust rapid response where this is appropriate, long term condition management, geriatrician, mental health, social and voluntary sector care, equipment and housing support. They will actively support GP practices to identifying people who are at risk of admission to hospital or residential / nursing home care where indications are that, with some immediate intensive input, equipment and support, such admissions can be avoided. They will work seamlessly with the Acute Hospital and

social care, through the integrated discharge team, to ensure that patients receive the treatment they need and are rapidly discharged with health, social and voluntary sector care and housing support to return back to independent living. Assistive technology, telecare, telemedicine and Disabled Facilities Grant (DFG), will be more effectively used to support patients to be independent and they will be actively utilised in care homes with support to enable patients to be managed when in acute crisis.

5.1.5. **Rapid Response services 24/7 linked to the Local Referral Unit (LRU) and Crisis response (Community Based) –** This will focus on admission avoidance and where possible attendance avoidance, where patients either known to the system or unknown, have reached crisis point. It is anticipated that through more robust integrated community working, that the number of patients unknown will be reduced. However, it is accepted that patients will have long term and enduring conditions that will require rapid response at times of acute need. Similarly, people without long term conditions, may require time-limited support to prevent exacerbation of an acute health or social care episode. This team will be centralized to cover a greater geographical area than for GP networks, to ensure effective use of skills and resources. However, there will be strong links between the Local Referral Units and networks. For example, acceptance of each other's assessments and referrals.

There will also be an improved approach to crisis management and recovery. Supporting rapid escalation and action when a crisis occurs in the life of an older person; this is likely to involve a coordinated response from all agencies (including social care and mental health) working in multi-disciplinary teams, 7 days a week, to provide intensive support in the short term and encompassing services such as respite care and supportive discharge planning. Support should focus on ensuring that when the crisis is over older people and their carers remain as independent as possible and avoid short term crises triggering a deterioration which leads to long term health or social care need.

The team will comprise:

- Duty Social worker / case managers
- Nursing Staff
- Therapy staff (minimum OT and Physiotherapy plus technicians and re-ablement workers)
- Access to enablement and domiciliary care to provide 24/7 support as required
- Crisis Mental Health Teams (including functional and Dementia)
- Social and Voluntary Sector Care Crisis response services
- Clinical assessment utilizing specialist nurses, paramedic practitioners and roving GPs

5.1.6. Integrated Discharge Team (Hospital in-reach and links to LRU for early supportive discharge and admission avoidance. 7 days per week (8am – 10pm) – (See attached specification and Heads of agreement)

5.1.7. **Community Hospital Re-design and Estate reconfiguration using evidence for the Oaks Group and Kings Fund.** It is accepted that the current community hospital resource is not fit for purpose or utilized appropriately. Re-profiling of beds and criteria is required, in line with the Kings Fund and Social Care Accommodation solutions work which includes the definition of medical cover required to support any non-acute bed based facility. Community Hospital services will become integrated health and social care centres that will enable patients to receive the appropriate rapid support that they

need. In addition as part of the Social Care Accommodation Strategy support in Extra Care Sheltered Housing will be developed to support avoidance of admissions to hospital and long term care and hospital discharge. A review of KCC accommodation is currently in progress as part of the development of the strategy, and includes links to all partners in health and housing. This work is aiming to ensure understand and manage the market, linking into the needs analysis and ensuring that future care is provided in the most appropriate setting for individuals.

A joint accommodation strategy and implementation plan is required, with appropriate range of accommodation available. This needs to include, care for vulnerable adults needing accommodation and care input, including those with dementia, learning or other disability or with mental health needs unable to remain in their home such as extra care housing. Extra care provides the security of having your own home as well as the availability of having care on site. This will include health and social care centres running within community hospitals. Further projects and schemes will be developed to support implementation of the Strategy following completion of the current review.

6. The Financial Implications

6.1. Our ambition

In developing our plans for jointly funded services from 2014/15 onwards, our starting point has been the scale and scope of our existing investments in re-ablement and carers services as well as transfers from health to local government and the services that they support.

Whilst these existing transfers have delivered benefits for individuals, communities and for our local public service organisations, we recognise that the financial challenges ahead are significant. We will need to build upon the work to-date if we are to provide high-quality services in a sustainable way.

We already have a number of schemes which can be considered as BCF in 2014/15, which will grow to £23.8m in 2015/16 across the health and social care system.

6.2. Changing the dynamic of local health and care funding

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 proposals 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.

6.3. What are the key areas for investment through the BCF?

6.3.1. In 2015/16 the Better Care Fund Plan will be created from the following funding streams, a significant proportion of which is already being spent by the local authority on joint health and social care priorities. The sums currently allocated to in this way are identified in the table below.

Table1: Analysis of Better Care Fund Plan Funding Streams (based on 2014/15 data)

Funding Stream	**National 'Pot'**	**DGS CCG Allocation 2014/15**	**Swale CCG Allocation 2014/15**
NHS Funding	**£1.9billion**		
Carers Breaks Funding	£130m	£205k	£204k
CCG Reablement Funding	£300m	£730k	£464k
Current transfer from NHS to Social Care (Non recurrent)	£900m	£3,278k	£1,440k
Additional transfer from NHS (from 2014/15)	£200m	£759.6k	£338.6k
TOTAL	£1,884m	**£4972.6k**	**£2,651k**

Table 2: Analysis of Better Care Fund Plan Funding Streams 2015/16

Provisional Kent allocation from DGS CCGs 2015/16	£m	Provisional Kent allocation from Swale CCGs 2015/16	£m
NHS DGS CCG	£14.947	NHS Swale CCG	£6.556
Social Care Capital Grant - DGSCCG	£0.483	Social Care Capital Grant – Swale CCG	£0.208
Disabled Facilities Grant - DGSCCG	£0.890	Disabled Facilities Grant – Swale CCG	£0.811
Total Better Care Fund DGSCCG	**£16.32**	**Total Better Care Fund Swale CCG**	**£7.575**

*NB: Due to differences between Local Authority and CCG boundaries - Swanley is 42% of the population of Sevenoaks and therefore DGS CCG requires an additional 42% of the DFG budget; and Faversham is 22% of the Swale BC population (137,700) and therefore the DFG budget for Swale CCG is reduced by £97k

In 2014/15, we intend to invest a total of £2m (£1m from existing CCG budgets for reablement and carers, and £1m relating to allocations relating directly to the BCF). This investment is not about immediate financial returns, but rather creating the capabilities and infrastructure to enable outcomes in 2015/16; whilst ensuring local social services can continue to meet the care needs of our population. This will include the development of a joint programme management structure, as well as supporting delivery of these schemes. This funding is in addition to current funding streams which will also support delivery of these schemes, outlined below.

Table 3: We will use the BCF for the following agreed priority schemes:

No.	Schemes 2014/15	Description	Funding
For 2014/15 the additional investment to be made by the CCG and KCC of £2m (*Note the KCC investment is proposed to come from the additional transfer from NHS to LA and will be subject to the plan being approved and the allocation from NHS England being received*) will be supporting the following BCF schemes identified as BCF01-03. This joint approach will enable us to review impact and develop the key schemes for 2015/16			
BCF01	Integrated Primary Care Teams	The integrated primary care teams will be based around the General Practice networks and focused on the needs of patients which includes the important focus on dementia (includes Carers Support of £409k) The team will have extended 7 days access to health and social care and will be supported by 2 Physicians from the acute Trust. Additional Dementia support working with Care Homes and Excellence programme	Core Provider contract funding and additionally funding support from the indicative £2m pot, identified jointly by KCC and North Kent CCGs

No.	Schemes 2014/15	Description	Funding
BCF02a	Integrated Discharge Teams (DVH and MFT) Strengthen 7 day social care provision in hospitals within IDT	7 day per week provision 8am – 10pm. In line with the specification and establishment attached. This scheme will extend current arrangements for increasing social care provision in hospitals, to provide full 7-day social care support from 8am to 10pm all year. This will help to deliver the reduction in delayed discharges.	Core Provider contract funding / S.256 and additionally funding support from the indicative £2m pot, identified jointly by KCC and North Kent CCGs
BCF02b	Local Referral Units and Crisis Response	To involve a coordinated response from all agencies working in multi-disciplinary teams, 7 days a week, to provide intensive support in the short term and encompassing services such as respite care and supportive discharge planning. Support should focus on ensuring that when the crisis is over older people and their carers remain as independent as possible and avoid short term crises triggering a deterioration which leads to long term health or social care need. The integrated Assistive Technology Monitoring centre will support this work through telemonitoring as well as through teletechnology provision,(costs included in BCF09) We will be working with the Ambulance service to enhance their service provision with a social care practitioner to improve further admission avoidance.	Core Provider contract funding and additionally funding support from the indicative £2m pot, identified jointly by KCC and North Kent CCGs
BCF02c	Social Care provision within the LRU 24/7	This scheme will be extended and made more robust for increasing social care support within the LRU team	Core Provider contract funding / S.256 funding and additionally funding support from the indicative £2m pot, identified jointly by KCC and North Kent CCGs
BCF03	Integrated Dementia service	Additional dementia nurses to be employed within the community and rapid response teams to prevent unnecessary attendance to acute care and facilitate	Core Provider contract funding and additionally funding support

No.	Schemes 2014/15	Description	Funding
		timely and appropriate discharge where an episode of acute care is required.	from the indicative £2m pot, identified jointly by KCC and North Kent CCGs
BCFE01(enabler)	IT Integration	Project costs to implement an IT solution to link North Kent Social Care Systems to the GP system and other relevant health provider systems to ensure complete patient record is available and uses consistent use of the NHS Number as the primary identifier Through the Integration Pioneer work we are identifying solutions for Shared Care Planning	Core Provider contract funding and additionally funding support from the indicative £2m pot, identified jointly by KCC and North Kent CCGs

The following schemes are provided via current funding streams which will support delivery of the BCF priority schemes:

Table 4: 2014/16 BCF supporting schemes

No.	Schemes 2014/15	Description
The following schemes are for joint implementation during 2014/16 and will enable system wide change to be embedded and will support the key developments for BCF in 15/16 and onwards. The funding for these schemes is within current CCG and Local Authority baselines and will be assessed and identified as part of the BCF 15/16 development plan.		
BCFE02	Primary Care development	Local reconfiguration of Locally Enhanced Services budget – including the Visiting Medical Officer (VMO) and re-commissioning of GP Out of Hours and GP walk-in-centre to ensure improved alignment with the Integrated primary care teams and 7 day working approach.
BCFE03	Community Beds	Review and reconfiguration of community hospital estate. The revised model to be funded through the implementation of the joint health and social care estate strategy and will link in with the social care Accommodation strategy where Extra Care Sheltered Housing will also be utilised for Intermediate Care.
BCFE04	Developing self-management and peer support	Working with individuals and through Community Pharmacy teams, local voluntary and community groups to co-design, co-develop and co-produce improved health and care outcomes, ensuring that the patient and service user capacity within the system is maximised. We will be commissioning a “Core Offer” from the voluntary sector and through the Care Navigator or Health , Social Care Coordinators and teletechnology individuals will be supported in self management.
BCFE05	Primary Prevention	Delivery of agreed health inequality reduction strategy and implementation plan

No.	Schemes 2014/15	Description
BCFE06	Care Home Support	Additional support is being provided to Care Homes to support them to enable residents to remain as independent as possible and remain or return to their home in a timely manner.
BCFE07	Housing adaptations	Issued subject to a means test and are available for essential adaptations to give disabled people better freedom of movement into and around their homes, and to give access to essential facilities within the home (DFG)
BCFE08	Accommodation Strategy	A joint accommodation strategy and implementation plan is required, with appropriate range of accommodation available. Financial impact not yet available – to be confirmed on completion of workshops and agreement of projects
BCFE09	Adult Social Care Capital Grant	Joint working with the integrated primary care team to identify effective utilisation of this grant to support independence and enable people to maintain living in their own homes.
BCFE10	Support for people with Autistic Spectrum Disorder	We will be commissioning a diagnostic, assessment and support service for people with high functioning Autistic Spectrum Disorder , to support access to the community , employment and self management for individuals.

During 2013/14 a number of the above schemes have commenced and will be accelerated in 2014/15 through the use of CCG re-ablement fund, the indicative additional transfer from NHS and health commissioning intention investments aligned to non-elective reductions and achievement of the 10% reduction in conversion to admission expected this year. This will be progressed to 15% in 2015/16.

7. **How will we know if we have achieved our vision?**

7.1. GPs, Pharmacists, community health workers, social workers, housing workers and other professionals in the health and social care system should expect and will work more closely together with the express intention of supporting the patient or service user to require as little support as possible to live independently. This is likely to involve a single assessment process, a joint care plan, and system-wide common ways of identifying risk and measuring outcomes. There will be trust between organisations to help the patient or service user make good decisions about what support they need next, and all agencies will work cooperatively and understand that getting things right for the patient or service user is in everyone's interests. They should have wide room for professional judgment, and wherever possible make preventative interventions to stop deterioration, even if that intervention is more expensive in the short term. They will be able to access more information about the patient or service users support from other agencies, and they will make time for working together.

7.2. Hospital staff will expect to see proportionately fewer frail and elderly patients. This does not mean that these service will not be required. The skills of key physicians and, in particularly geriatricians, will extend into the community. This is supported by the recent report published by the royal college of physicians, which recognises the value of such skills within the community. Hospitals need to recognise that delivery of care is not and should not be confined to beds within an institution, but delivered in a number if settings to support and maintain independence. We should, therefore, see a reduction in the number of unplanned admissions of other adults with social care needs. They will work closely with professionals who are based

in community services, whether that is medical, social, housing or voluntary. They will have access to more information about patients, including non-medical involvements by other services, and they will use this information to help them make good decisions with patients about the most appropriate care for them. Sometimes, this might mean not treating people in hospital, and community based services will be easier to access and take on complex cases.

7.3. Primary, community care and mental health services will be working closer together, along with voluntary organisations and other independent sector organisations.

7.4. People will get the 'right care, in the right place at the right time by the right person'. We will measure the success of this by measuring if there has been a reduction in the time people currently spend waiting for a service or treatment when required

7.5. Pressure on the acute hospitals will reduced, we will see fewer acute emergency / non elective admissions and reduced length of stays.

7.6. We will see more people remaining in their own homes and a reduction in care home admissions, and people will be living more independently following re-ablement and / or intermediate care, taking into account the increase in population. We will see;

- People and particularly those patients with long term conditions accessing support and information to manage their own health and social care to proactively prevent deterioration of their condition
- Improved access and compliance/concordance to Medicines through improved Medicines Optimisation services in the community
- Carers supported and they will have access to services that enable them to manage their own health.
- Feedback from people with long term conditions demonstrating that they feel more enabled to manage their health
- Ill Patients having improved experience and feeling supported to manage their health and social care.
- Easier access to information, advice and guidance will be available.
- Increase in the early diagnosis and intervention for the highest impact conditions identified within the health inequalities documents, CVD, diabetes and dementia being the highest.

7.7. Given the growth in NK population in general and in particular within the elderly (over 85) cohort we will and should see a growth in activity in some areas to provide active intervention earlier on. We should, therefore, see a reduction in non-elective care that often results in expensive reactive care. By intervening earlier we provide the individual with the greatest opportunity of self-management and therefore reduced long term multiple care inappropriate to need.

7.8. This paper sets out a vision for use of the Better Care Fund, to bring together all of the public agencies that provide health and social care support, especially for older people, to co-ordinate services such as health, social care and housing, to maximise individuals' access to

information, advice and support in their communities, helping them to live as independently as possible in the most appropriate setting.

7.9. The vision sets out a range of principles that we think are important to how we will use the Better Care Fund in North Kent. The King's Fund emphasises that it is important to find common cause care matters, and put together a persuasive vision to describe what integrated care will achieve. We would like this paper to start this conversation.

7.10. We have not set out any specific projects in detail. There are many other projects already up and running that need to be progressed and monitored to ensure that they deliver the transformational changes required. This paper sets out the vision and principles that we believe are important to deliver an integrated system that provides the right care for patients within the extremely tough economic environment.

8. Suggested Metrics for development

In line with the overall Kent level Better Care Fund metrics we will monitor achievement against the following metrics:

- Permanent admissions to residential and care homes: Reduction in admissions based on rate of council-supported permanent admissions to residential and nursing care
- Effectiveness of reablement – those 65+ still at home 91 days after discharge. Performance to be between 82-88% and not show a reduction over 2 years.
- Delayed transfers of care: Reduction in DTOC using total number of delayed transfers of care for each month.
- Avoidable emergency admissions: 15% reduction in admissions.
- Local Metrics:
    - Social Care Quality of Life
    - Injuries due to falls in people aged 65 and over

It should be noted that the indicators relating to delayed transfers of care (reported on an acute Trust basis) and avoidable emergency admissions (a composite indicator) are currently based on the data for Dartford, Gravesham and Swanley CCG / Dartford and Gravesham NHS Trust. This is due to the need to review the data for Swale CCG, which relates to a proportion of the activity at Medway NHS Foundation Trust. Work will be undertaken to review the baseline data and levels of ambition for all indicators and finalise trajectories by September 2014.

However, to support these higher level indicators the following will be measured locally:

- **Reduction of emergency admission by minimum of 15% from a 2012/13 baseline** (significant progress in 14/15 – link to the Oaks group Non-qualified admissions of reduction by 10-15%). The expectation is that there will be a significant decrease in patients attending and being admitted non electively for specifically HF, CVD, COPD, diabetes, which are the areas for highest inequalities.

- **Increase in the number of patients discharged from A&E with support** and reduction in the number of patients re-attending. (80% w/e 12th Jan)

- **Reduction in Length of Stay per speciality** to within a minimum of HRG trim point per condition.

- **Primary care – 80% over 75yr and those with complex needs have an accountable GP** and have been reviewed to understand their needs and packages of care. Clear specification, for the management of patients in care Homes.

- **Patient experience –** identifying that patient accessing greater support that manages their condition

- **Increasing the number of patients who die in their place of choice.** Increasing the number of patients to 90% who are at the end of life stage to be on the end of life care register and have agreed plan in place with all relevant providers of their care. Improved anticipatory prescribing and access to end of life medicines

- **Increasing the % of patients diagnosed with dementia from 50% to 65%** with 90% having an agreed treatment plan in place and enacted with appropriate professionals and voluntary sector support.

- **Increase in the number of patients receiving planned care for HF, CVD, COPD, diabetes**. (Note in order to support the reduction in the more expensive non-elective admissions.)

- **Integrated Primary Care Teams within the defined locality areas,** including acute physicians, community nursing and therapy, Pharmacy input, mental health and social care, resulting in the total achievement of non-elective reductions, care home reductions, mental health placement reductions. We see this as the enabler to the achievement of the above metrics.

- **To achieve the financial efficiencies defined**, and operate within designated financial envelope for health and social care.

9. How we will govern and manage these developments?

Across North Kent, we have invested significantly in building strong governance that transcends traditional boundaries. The Health and Wellbeing Board and the local health and Wellbeing Board are maturing and our transformational plans and programmes are formally discussed and approved at local borough governance levels within each local authority and CCG. The North Kent CCGs of DGS and Swale CCG have implemented the following governance arrangements to support the system changes and implementation of schemes. These include:

- We have established Executive Programme Boards in both Swale/ Medway and DGS localities where the Executives of the Provider organisations, CCG and KCC meet monthly to discuss and develop system changes to deliver improved outcomes for our patients.
- Regular monthly Strategic Commissioning meetings are held with KCC to discuss and agree Strategic Commissioning priorities and partnership working.
- HASCIP working groups are operational in DGS and Swale CCGs
- CCG Clinical Cabinet Committees

An overview of the governance structure is included as Appendix 2.

9.1. Providing effective oversight and co-ordination

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

Throughout this process, we will ensure that the 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.

Across North Kent, the Executive Programme Boards, combining health and local authority membership, will continue to provide direction and sponsorship of the development of integrated care across the geography. This will ensure 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.

Discussions have taken place and we propose a joint project management approach to review the current schemes in detail, add to them and ensure that there are clear implementation plans for delivery. Furthermore, there is a requirement to continually evaluate impact of schemes to ensure that we learn and adapt and mover towards full integration. We therefore propose a project director to be appointed across the CCGs and KCC, supported by an appropriate team. This team will report into respective Boards, the Executive Programme Board, which providers and KCC attend and through the local and Kent Health and Wellbeing Boards.

9.2. Engagement

Engagement, both with providers, commissioners, stakeholders and patients and the public, remains an ongoing element of the development, implementation and evaluation of the Better Care Fund Schemes.

As outlined in section 2, the vision underpinning the development of the schemes described above is based on feedback from patients and the public, as well as GPs, from both CCG areas. This feedback has been gathered, considered and reviewed through a number of events locally as part of the development of CCG five year Strategies. Ongoing engagement will be aligned with the annual engagement programme for commissioning plans (currently in development). However, this will initially be undertaken via the Patient Reference Groups / Patient Participation Groups within each CCG, during Quarter 1, to gain feedback and assurance that the proposed schemes address concerns, issues and ideas raised during earlier discussions.

Engagement and discussion with healthcare providers, and health and Social Care commissioners – as well as KCC and Local Authority teams - has been undertaken through a number of routes, with the review of local services supported by the Kings Fund / Oak Group work across North Kent (including Medway CCG) providing significant opportunity to review data, and develop and agree plans. In addition to this work 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
- Integrated / Strategic Commissioning Meetings
- Attendance at District / Borough Council meetings
- Executive Programme Boards for Dartford, Gravesham and Swanley and Medway / Swale.

10. Next Steps and Development of Plans

This document has been developed to share current progress and thinking around the development of the BCF in North Kent. The proposals within this document have been refined, developed and signed-off through the following timeframe:

Date	Governance Process for submitting the BCF Bid
Sept 13	Winter plan / Funding schemes agreed and schemes commenced with the view that the majority would be tested and built into the BCF bid
13th Jan	Pioneer Steering group – sharing of information and challenge
16th Jan	BCF Kent workshop
17th Jan	Submission of CCG Draft Vision (version 1)
29th Jan	North Kent executive commissioner (CCGs and KCC) and provider planning and agreement meeting. Three priority areas agree for 1014/15 as a prelude and move towards delivery of the BCF from 2015.
Jan 14	CCG Governing Body approval of CCG draft vision
31st Jan	Circulation of the Final draft of vision and initial financial projection
Feb	Signature of support and commitment to delivery within the draft by all provider and Commissioner Executive CEO
14th Feb	Submission of NK BCF bids to KCC project team
Feb/ Mar	Further update and development of schemes
26th Mar	Approval by Kent Health and Wellbeing Board
4th Apr	National deadline for submission of final schemes

During the NK executive commissioner (CCGs and KCC) and provider planning and agreement meeting on the 29th January, 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 table on page 15.

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 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.
- **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 cluster of GP Networks. It has been proposed to cluster DGS practices using collaborative agreements in the first instance with practice population sizes of between 9-15,000 based on the Cumbria experience. This will be developed in line with the LRU expansion as described above. 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 has been commenced and led by Dr David Woodhead and full timeline for implementation will be built into the final submission. However, we anticipate requesting support from the Pioneer to ensure the complexities and risks around IG are mitigated.

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 dementia specialist 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.

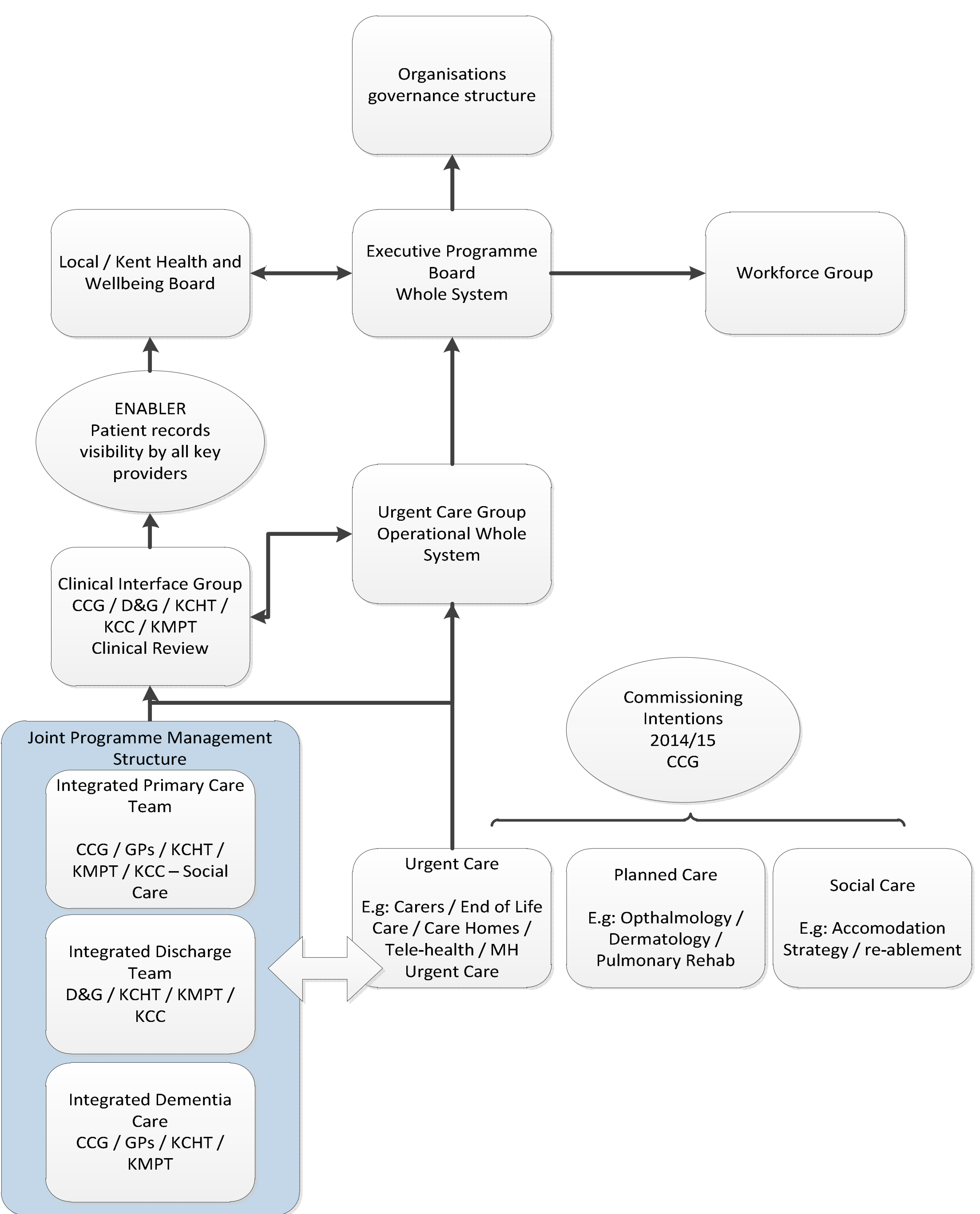
The Joint Programme Management Office will take forward the proposals and will report to the Executive Programme Board and organisational governance structures on progress.

Date	Governance Process for implementation of BCF 2014/15 - key priorities
29th Jan	North Kent executive commissioner (CCGs and KCC) and provider planning and agreement meeting. Three priority areas agree for 2014/15 as a prelude and move towards delivery of the BCF from 2015.
Feb 14	Strategic Commissioning Meeting - Detailed agreement of the implementation planning and outcome measures for 2014/15
Feb 14	Kings Fund workshops to confirm commitment to delivery within the draft by all provider and Commissioner Executive CEO
March 14	Interviews for Senior Project management support to implement and deliver the key priorities
Feb / March	Agreement of Integrated Primary Care Teams and LRU/Crisis Response service specifications and outcome measures implementation plan and contracts signed off
April - March	Performance monitoring of the agreed plan and outcomes reporting to the Health and Well-being Boards and Governing Bodies.

Appendices:

1. **DGS Health Economy Integrated Discharge Team SLA**

2. **System Governance Structure:**



Organisations governance structure
Local / Kent Health and Wellbeing Board
Executive Programme Board Whole System
Workforce Group
ENABLER Patient records visibility by all key providers
Urgent Care Group Operational Whole System
Clinical Interface Group CCG / D&G / KCHT / KCC / KMPT Clinical Review
Commissioning Intentions 2014/15 CCG
Joint Programme Management Structure
Integrated Primary Care Team
CCG / GPs / KCHT / KMPT / KCC – Social Care
Integrated Discharge Team D&G / KCHT / KMPT / KCC
Integrated Dementia Care CCG / GPs / KCHT / KMPT
Urgent Care
E.g: Carers / End of Life Care / Care Homes / Tele-health / MH Urgent Care
Planned Care
E.g: Opthalmology / Dermatology / Pulmonary Rehab
Social Care
E.g: Accomodation Strategy / re-ablement

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Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Kent County Council**
Clinical Commissioning Groups	**Dartford, Gravesham and Swanley (DGS)**
	Swale
	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
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 (CCG) health and wellbeing boards, as well as review by the Kent health and wellbeing board will ensure any gaps or issues are identified and minimised.
Date agreed at Health and Well-Being Board:	**26/03/2014**
Date submitted:	**14/03/2014**
Minimum required value of ITF pooled budget: 2014/15	**£5,816.2**

2015/16	**£30,676.54m**
Total agreed value of pooled budget: 2014/15	**£5,816.2m**
2015/16	**£30,676.54m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Dartford, Gravesham and Swanley CCG
By	Patricia Davies
Position	Accountable Officer
Date	<date>

Signed on behalf of the Clinical Commissioning Group	Swale CCG
By	Patricia Davies
Position	Accountable Officer
Date	<date>

Signed on behalf of the Council	Kent County Council
By	Paul Carter
Position	Leader of Council
Date	<date>

Signed on behalf of the Health and Wellbeing Board	Kent Health & Well-being Board
By Chair of Health and Wellbeing Board	Roger Gough
Date	<date>

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

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 from 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.

In addition to this work 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:

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- 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.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Feedback has been gathered, considered and reviewed through a number of events locally as part of the development of the CCGs Two year Operating Plan and Five year Strategies. Ongoing engagement has been aligned with the annual engagement programme for commissioning plans and undertaken via the Patient Reference Groups / Patient Participation Groups within each CCG, which will continue during Quarter 1, to gain feedback and assurance that the proposed schemes address concerns, issues and ideas raised during earlier discussions.

A deep dive consultation was also undertaken with patients and carers on a community services review. The feedback from this has also been fed into the development of the BCF plan.

e) 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**
Project plans in development	
Draft CCG Operating Plans 2014-2016	
Better Care Fund Vision document	
Integrated Discharge Team service specification / Heads of Agreement	
NHS DGS CCG and NHS Swale CCG Community Services Review Developing the Future Model based on Patient Insights DEEP DIVE REPORT	

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2) VISION AND SCHEMES

a) Vision for health and care services
Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our vision for whole system integrated care is based on what people have told us is most important to them (details available within the CCG Community Services Engagement Deep Dive document). Through patient and service user workshops, interviews and surveys across Dartford Gravesham Swanley and Swale we know that what people want is choice and control, and for their care to be planned with people working together to help them reach their goals of living longer and living well. They want their care to be delivered by people and organisations that show dignity, compassion and respect at all times.

We recognise that realising this 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. 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 behavioral and attitudinal change in the acute sector, 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 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

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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

<u>Our vision - What this will mean for our health and social care services</u>

Effects on services

We think it is important to be clear about what this will mean, especially because this is not new investment in the system, but a re-organisation of existing funding and services. There is likely to be an increase in the support available in the community through an investment in self-care and early intervention, and by managing demand in this way, a decrease in the need for more intensive social care support or health support at acute level, with corresponding changes in acute services. We will be working towards single health and social care assessments that will require a much closer level of integration between primary health (GPs, community Pharmacists), community health (e.g. district nursing, physiotherapy), mental health (e.g. primary care mental health workers, dementia nurses), social care (support to live independently) voluntary sector support, 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.

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 social care

This is easy to say and hard to do. Recognising that the way that change is done is as important as the change that is aimed at, the next four principles set out 'rules' we are proposing to govern what we do to achieve this vision. The following summarises the key impact on healthcare providers:

Acute Trusts and Ambulance Trust	Reduction of bed pressures, via
	
	• Reduction in non-elective admissions by 15% over two years at:
	    o Dartford and Gravesham NHS Trust –
	    o Medway NHS Foundation Trust -
	• Reduction in length of stay
	    o Dartford and Gravesham NHS Trust –

	○ Medway NHS Foundation Trust – NB – contracts currently in negotiation.
Community health providers including mental health	Increase in community activity – to be defined.

b) Aims and objectives
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

We recognise that realising this 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. 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 in the acute sector, 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 communities.

Measuring success

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:

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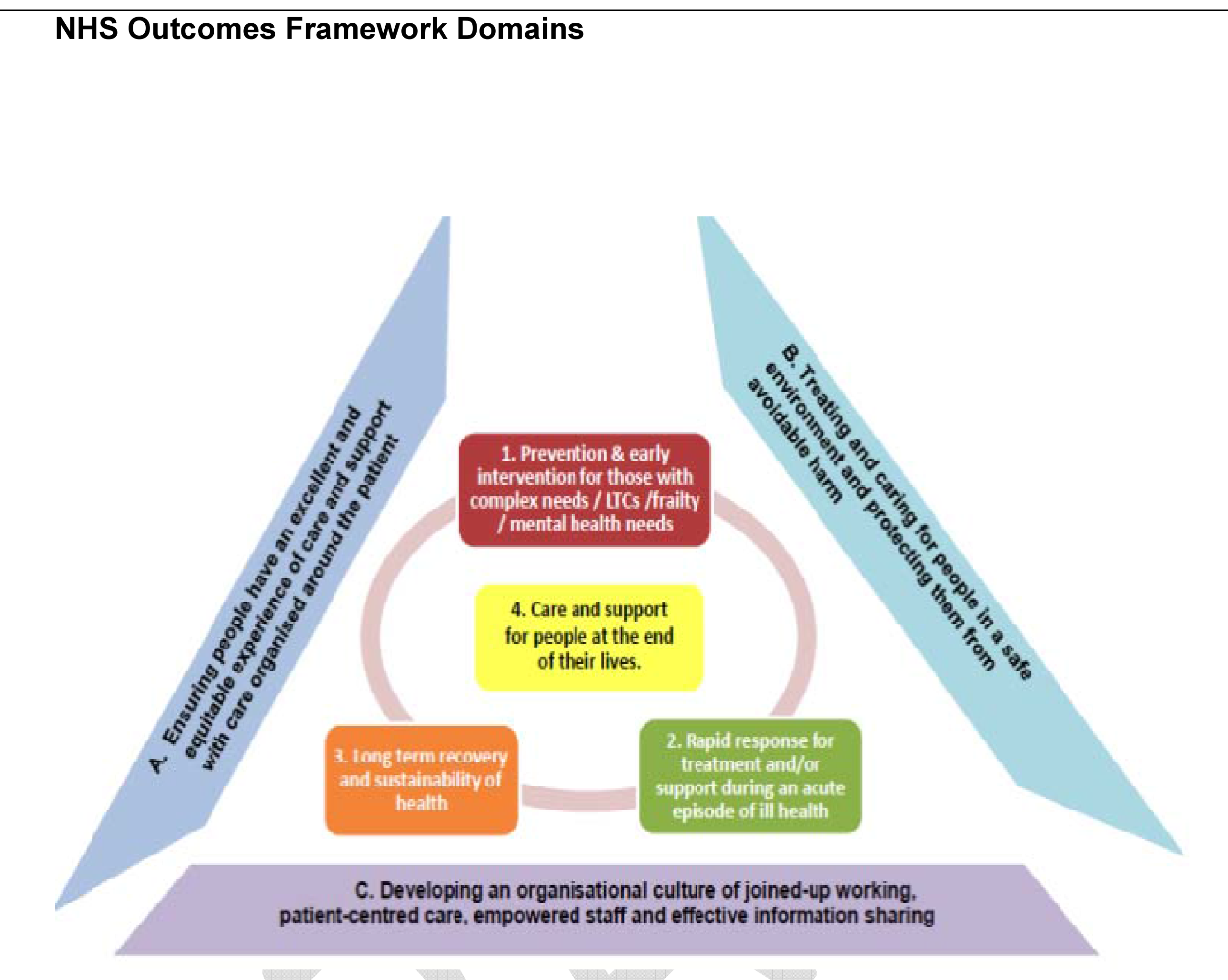
NHS Outcomes Framework Domains



We will also use other measures that show us whether the system is effective, such as delayed transfers of care, the effectiveness of short-term recovery-focused services like re-ablement, and patient and user experience of services. We will therefore seek to deliver services that have a positive impact as measured by these measures.

3.2 This strategy is based on 3 core principles:

i. People will be empowered to direct their care and support, and to receive the care they need in their homes or local community.

ii. GPs will be at the centre of organising and coordinating people's care.

iii. 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.

Open, Honest and evidence-based

It is recognised that the basis of the funding for the Better Care Fund is money that is already committed to health and social care services of many different types. Some services will need to change to support the aim set out above, others will need stability. Discussions should be open, honest and evidence-based in order to make sure we use the money in the best way.

Early intervention and supporting independence

The plans set out in the Better Care Fund should align with existing or developing strategies, such as the CCGs, Kent County Council and Local Authority Strategic Plans, including the Kent Health and Well-being Strategy, Pioneer plan and Health Inequality plans. A key principle of all of these strategies is that people experience the best outcomes when they are able to live independently at home, and supporting them to do so will be a theme throughout all proposals in the Integration Plan. There will be other important themes, including coherence and integration of services, the importance of identifying vulnerability and acting to prevent deterioration, ensuring professional judgement is valued and free to be flexible, and that services are person-centred.

Support for everyone

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 are continued 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.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

A Proposed Model

We are proposing to develop the model 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.

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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. We understand the need for pace and the financial climate dictates that the system needs to change in the short, medium as well as the 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. We will build on our current plans with providers, KCC and North Kent District Councils, to deliver the critical transformational changes required to deliver the key priorities identified by our public and patients. These will include;

1. **A united approach to advice and information on community and public sector services.** This will include developing robust and reliable sources of advice and support for older people before they become frail or need to access the statutory system; and providing universal information and advice about services from all partner agencies, which should be quick to access, clear, friendly and personalised. This will include developing access to transport for vulnerable people who need it to prevent social isolation and access to medical appointments. We will ensure that Patients can See their pharmacist more often and have more opportunities to discuss their health and wellbeing and early detection of serious illness. Be signposted to community services and facilities aimed at helping to address some of the underlying determinants of health. This includes links with existing services such as:

    - **Postural Stability**

    Falls and fractures are a significant public health issue particularly amongst older people with estimates that one in three people aged over sixty five will fall each year and one in two people aged over eighty. It is estimated that falls account for between 10% and 25% of ambulance callouts at £115 per call-out. Postural Stability group exercise programmes improve the balance, strength, gait/mobility and confidence of frail, ambulant older adults at risk of falling. KCC currently commission community based postural stability classes through a variety of public and voluntary sector providers as an integral part of an emerging Falls Framework and care pathway but provision has been fragmented. Significant work is underway with KCC Social care to tender a new integrated enhanced model during 2014/15.

    - **Winter Warmth**

    Excess Winter Mortality (EWMs) are the ‘extra’ deaths that occur in the winter months compared to the rest of the year. The causes of death are complex and interlinked with cold weather, fuel poverty, poor housing and health inequalities, as well as infectious diseases such as flu and noro-virus, and the extent of snow and ice. Many, but not all are likely to be

preventable.

KCC and Local Borough Councils, commission and provide a range of interventions to support at risk groups including funding low level interventions through Home Improvement Agencies, supporting Eco provision for at risk households, training frontline service providers and grant funding for a volunteer led homeless shelter.

2. **Coordinated and intelligence-led early identification and early intervention.** Implementing community record and information sharing between the range of organisations supporting individuals at risk of requiring more support in the future. Ensuring that the workforce are able to feed back as much intelligence as possible as to the needs of the service users they are supporting and how service delivery and deployment of available resources can be improved.

3. **Integrated Primary Care Teams - 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 main stream 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 collaborate in networks focused on populations between 9,000 and 15,000 within given geographies, with community, social care, mental health and specialist services, organised to work effectively with these networks. 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 a long-term condition should expect Pharmacists and GP's working in partnership to ensure the best possible care, with linked IT systems Pharmacists to help them to manage their medicines needs on an ongoing basis. With Support available from pharmacists and their teams to enable self-management of patients conditions so that they can stay well in and out of hospital. This will include early detection of problems or deterioration in their condition through routine monitoring. Pharmacists will be able to consult with them in a range of settings appropriate and convenient to them. For example pharmacy consulting rooms, GP practices, home visits,

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We expect the core team that will function around the GP network to be as follows:

- Generalist District Nursing Service (see specification attached). This will include District Nursing sisters who will act as case holders and managers working with and delegating work to their team of registered staff nurses, health care assistance / re-ablement workers, using peripatetic skills across therapy, nursing and social care.
- Named Social Care Workers who together with district nurses will take responsibility for case management (inclusive of enablement and re-ablement services)
- Named community Pharmacy of patients choice
- Primary Care Mental Health Practitioner (see job specification attached)
- Primary Care Dementia Practitioner (see job specification attached)
- Primary Care Health Visitor linked to vulnerable adults using public health skills (NHS England responsibility)
- Health Trainers, Health prevention workers and Health and Social Care navigators
- We would expect District Nurses to provide end of life care but access hospice and palliative care specialists (on discussion with GP and the MDT as required)

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.

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 diabetiologists supporting risk stratification and maintenance management as required. Assistive technology, telecare and telemedicine will be more effectively used to support patients to be independent.

4. **Investment in community capacity as described above, to enable people to meet their needs with support in their local community.** The integrated primary care teams will be based around the General Practice networks and focused on the needs of patients. They will deliver robust rapid response where this is appropriate, long term condition management, geriatrician, mental health, social and voluntary sector care, equipment and housing support. They will actively support GP practices to identifying people who are at risk of admission to hospital or residential / nursing home care where indications are that, with some immediate intensive input, equipment and support, such admissions can be avoided. They will work seamlessly with the Acute Hospital and social care, through the integrated discharge team, to ensure that patients receive the

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treatment they need and are rapidly discharged with health, social and voluntary sector care and housing support to return back to independent living. Assistive technology, telecare, telemedicine and Disabled Facilities Grant (DFG), will be more effectively used to support patients to be independent and they will be actively utilised in care homes with support to enable patients to be managed when in acute crisis.

5. **Rapid Response services 24/7 linked to the Local Referral Unit (LRU) and Crisis response (Community Based) –** This will focus on admission avoidance and where possible attendance avoidance, where patients either known to the system or unknown, have reached crisis point. It is anticipated that through more robust integrated community working, that the number of patients unknown will be reduced. However, it is accepted that patients will have long term and enduring conditions that will require rapid response at times of acute need. Similarly, people without long term conditions, may require time-limited support to prevent exacerbation of an acute health or social care episode. This team will be centralized to cover a greater geographical area than for GP networks, to ensure effective use of skills and resources. However, there will be strong links between the Local Referral Units and networks. For example, acceptance of each other's assessments and referrals.

   There will also be an improved approach to crisis management and recovery. Supporting rapid escalation and action when a crisis occurs in the life of an older person; this is likely to involve a coordinated response from all agencies (including social care and mental health) working in multi-disciplinary teams, 7 days a week, to provide intensive support in the short term and encompassing services such as respite care and supportive discharge planning. Support should focus on ensuring that when the crisis is over older people and their carers remain as independent as possible and avoid short term crises triggering a deterioration which leads to long term health or social care need.

   The team will comprise:

   - Duty Social worker / case managers
   - Nursing Staff
   - Therapy staff (minimum OT and Physiotherapy plus technicians and re-ablement workers)
   - Access to enablement and domiciliary care to provide 24/7 support as required
   - Crisis Mental Health Teams (including functional and Dementia)
   - Social and Voluntary Sector Care Crisis response services
   - Clinical assessment utilizing specialist nurses, paramedic practitioners and roving GPs

6. **Integrated Discharge Team (Hospital in-reach and links to LRU for early**

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supportive discharge and admission avoidance. 7 days per week (8am – 10pm) – (See attached specification and Heads of agreement)

7. **Community Hospital Re-design and Estate reconfiguration using evidence for the Oaks Group and Kings Fund.** It is accepted that the current community hospital resource is not fit for purpose or utilized appropriately. Re-profiling of beds and criteria is required, in line with the Kings Fund and Social Care Accommodation solutions work which includes the definition of medical cover required to support any non-acute bed based facility. Community Hospital services will become integrated health and social care centres that will enable patients to receive the appropriate rapid support that they need. In addition as part of the Social Care Accommodation Strategy support in Extra Care Sheltered Housing will be developed to support avoidance of admissions to hospital and long term care and hospital discharge. A review of KCC accommodation is currently in progress as part of the development of the strategy, and includes links to all partners in health and housing. This work is aiming to ensure understand and manage the market, linking into the needs analysis and ensuring that future care is provided in the most appropriate setting for individuals.

A joint accommodation strategy and implementation plan is required, with appropriate range of accommodation available. This needs to include, care for vulnerable adults needing accommodation and care input, including those with dementia, learning or other disability or with mental health needs unable to remain in their home such as extra care housing. Extra care provides the security of having your own home as well as the availability of having care on site. This will include health and social care centres running within community hospitals. Further projects and schemes will be developed to support implementation of the Strategy following completion of the current review.

Suggested Metrics for development

In line with the overall Kent level Better Care Fund metrics we will monitor achievement against the following metrics:

- Permanent admissions to residential and care homes: Reduction in admissions based on rate of council-supported permanent admissions to residential and nursing care
- Effectiveness of reablement – those 65+ still at home 91 days after discharge. Performance to be between 82-88% and not show a reduction over 2 years.
- Delayed transfers of care: Reduction in DTOC using total number of delayed transfers of care for each month.
- Avoidable emergency admissions: 15% reduction in admissions.
- Local Metrics:

- Social Care Quality of Life
- Injuries due to falls in people aged 65 and over

It should be noted that the indicators relating to delayed transfers of care (reported on an acute Trust basis) and avoidable emergency admissions (a composite indicator) are currently based on the data for Dartford, Gravesham and Swanley CCG / Dartford and Gravesham NHS Trust. This is due to the need to review the data for Swale CCG, which relates to a proportion of the activity at Medway NHS Foundation Trust. Work will be undertaken to review the baseline data and levels of ambition for all indicators and finalise trajectories by September 2014.

However, to support these higher level indicators the following will be measured locally:

- **Reduction of emergency admission by minimum of 15% from a 2012/13 baseline** (significant progress in 14/15 – link to the Oaks group Non-qualified admissions of reduction by 10-15%). The expectation is that there will be a significant decrease in patients attending and being admitted non electively for specifically HF, CVD, COPD, diabetes, which are the areas for highest inequalities.

- **Increase in the number of patients discharged from A&E with support** and reduction in the number of patients re-attending. (80% w/e 12th Jan)

- **Reduction in Length of Stay per speciality** to within a minimum of HRG trim point per condition.

- **Primary care – 80% over 75yr and those with complex needs have an accountable GP** and have been reviewed to understand their needs and packages of care. Clear specification, for the management of patients in care Homes.

- **Patient experience** – identifying that patient accessing greater support that manages their condition

- **Increasing the number of patients who die in their place of choice.** Increasing the number of patients to 90% who are at the end of life stage to be on the end of life care register and have agreed plan in place with all relevant providers of their care. Improved anticipatory prescribing and access to end of life medicines

- **Increasing the % of patients diagnosed with dementia from 50% to 65%** with 90% having an agreed treatment plan in place and enacted with appropriate professionals and voluntary sector support.

- **Increase in the number of patients receiving planned care for HF, CVD, COPD, diabetes**. (Note in order to support the reduction in the more expensive non-elective admissions.)

- **Integrated Primary Care Teams within the defined locality areas,** including acute physicians, community nursing and therapy, Pharmacy input, mental health

and social care, resulting in the total achievement of non-elective reductions, care home reductions, mental health placement reductions. We see this as the enabler to the achievement of the above metrics.

- **To achieve the financial efficiencies defined**, and operate within designated financial envelope for health and social care.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

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 proposals 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).

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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

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

How we will govern and manage these developments?

Across North Kent, we have invested significantly in building strong governance that transcends traditional boundaries. The Health and Wellbeing Board and the local health and Wellbeing Board are maturing and our transformational plans and programmes are formally discussed and approved at local borough governance levels within each local authority and CCG. The North Kent CCGs of DGS and Swale CCG have implemented the following governance arrangements to support the system changes and implementation of schemes. These include:

- We have established Executive Programme Boards in both Swale/ Medway and DGS localities where the Executives of the Provider organisations, CCG and KCC meet monthly to discuss and develop system changes to deliver improved outcomes for our patients.
- Regular monthly Strategic Commissioning meetings are held with KCC to discuss and agree Strategic Commissioning priorities and partnership working.
- HASCIP working groups are operational in DGS and Swale CCGs
- CCG Clinical Cabinet Committees

An overview of the governance structure is included as Appendix 1

a. Providing effective oversight and co-ordination

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

Throughout this process, we will ensure that the 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.

Across North Kent, the Executive Programme Boards, combining health and local

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authority membership, will continue to provide direction and sponsorship of the development of integrated care across the geography. This will ensure 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.

Discussions have taken place and we propose a joint project management approach to review the current schemes in detail, add to them and ensure that there are clear implementation plans for delivery. Furthermore, there is a requirement to continually evaluate impact of schemes to ensure that we learn and adapt and mover towards full integration. We therefore propose a project director to be appointed across the CCGs and KCC, supported by an appropriate team. This team will report into respective Boards, the Executive Programme Board, which providers and KCC attend and through the local and Kent Health and Wellbeing Boards.

3) NATIONAL CONDITIONS

a) Protecting social care services
Please outline your agreed local definition of protecting adult social care services.

Central to these plans is the need to build capacity and resilience into all health and social care teams, by making best use of sharing information and resource, and use of technology to streamline processes. The aim is to have a joint plan that will deliver the required savings for both health and social care to ensure that both are financially sustainable over the next 2-5 years.

Please explain how local social care services will be protected within your plans.

All proposed schemes include the need to ensure that integration between health and social care providers is central to delivering the overall aims. Joint performance metrics have been developed to ensure that there is improved quality of care for patients that deliver the required savings impact for both social care and the CCG and not cost shifting.

b) 7 day services to support discharge
Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and 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 has 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, 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 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.
- **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 cluster of GP Networks. It has been proposed to cluster DGS practices using collaborative agreements in the first instance with practice population sizes of between 9 - 15,000 based on the Cumbria experience. This will be developed in line with the LRU expansion as described above. 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 has been commenced and led by Dr David Woodhead and full timeline for implementation will be built into the final submission. However, we anticipate requesting support from the Pioneer to ensure the complexities and risks around IG are mitigated.

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 dementia specialist 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 Joint Programme Management Office will take forward the proposals and will report to the Executive Programme Board and organisational governance structures on progress.

Swale and DGS CCG has submitted a bid for the PM Challenge Fund to accelerate the integrated primary care team model. Proposals from GPs are currently being worked through in terms of developing federated models of practices working with integrated teams 7 days per week.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

A proportion of NHS numbers are held within KCC's Adult Social Care System SWIFT.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Monthly batches of client records are sent to the NHS matching service (MACS) and if

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they can match to a single record on their system they return the NHS number which is uploaded into SWIFT. The NHS number is predominately used to facilitate the matching of data sets for Year of Care and Risk Stratification, not for correspondence or to undertake client checks, the numbers are too low. We would use name: address and date of birth as the key identifiers at present. Further work will be required to ensure NHS number is used across all correspondence.
KCC achieved approx. 80% matching of records to NHS numbers when we started, improvement to this percentage would need significant additional resource.
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).

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Yes

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Yes

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

We are developing single health and social care assessments that will require a much closer level of integration between primary health (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.

GPs generally identify that patients who are at high risk of hospital admission already have an accountable lead professional. The aim of the new integrated primary care teams will be to support patients and the GPs to identify patients earlier through targeting and MDT working. Joint plans will be implemented through the integrated primary care teams and as part of implementation of the new GMS contract. This will include support for people with both physical and mental health, especially dementia, needs.

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RISKS

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

Risk	Risk rating	Mitigating Actions
Workforce – issues with recruitment across all sectors due to proximity to London / aging workforce	4x4 = 16 (RED)	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.
Financial sustainability on NHS Providers	4x4 = 16 (RED)	To be considered through contract negotiations.
Failure to deliver the reduction in acute emergency admissions	3x4 = 12 (AMBER)	Provider agreement to the reduction by 10% 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
Lack of GP engagement in supporting the integrated primary care teams	2x3 = 6 (GREEN)	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
Lack of patients behavioural change to affect reductions in A&E attendances and admissions	3x3 = 12 (AMBER)	Implemented a Health Help Now App for patients to help them navigate the health system (currently has reached 10,000 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.

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Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 (k)	Minimum contribution (15/16) (k)	Actual contribution (15/16) (k)	notes
Dartford Borough Council	N		£ 259.00	£ 259.00	disabled funding grant
Swale CCG	N	£ 668.00	£ 6,556.00	£ 6,556.00	reablement + carers break funding
Dartford, Gravesham and Swanley CCG	N	£ 935.00	£ 14,947.00	£ 14,947.00	reablement + carers break funding
Gravesham Borough Council	N		£ 431.00	£ 431.00	disabled funding grant
Sevenoaks District Council	N		£ 200.34	£ 200.34	42% of total disabled funding grant due to CCG boundaries
Swale Borough Council	N		£ 811.20	£ 811.20	78% of total disabled funding grant due to CCG boundaries
Kent County Council	N	£ 5,816.20	£ 7,472.00	£ 7,472.00	s256 health monies only for 2014/15; includes + care bill +carers break funding for 1
BCF Total		**7419.2**	**30676.54**	**30676.54**	

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some

1. discussions are in progress across the health and social care system to prioritise and implement those schemes which will have both immediate and longer term impacts, enabling changes to the system to be seen during 2014/15 to support longer term transformation during 2014/15 and beyond.
2. discussions are in progress with health providers as part of the negotiation period for contracts for 2014/15 to build financial stability across the whole health economy
3. This work is supported by the implementation of CQUINs (currently in discussion as part of contract negotiation) to deliver a 10% reduction in non-elective admissions across all providers for 2014/15 (acute, Kent Community Health and KMPT).
4. An agreed governance and joint programme management approach provides assurance but also enables swift action to be agreed and taken across both health and social care, should schemes fail to deliver expected impact

Contingency plan:		2015/16 (£k)	Ongoing
Outcome 1 - reduction in NEL admissions	Planned savings (if targets fully achieved)	5,340.3	
	Maximum support needed for other services (if targets not achieved)	5,340.3	
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits		
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	note
Integrated Discharge Team	DVH / MFT	*360k*		*£3201k to £6324k*	*0*			*£2811k to £5934k*	*0*	*benefits calculated on 5-10% reduction in NEL admissions each year - with the aim of achieving a total reduction (compared to 2013/14 levels) of 15% over two years.*
Integrated Primary Care Team	KCHT	*1080k*		*included in integrated discharge team benefits*	*0*			*included in integrated discharge team benefits*		
Specialist Dementia Team	KCC	*360k*		*not yet identified*	*not yet identified*	*not yet identified*	*not yet identified*	*not yet identified*	*not yet identified*	
IT Integration	KCC / CCG	*not yet identified*	*not yet identified*	*enabler to deliver other schemes*	*enabler to deliver other schemes*	*not yet identified*	*not yet identified*	*enabler to deliver other schemes*	*enabler to deliver other schemes*	
Total										

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Permanent admissions to residential and care homes: Reduction in admissions based on rate of council-supported permanent admissions to residential and nursing care - measured as part of ongoing social care monitoring. .CCG level trajectory to be developed.

Effectiveness of reablement – those 65+ still at home 91 days after discharge: Range to be between 82-88% and not show a reduction over 2 years. measured as part of ongoing social care performance monitoring. .CCG level trajectory to be developed.

Delayed transfers of care: Reduction in DTOC using total number of delayed transfers of care for each month. Metric for North Kent being developed - data is only available on an acute Trust basis, which for North Kent means two Trusts. Therefore the data is currently under review to determine how an amalgamated indicator can be developed, given that Swale CCG only has 30% of the activity undertaken at Medway NHS Foundation Trust and data could be skewed given the number of agencies from Medway and Kent involved in patients care for the overall trust. The data below is therefore based on that for Dartfrod, Gravesham and Swanley CCG (i.e. Dartford and Gravesham NHS Trust)

Avoidable emergency admissions: levels of ambition set on a CCG basis; however, amalgamated indicator for North Kent currently not possible as both CCGs use different acute trusts. data to be

Local Metrics:
Social Care Quality of Life - measured as part of ongoing social care monitoring .CCG level trajectory to be developed.
Injuries due to falls in people aged 65 and over measured as part of ongoing public health performance monitoring. CCG level trajectory to be developed.

Further local metrics will be used at CCG level, however as part of the Kent HWB dashboard improvements will be required in quality of life and reduction in injuries due to falls.

Where conposite indicators require further development, this will be completed by September 2014, and complemented by local (generally CCG level) indicators to provide a robu

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

National metric to be used.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

Full joint programme management arrangements to be implemented, which will report into the local governance arrangements via Executive Prorgramme Boards, district and Kent Health and Wellbeing Boards. See Appendix 2 of North Kent BCF Vision Document.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Not applicable.

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*		N/A	
	Numerator			
	Denominator			
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*		N/A	
	Numerator			
	Denominator			
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*			
	Numerator			
	Denominator			
		(April 2013 to December 2013)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	2070.1	2040.4	2010.6
	Numerator			
	Denominator			
		April 2012 to March 2013	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]			N/A	
		(insert time period)		*(insert time period)*
Injuries due to falls in people aged 65 and over	*Metric Value*	TBC		
	Numerator			
	Denominator			
		April 2013 to December 2013	*(insert time period)*	*(insert time period)*

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Appendix F West Kent BCF Plan

Owner: The West Kent Health and Wellbeing Board

Date: 11 March 2014

Version No: 0.7 draft

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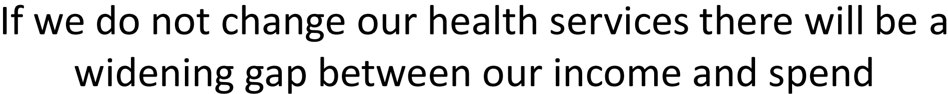
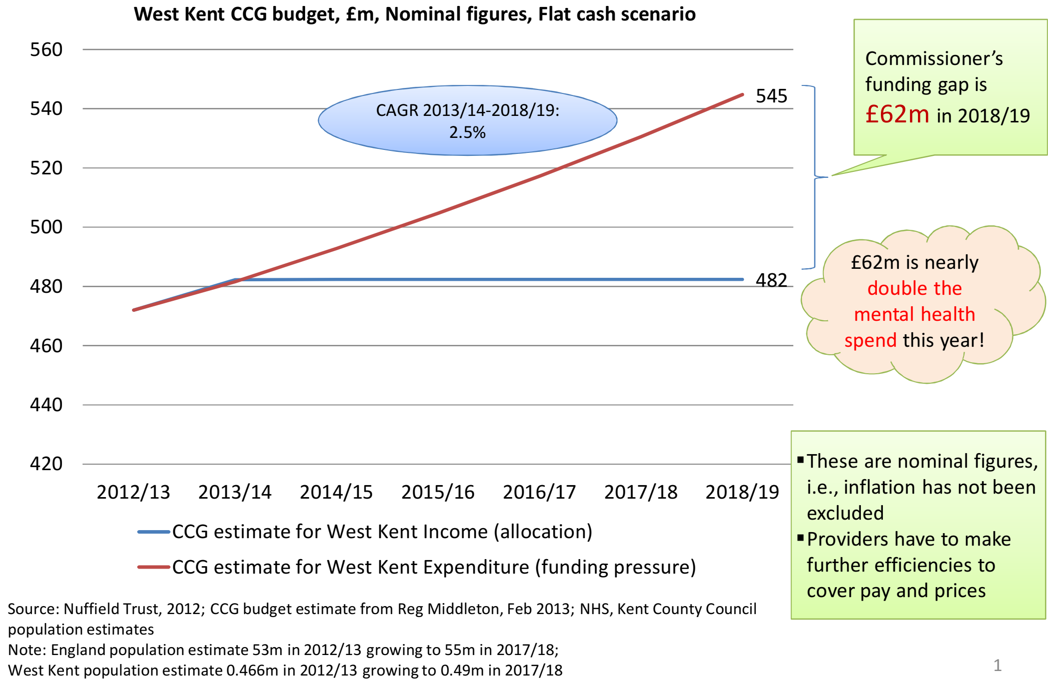
1. Introduction

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

NHS West Kent Clinical Commissioning Group (CCG) budget for 2014/15 will be £489 million to spend on healthcare in the area. If we continue to deliver services in the way we do now and meet demands for care, by 2018-19, it is estimated we will have a funding gap of approximately £60 million





In 2013/14 although the local system has met the vast majority of constitutional pledges to its population, it has struggled to maintain performance in a number of key areas, specifically those around waiting time in A&E, delayed discharges from hospital, and the 18 week Referral To Treatment (RTT) target.

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

- Increasing needs of ageing population
- Lack of integrated information systems
- Inability to move patients onto rehabilitation pathways, especially neuro-rehabilitation and slower stream
- At times of pressure there is over-reliance on key individual members of staff
- Insufficient level of capacity outside of acute hospitals meaning sometimes patients stay in acute beds longer than is necessary, creating bottlenecks and pressures elsewhere in the system i.e. A&E and acute medical wards
- Insufficient number of Elderly Mental Infirm (EMI) placement beds in West Kent
- Delivering on 18 week referral to treatment time constitutional commitment
- Delivering timely reporting of diagnostic investigations, although the tests are achieved within the target time
- Higher than desired number of patients admitted to acute hospitals for end of life care
- Gaps in expected levels of detected disease leading to health inequalities
- Opportunity for patients with long term conditions to be more involved in their own condition management and for them to receive more of their necessary care in a planned way outside of hospitals
- Timely provision of equipment to keep patients at home
- Delivery of the desired ambulance response times
- Recruitment to specific specialist roles
- Achieving timely access to Children and Adolescent Mental Health (CAMHS) and Improving Access to Psychological Therapies (IAPT) services

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

Mapping the Future is a programme of work which has been started in West Kent to describe what the system needs and what a modernised health and care service for the 463,730 people who live in West Kent will look like. The programme has produced an initial future picture of the modern, efficient health and care services that we will need to provide in order to meet the changing needs of people in West Kent over the next 5 years. This programme is delivering the NHS Call to Action within West Kent.

To help develop the Mapping the Future programme four workshops have been held involving patient representatives, clinicians, health and care professionals and managers.

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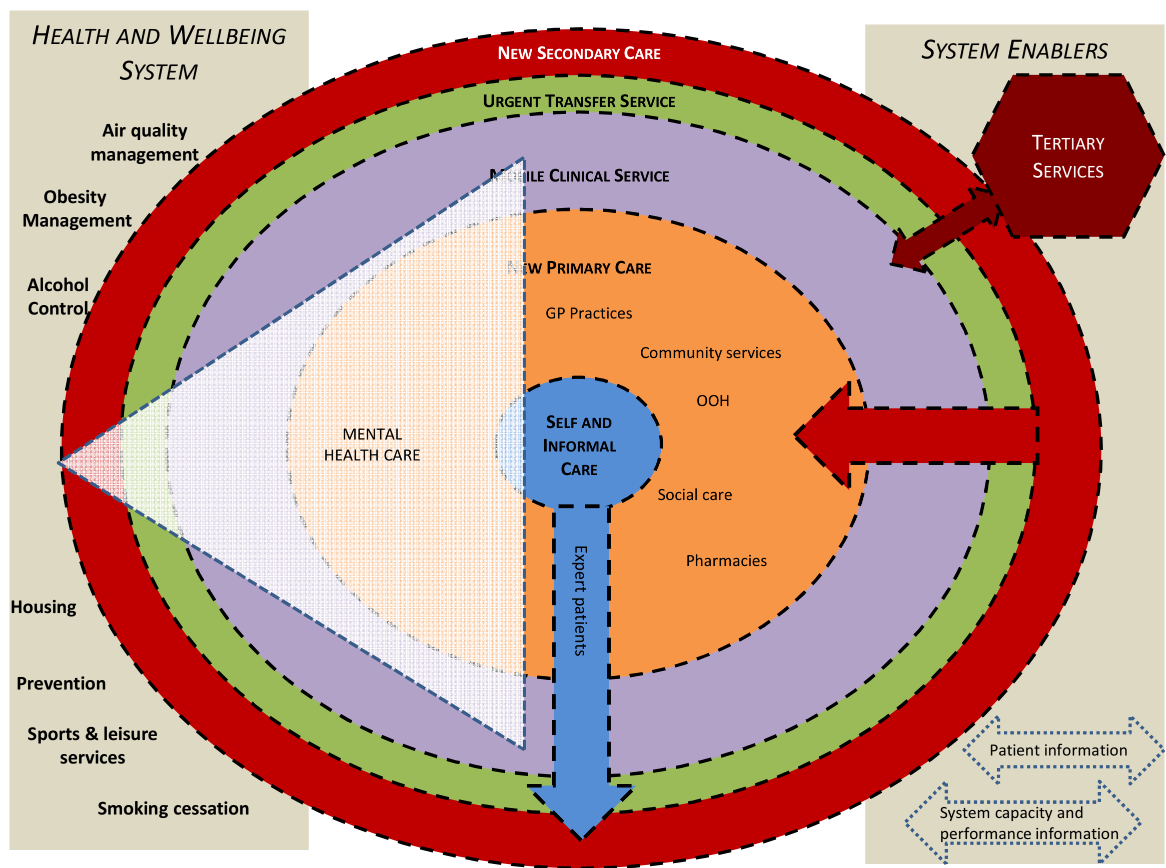
2. West Kent's Vision

Mapping the Future sets out a whole system approach for West Kent where all health and well-being system partners use their individual and collective efforts to tackle the root causes of health and well-being problems where people are encouraged and supported to take greater responsibility for their health and healthy choices (the Blueprint). This blueprint places self and informal care at the centre, enhancing the capacity of communities and individuals to support themselves and each other. People are fully informed and take part in planning their care helping are supported to stay at home and independent longer.



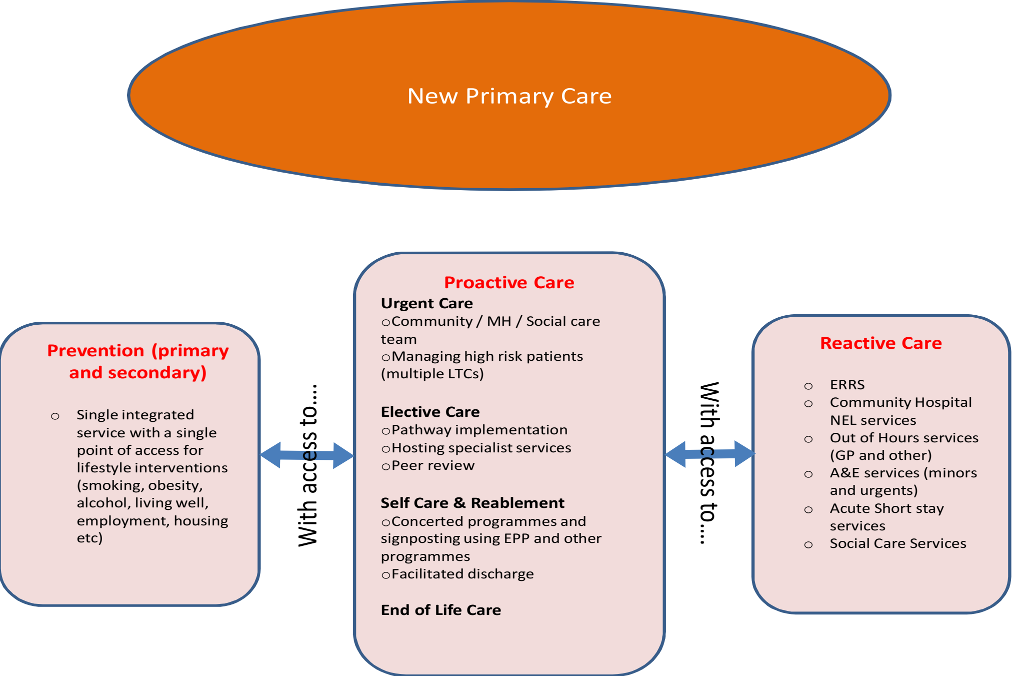
It introduces a new model of Primary Care focusing on three distinct but interlinked areas of care (prevention, proactive and reactive) creating larger scale GP led multi-disciplinary teams which are wrapped around a suitably sized group of practices.

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

The teams will include clinically-led professionals that take a care management and coordination role for patients who are elderly and those with the most complex needs. They will operate within a framework of clear clinical pathways spanning the health

and care system and will have access to consultant opinion to enable them to support patients, most often without the need to send them to hospital.

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



Community based support and prevention will be available to residents of West Kent. A core offer will be developed and commissioned which will ensure a comprehensive range of universal support services are available to people. Some will be targeted services for particular populations e.g. smoking cessation, weight management, and employment support. Other support services commissioned via voluntary sector organisations will help reduce demand on more specialist health and social care services through preventative activities. Some will be linked to care pathways, for example, falls prevention classes, while others will offer universal access e.g. carer support, or dementia support.

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

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

Mobile clinical services (MCS) will provide direct care to people at the point it is needed by taking care to the patient wherever possible and clinically appropriate to do

so. The MCS will work as a complementary workforce to the new Primary Care System using similar pathways, protocols and medical records.

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

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

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

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

3. West Kent's Aims and Objectives

West Kent CCG and Kent County Council are committed to commissioning care for people to ensure these commitments are honoured. Mapping the Future has identified that in the West Kent health system a significant reduction is required over the next 5 years in the level of activity which is currently delivered as non-elective care in hospitals. This is required

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

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The outcomes we are aiming for are

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

We will use the BCF to

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

Interventions provided from the Better Care Fund need to achieve

- Reduced admissions to residential care (national measure)
- Avoidable emergency admissions (national measures)
- Reduced admission to care homes (national measure)
- Effectiveness of reablement (national measure)
- Delayed transfers of care (national measure)
- Injuries due to falls in people aged 65 and over (local measure)
- Social Care related quality of life (local measure)
- Health related quality of life for people with long term conditions (local measure)
- Reduced occupied number of bed days (draft local measure)

Delivery of these initiatives will require support to:

- Improve information sharing
- use of year of care tariffs where appropriate
- Use of Risk stratification and case finding tools.

Our success will be dependent on ensuring the achievement of the productivity benefits that are promised by integration.

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4. Financial Implications

2015/16 Scheme Proposed	Description	Investment Baseline BCF (£000)
Reactive Care (including GP OOH, Community Hospitals, Rapid Response services, etc.)	• Combine current in reach and outreach teams to integrate the approach to assessment and eliminate delays • Commission and secure wider use of enhanced rapid response services after pilot evaluation (from 2014) • Continue to develop carer specific support – including carers breaks	11,747*
Proactive Care	• Support the principle of unequal investment to close the health inequality gap by addressing specific needs in specific areas to improve health outcomes • Minimise use of physical resources ie hospital buildings and maximise use of human resources ie skilled workforce with a multi-disciplinary health and social care approach	0
Effective reablement	• buy more provision of reablement and care packages to keep people independent in their own homes	2,111*
Reducing admissions to residential care	• Ensuring people have anticipatory care plans in place. • Enable consultant access via technology – video conferencing, improved access to integrated health and social care team	1,379*
Better data sharing between health & social care	• promotion of the NHS number as the prime identifier; better exchange of health information; use of the health and social care information centre; patients accessing own health records; GPs linked to hospital data	0
Protection for social services	• Includes monies for Care Bill Implementation e.g. Carers assessments and support services; safeguarding adults boards and national eligibility	3,001*
Self-Care/Self-Management	• Co-produce with patients, service users, public and voluntary and community sector improvements in self-care. Including care navigators, advanced assistive technology, patient held records and the development of Dementia Friendly Communities	0
Section 256 Social Care to Benefit Health	• Ensure existing services commissioned under s256 agreements are aligned to the objectives of the transforming integrated working and continue to protect social care	* indicates value includes an element of s256
ASC Capital Grants	• Home support fund and equipment	Unable to break out WK figure
Facilitating discharge /delayed transfers of care and 7 day working including: Enhanced Rapid Response Integrated Discharge Referral Service Integrated urgent care/LTC model	• commission and secure wider use of enhanced rapid response service • Integrate LTC teams, with GPs coordinating care and involving mental health and dementia services. • Integrated contacts and referrals, where possible through a single point of access. • Workforce implications and access to specialist input such as community geriatricians • Ensure provision of mental health and dementia is within all services	8,156*
Disabled Facilities Grant	• Equipment and adaptations are a key enabler to maintaining independence we will work with Districts to consider future actions required in delivering	2,050i
Total		28,444

i figures is calculated from district level figure provided for Maidstone, Tonbridge and Malling, Sevenoaks and Tunbridge Wells, Sevenoaks figure includes Swanley which is in the Dartford and Gravesham Clinical Commissioning Group area

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Mapping the Future sets out ambitious targets for reducing urgent care costs by £25m by 2018-19. Our plans for the forthcoming operating plan period up until the end of 2015-16 are to secure cost reductions totalling £10m.

In order to drive out this level of cost reduction, there will need to be significant reduction in the level of emergency admissions and A&E attenders in the acute care setting. By the end of 2015-16 the target level of avoided urgent care admissions could represent up to 18% of the level of today's emergency admissions, with a target end point of 33% by 2018-19.

Similar reductions in interventions will be targeted in A&E attendances, and ambulance conveyances.

In the event that these admissions are not avoided, the CCG will continue to incur costs above planned levels, putting at risk the longer term sustainability of the local health system. Contingency plans will need to be put in place to underpin the risk of this scenario.

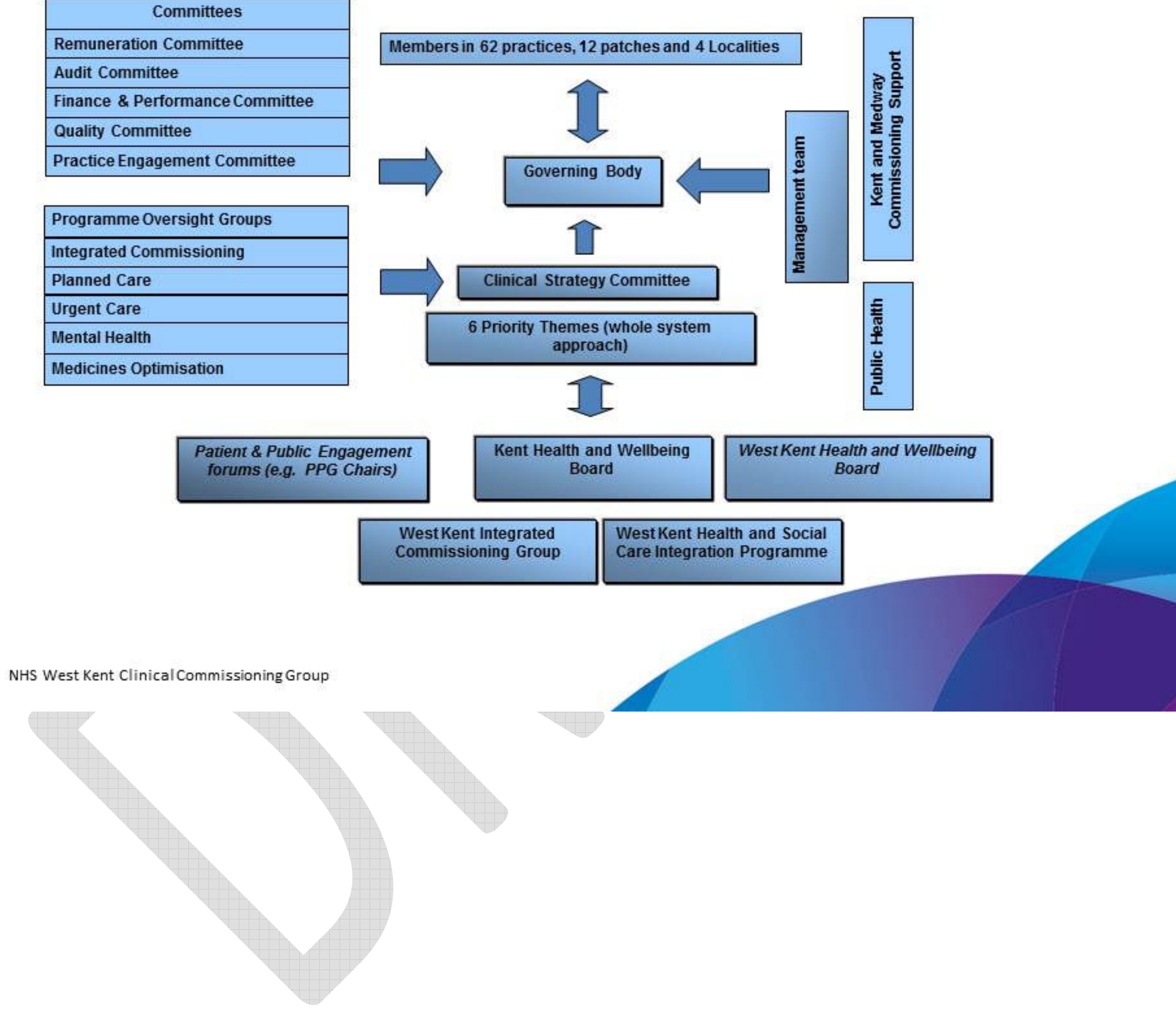
Metrics

The West Kent Better Care Fund Plan will contribute to the outcomes identified in the Kent Integrated Care and Support Pioneer Bid and support delivery of the 5 outcomes identified within the Kent Health and Wellbeing Strategy.

The Better Care Fund Plan will also contribute towards the West Kent Clinical Commissioning Group' Strategic commissioning Plan.

Metric	Current Baseline (April 2012 – March 2013)	Target
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	845	Tba a reduction in admissions based on rate of council-supported permanent admissions to residential and nursing care
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	0.84	0.84 Range to be between 82-88% and not show a reduction over 2 years.
Delayed transfers of care from hospital per 100,000 population (average per month)	5.10	Tba Reduction in DTOC using total number of delayed transfers of care for each month.
Avoidable emergency admissions (composite measure) (	618*	525.3 (15% reduction in admissions)
Patient / service user experience - West Kent will be using the national metric (under development)	Tba	
Injuries due to falls in people aged 65 and over	Tba	
Social Care related quality of life (from ASCOF 1A, linked to NHSOF 2)	Tba	
*timeframe covers July 2012 to June 2013		

5. Governance and management of Better Care Fund



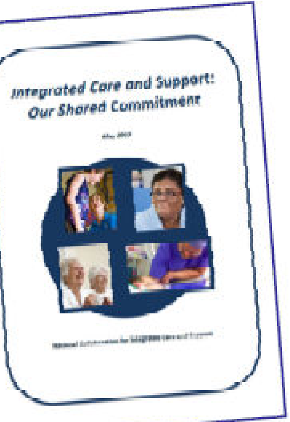
West Kent Better Care Fund

Integrated Discharge Teams: Acute Hospital sites; 7 days a week working

Non Acute Bed Provision: Step down & step up; Consultant and GP support; Integrated Care Centres; Extra Care; Rehab Units; Community Hospital beds; Private Residential and Nursing bed provision

Integrated Enhanced Rapid Response: Rapid Response; active reablement; "Going Home Teams"

Crisis Response Services: Access to Shared Anticipatory Care Plans by the Ambulance service, Enhanced Rapid Response, Enablement Services and Voluntary Sector based crisis response services



"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

Integrated Long Term Conditions/ Neighbourhood teams: 24/7 access to multi-disciplinary teams coordinated by the GP, inc mental health/dementia; Risk Stratifying patients; Anticipatory Shared Care Planning; Access to one Care Plan for patient/service user & professionals

Integrated Care Home Support: Integrated teams including Consultant and GP support; Use of technology to Care Homes / Extra Care Housing providers to prevent unnecessary admissions to hospital

Integrated Access: Integrated Locality Referral Unit; 7 days a week direct access and 24/7 crisis response; Access to 1 Care Plan based on integrated platform

Integrated Equipment, DFGs, Capital adaptations & Assistive Technologies at the front end of all the services video conferencing with clinicians, teletechnology, equipment development of new pathways

Improved data sharing Promotion of NHS number, better exchange of health information, use of the health and social care information centre, patients accessing own health records, GPs linked to hospital data

Operating model: Integrated skill mix, assessors accessing integrated care direct: i.e. nurses accessing social care and case managers nursing care, skills for mental health/dementia

Integrated Therapy Services: in the acute community, social care and housing settings

Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Kent County Council
Clinical Commissioning Groups	West Kent CCG
Boundary Differences	There are some boundary differences between West Kent CCG and Sevenoaks District Council affecting the Swanley area. In developing this plan discussions planned to take place to ensure consistency of outcomes.
Date agreed at Health and Well-Being Board:	26 March 2014
Date submitted:	4 April 2014
Minimum required value of ITF pooled budget: 2014/15	£5,136,000 Kent Wide contribution
2015/16	£26,394m CCG contribution only
Total agreed value of pooled budget: 2014/15	£5,136,000 Kent Wide contribution
2015/16	£101,404m Kent Wide contribution

WORKING DRAFT

b) Authorisation and signoff

Signed on behalf of the West Kent Clinical Commissioning Group	
By	Ian Ayres
Position	Accountable Officer
Date	26 March 2014

Signed on behalf of the High Weald Lewes Havens Clinical Commissioning Group	
By	Frank Sims
Position	Accountable Officer
Date	26 March 2014

Signed on behalf of Maidstone Borough Council	
By	Alison Broom
Position	Chief Executive
Date	26 March 2014

Signed on behalf of Sevenoaks District Council	
By	Pav Ramewal
Position	Chief Executive
Date	26 March 2014

Signed on behalf of Tonbridge & Malling Council	
By	Julie Beilby
Position	Chief Executive
Date	26 March 2014

Signed on behalf of Tunbridge Wells Borough Council	
By	William Benson
Position	Chief Executive
Date	26 March 2014

Signed on behalf of the West Kent Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Dr Bob Bowes
Date	26 March 2014

Signed on behalf of the Kent Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Roger Gough
Date	26 March 2014

WORKING DRAFT

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

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

Mapping the Future is a programme of work which has been started in West Kent to describe what the system needs and what a modernised health and care service for West Kent will look like. This programme will deliver the NHS Call to Action within West Kent.

As part of the development of the BCF plan engagement events have taken place with providers via our existing Health and Social Care Integration Programme, the Integration Pioneer Steering Group and through a facilitated engagement event led by the Kent Health and Wellbeing Board under the Health and Social Care system leadership programme. The Kent HWB undertook a mapping exercise across the care economies to review current activity and priorities.

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

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

The blueprint for Kent becoming an Integrated Care and Support Pioneer is based on detailed engagement with patients, service users and the public. On a local level there is sustained involvement with the public through patient participation groups and the local health and social care integration implementation group.

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

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

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

WORKING DRAFT

e) Related documentation

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

Document or information title	Synopsis and links
Joint Strategic Needs Assessment	http://www.kmpho.nhs.uk/commissioning/needsassessments/
Kent Health and Wellbeing Strategy	Health and Wellbeing Strategy.pdf
Kent Integrated Care and Support Programme Plan	**To be inserted**
Mapping the Future presentation – select version	MTF_Operational_Considerations_v311.pp
WKCCG 5 year Commissioning Plan	**To be inserted**
Pioneer Bid	EMBARGOED Pioneer bid FINAL 011113.do

WORKING DRAFT

VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

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

By 2018 we want to achieve a care economy that is sustainable for the future with improved outcomes for people. Our vision is to be providing care that crosses the boundaries between primary, community, hospital and social care with services working together, along with voluntary organisations and other independent sector organisations, to forge common goals for improving the health and wellbeing of local people and communities.

Mapping the Future sets out a whole system approach for West Kent where all health and well-being system partners use their individual and collective efforts to tackle the root causes of health and well-being problems where people are encouraged and supported to take greater responsibility for their health and healthy choices (the Blueprint). This blueprint places self and informal care at the centre, enhancing the capacity of communities and individuals to support themselves and each other. People are fully informed and take part in planning their care helping are supported to stay at home and independent longer.

It introduces a new model of Primary Care focusing on three distinct but interlinked areas of care (preventative, proactive and reactive care) creating larger scale GP led multi-disciplinary teams which are wrapped around a suitably sized group of practices.

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

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

The focus will always be to support citizens to manage and coordinate their own care whenever possible. Community based support and prevention will be available to residents of West Kent. A core offer will be developed and commissioned which will ensure a comprehensive range of universal support services are available to people. Some will be targeted services for particular populations e.g. smoking cessation, weight management, employment support. Other support services commissioned via voluntary sector organisations will help reduce demand on more specialist health and social care services through preventative activities. Some will be linked to care pathways, for example, falls prevention classes, while others will offer universal access e.g. carer support, or dementia support.

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

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

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

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

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

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

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

WORKING DRAFT

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Objectives

West Kent CCG and Kent County Council are committed to commissioning care for people to ensure these commitments are honoured. Mapping the Future has identified that in the West Kent health system a significant reduction is required over the next 5 years in the level of activity which is currently delivered as non-elective care in hospitals. This is required

- to ensure that the urgent care elements of the local health system can function safely and efficiently,
- to ensure that those patients requiring planned care do not experience unexpected delays due to emergency pressures
- to enable the system to operate at optimum capacity which allows it to cope with peaks in demand when necessary

- to allow as much of a patient's diagnosis and care delivery to take place in a planned and therefore well managed way
- to allow people with health and social care needs to be in greater control of their health and social care support and are enabled to keep themselves well through access to self care services
- to allow a reduction in the level of funding spent on care provided in hospitals and residential care and use this more effectively to provide care in a planned way and outside of the hospital or care home setting
- to meet the challenges presented as a result of demographic demand pressures

Outcomes Sought

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

WORKING DRAFT

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Success will include:

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

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Mapping the Future sets out ambitious targets for reducing urgent care costs by £25m by 2018-19. Our plans for the forthcoming operating plan period up until the end of 2015-16 are to secure cost reductions totalling £10m.

In order to drive out this level of cost reduction, there will need to be significant reduction in the level of emergency admissions and A&E attenders in the acute care setting. By the end of 2015-16 the target level of avoided urgent care admissions could represent up to 18% of the level of today's emergency admissions.

In the event that these admissions are not avoided, the CCG will continue to incur costs above planned levels, putting at risk the longer term sustainability of the local health system.

Contingency plans will need to be put in place to underpin the risk of this scenario.

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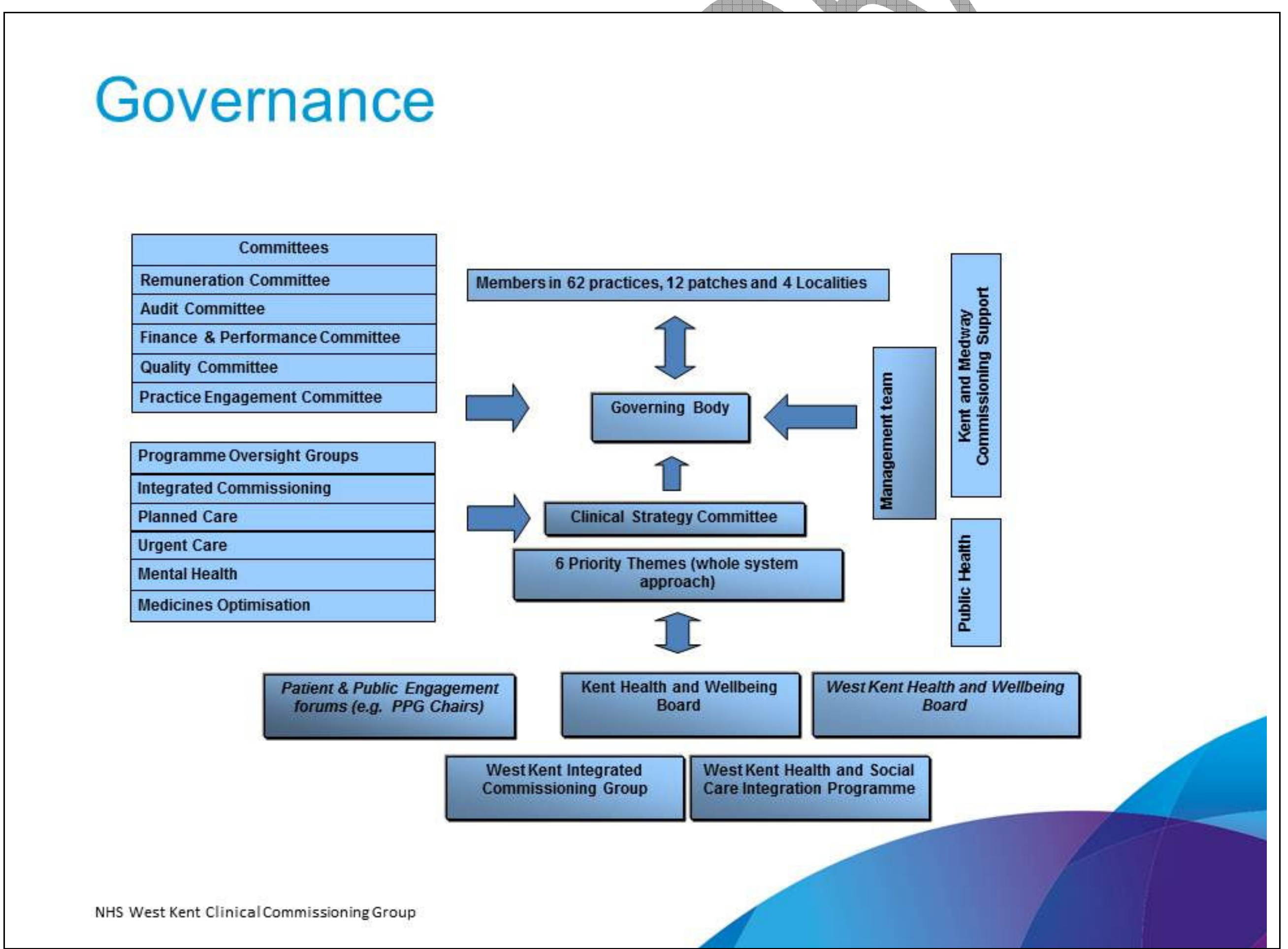
e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes



2) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

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

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

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

Please explain how local social care services will be protected within your plans

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.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

As part of our Kent Pioneer programme we are committed to not only providing seven-day health and social care services but also furthering this to a proactive model of 24/7 community based care. Adult Social Care has recently shifted working hours to be 8-8, 7 days per week as standard.

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

c) Data sharing

Please confirm that you are 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. Further work may need to take place to ensure this is used in all correspondence.

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If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Health and social care providers must use the NHS number as the primary identifier and WKCCG will work with key stakeholders and key providers to identify practical ways to achieve compliance. The BCF will be used to further support this shift and Adult Social Care has made a commitment to use the NHS number within all correspondence.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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

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

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

The BCF will be used to help further this work and enable real time data sharing across health and social care and with the public.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

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

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

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

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

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

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

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

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

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

3) RISKS

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

Draft Risks	Risk rating	Mitigating Actions
Shifting of resources will destabilise existing providers, particularly in the acute sector	**HIGH**	• The development of our plans for 2014/15 and 2015/16 will be conducted within the framework of our Kent Pioneer Programme. • This facilitates whole system discussions and further work on co-design of, and transition to future service models. • **Further work will be carried out with providers to ensure engagement and involvement in the Better Care Fund plan.**
Workforce and Training – The right workforce with the right skills will be required to deliver integrated models of care. A shift in the model of care delivery will impact on training requirements. Additional risk is presented by age demographics of GPs and future resources impacted by retirement.	**HIGH**	• Workforce and training is a key objective of Kent's Integration Pioneer Programme. • A programme of work is structured to explore the requirements of future workforce and implement changes to meet these requirements.
The introduction of the Care Bill will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	**HIGH**	• The implementation of the Care Bill is part of the schemes within the BCF; further work is required to outline impact and mitigation required.
Cost reductions arising from a reduction in urgent care admission do not materialise	**HIGH**	• **Further modelling required to test assumptions prior to submission.** • 2014/15 will be used to test • and refine these assumptions, with a focus on developing detailed business cases and service specifications. • Implementation supported by • Year of Care as an early implementer site.
Cost reductions arising from a reduction in occupied bed days do not materialise	**HIGH**	• **Further modelling required to test assumptions prior to submission.** • 2014/15 will be used to test and refine these assumptions, with a

WORKING DRAFT

Draft Risks	Risk rating	Mitigating Actions
		focus on developing detailed business cases and service specifications. • • Implementation supported by Year of Care as an early implementer site.
Cost reductions arising from a reduction in residential and care homes do not materialise	**HIGH**	**Further modelling required to test assumptions prior to submission.** • 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications. • Implementation supported by Year of Care as an early implementer site.
Reductions in delayed transfer of care are not achieved	**HIGH**	**Further modelling required to test assumptions prior to submission.** • 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications. • Implementation supported by Year of Care as an early implementer site.
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / care home activity by 2015/16, impacting the overall funding available to support core services and future schemes.	**HIGH**	**Further modelling required to test assumptions prior to submission.** • 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications.

WORKING DRAFT

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Reactive Care						*11747*			
Proactive Care						*0*			
Effective reablement						*2111*			
Reducing admissions to residential care						*1379*			
Better data sharing between health & social care						*0*			
Protection for social services	KCC	*8000*				*3001*			
Facilitating discharge /delayed transfers of care and 7 day working						*8156*			
Disabled Facilities Grant		*4700*				*2050*			
Total		*12700*		*5,000*		*28444*		*10000*	

ASSOCIATION

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
West Kent CCG			*26,394*	
District/Borough Councils (DFG)			*2,050*	
Kent County Council Social Care Capital Grant			*tba*	
BCF Total			*28,444*	

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		**2015/16**	**Ongoing**
Outcome 1 - reduction in urgent care admissions	Planned savings (if targets fully achieved)	10042	25104
	Maximum support needed for other services (if targets not achieved)	10042	25104
Outcome 2 - reduction in number of occupied bed days	Planned savings (if targets fully achieved)	4600	
	Maximum support needed for other services (if targets not achieved)	4600	

Association England

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

National Metrics
Permanent admissions to residential and care homes: There will be a reduction in admissions based on rate of council-supported permanent admissions to residential and nursing care
Effectiveness of reablement – those 65+ still at home 91 days after discharge: Range to be between 82-88% and not show a reduction over 2 years.
Delayed transfers of care: Reduction in DTOC using total number of delayed transfers of care for each month.
Avoidable emergency admissions: 15% reduction in admissions.
Patient /Service Experience - to be agreed

Local Metrics
Injuries due to falls in people aged 65 and over (to support Kent Health and Wellbeing Strategy)
Social Care Quality of Life (to support Kent Health and Wellbeing Strategy):
Health related quality of life for people with long term conditions (supports West Kent CCGs Strategic Commissioning Plan)
Reduction in number of occupied bed days (supports West Kent CCGs Strategic Commissioning Plan)

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

West Kent will be using the national metric for 2015/16

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

Kent HWB assurance framework (including West Kent Integrated Commissioning Group and West Kent HASCIP)
Local Health and Wellbeing Boards
Integration Pioneer Steering Group
Ongoing development of the detail of the schemes in partnership with providers

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	845	N/A	
	Numerator	671		
	Denominator	79362		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	0.84	N/A	
	Numerator	404		
	Denominator	481		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	5.10		
	Numerator	23.50		
	Denominator	460428		
		(April 2012 to March 2013	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	618	595	585
	Numerator	3008	2873	2816
	Denominator	463886	473905	479631
		July 2012 to June 2013 (HSCIC	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]			N/A	
		(insert time period)		*(insert time period)*
draft local measure - Injuries due to falls in people aged 65 and over	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	*(insert time period)*	*(insert time period)*
draft local measure - Social Care related quality of life (from ASCOF 1A,	*Metric Value*			

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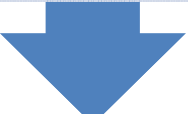
NHS
West Kent
Clinical Commissioning Group

Strategic Commissioning Plan 2014-19

Gail Arnold, Chief Operating Officer

5 NHS Outcome Framework Domains

Preventing people from dying prematurely	Best quality of life for people with long-term conditions including those with mental illness	Helping people to recover quickly and successfully from episodes of ill-health or following an injury	Patients have a great experience of all their care	Patients are kept safe and protected from all avoidable harm

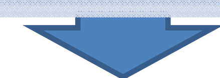


7 outcome measures

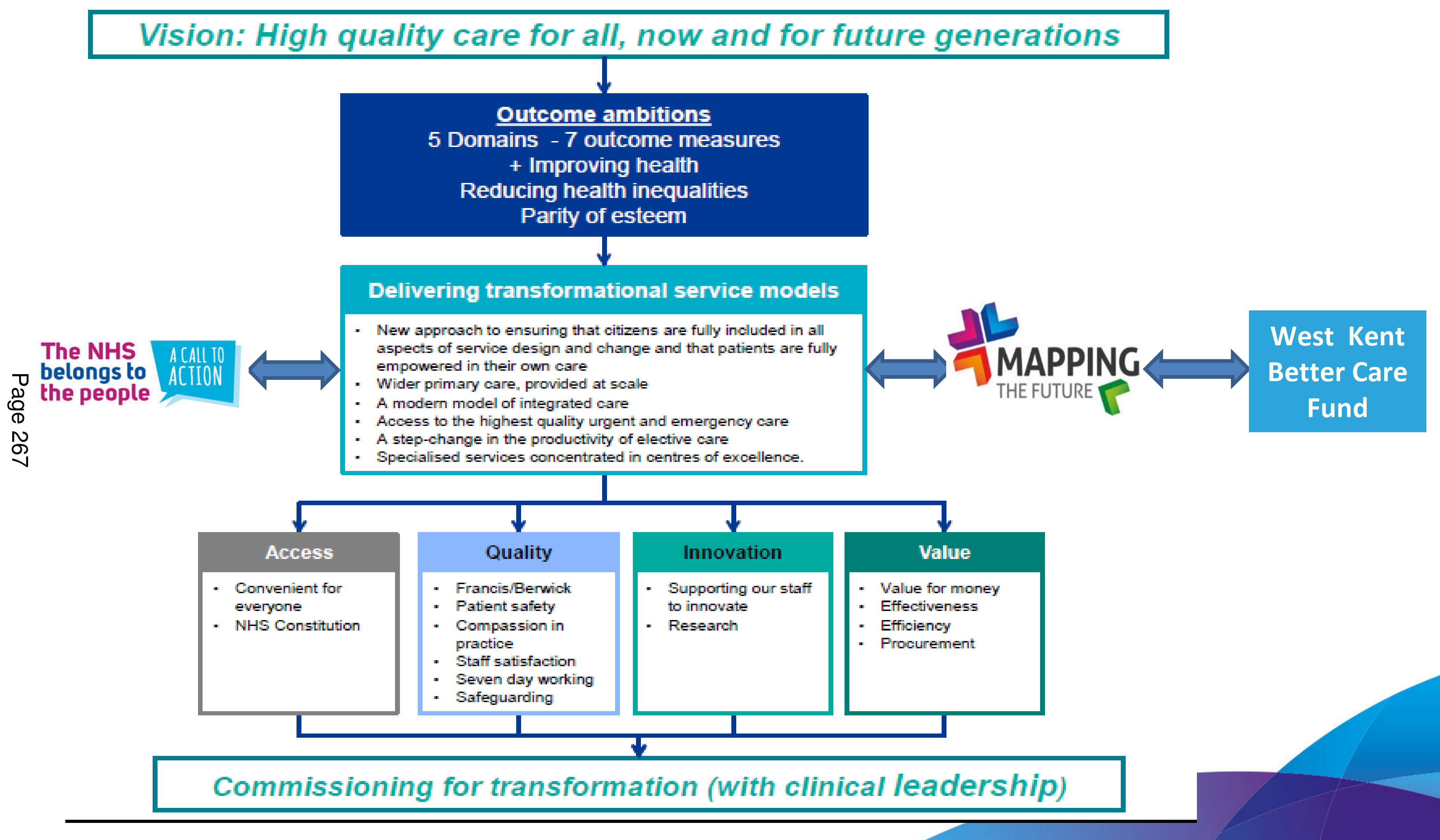
Securing additional years of life for the people of England with treatable mental and physical health conditions	Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	Increasing the proportion of older people living independently at home following discharge from hospital.	Increasing the number of people having a positive experience of hospital care.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

3 key improvement measures

improving health	reducing heath inequalities	parity of esteem



West Kent Specific Targets and Initiatives


Vision: High quality care for all, now and for future generations
Outcome ambitions
5 Domains - 7 outcome measures
+ Improving health
Reducing health inequalities
Parity of esteem
Delivering transformational service models
New approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
Wider primary care, provided at scale
A modern model of integrated care
Access to the highest quality urgent and emergency care
A step-change in the productivity of elective care
Specialised services concentrated in centres of excellence.
The NHS belongs to the people
A CALL TO ACTION
MAPPING THE FUTURE
West Kent Better Care Fund
Access
Convenient for everyone
NHS Constitution
Quality
Francis/Berwick
Patient safety
Compassion in practice
Staff satisfaction
Seven day working
Safeguarding
Innovation
Supporting our staff to innovate
Research
Value
Value for money
Effectiveness
Efficiency
Procurement
Commissioning for transformation (with clinical leadership)

Strategic Commissioning Plan

Commissioners are required to:	
Define/Describe	Case and context for change – i.e. what will be different for patients
At a strategic level	Deliver a 5 year plan Credible costed plans to deliver outcomes
At an operational level	Years 1 and 2 in detail (on a journey to achieve the 5 year plan) Align with Better Care Fund (BCF) Separate section showing usage of BCF
Evidence	Improved health outcomes Balancing the financial and planning framework
Respond to A Call for Action	Plan for transformation on a 5 year basis Ensure providers are best placed to deliver high quality services Deal with the financial gap Ensure appropriate risk and mitigations are in place
Focus	Less on what is done for the patients and more on the results of what is done i.e. the outcomes

Pioneer Bid and Better Care Fund

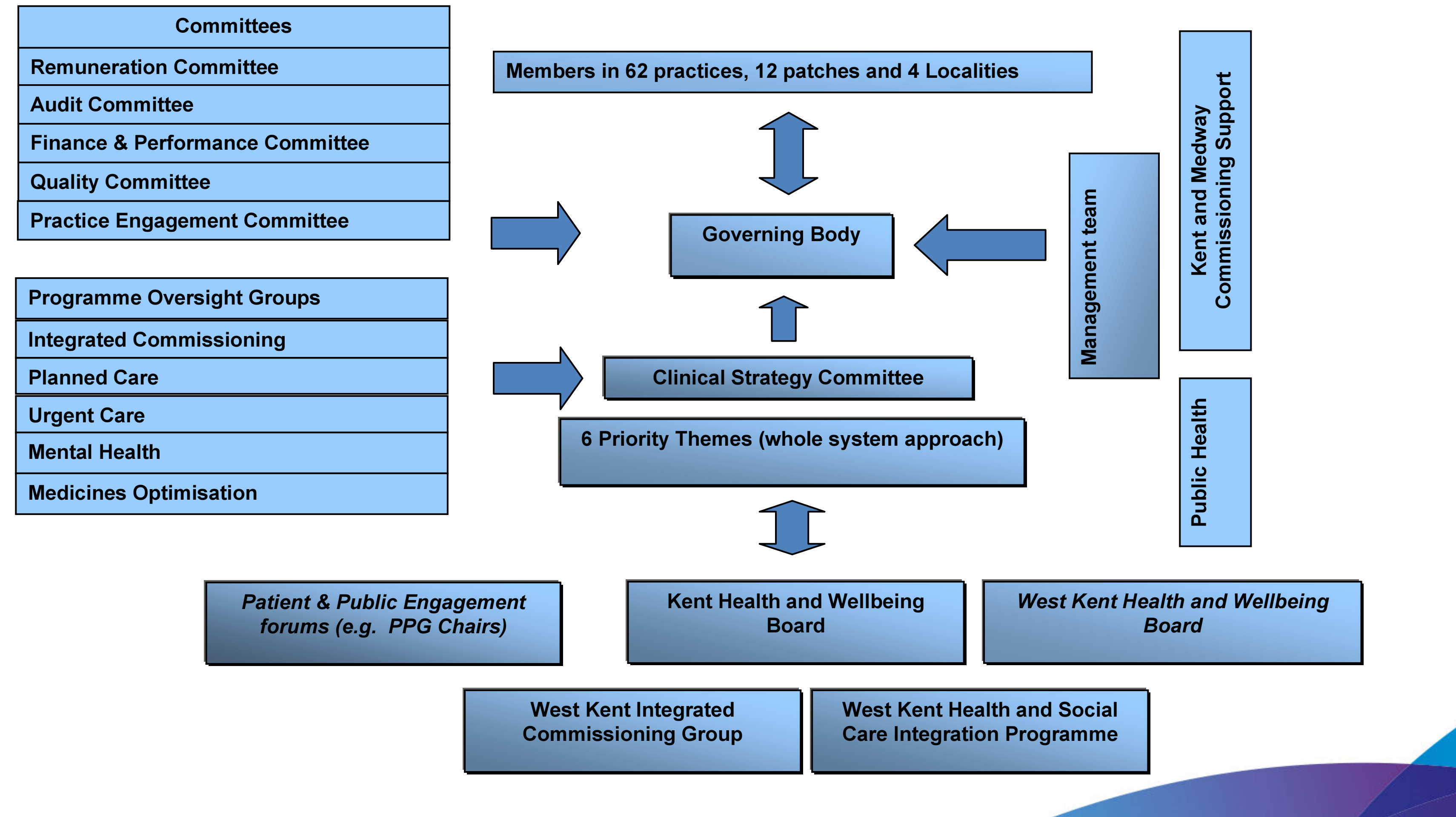
Kent Integration Care and Support Pioneer

- Kent Integration Pioneer Working Group – mix of commissioners and providers involved in developing integration plans which the Better Care Fund (BCF) is based upon
- Mapping the Future (MTF) delivery is West Kent integration work plan (part of Kent Care and Support Integration Pioneer programme)

Better Care Fund Outcomes

- buy more provision of reablement and care packages to keep people independent in their own homes
- rapidly develop integrated care through bringing together inreach/outreach services, community hospital provision, and GP out of Hours as part of a network of integrated multi-disciplinary teams. All of this will be delivered with strong medical/clinical leadership and joint assessment processes.
- use of year of care tariffs where appropriate
- minimise use of physical resources i.e. hospital buildings and maximise use of human resources i.e. skilled workforce with a multi-disciplinary health and social care approach
- support the principle of unequal investment to close the health inequality gap by addressing specific needs in specific areas to improve health outcomes
- BCF Local (Kent) indicators – injuries due to falls in people aged 65 and over & improve Social Care Quality of life

Scrutiny/Governance



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Stakeholder Engagement

- Kent Integration Pioneer Working Group - oversight of pioneer bid (ongoing)
- Mapping the Future - four programme workshops held involving patient representatives, clinicians, health and care professionals and managers (Summer 2013)
- Mapping the Future - discussions at West Kent Health & Well Being Board, West Kent CCG Governing Body Board and Annual General Meeting for all West Kent GPs (Summer/Autumn 2013)
- BCF workshop/engagement event led by Kent Health and Wellbeing Board under the Health and Social Care system leadership programme (January 2014)
- Local commissioning intention discussions/contracting monitoring and negotiation meetings with providers (February/March 2014)
- West Kent Integrated Commissioning Group, and the West Kent Health and Social Care Integration Programme (HASCIP) discussions on governance and implementation of BCF with - (Early March 2014)
- West Kent and Kent Health and Wellbeing Boards - Presentations on BCF and West Kent CCG Strategic Commissioning Plan – (mid/late March 2014)

Current Health Challenges in West Kent

- Increasing needs of ageing population
- Lack of integrated information systems
- Lack of integrated health & social care teams in the community to support vulnerable patients in their usual place of residence
- Inability to move patients onto rehabilitation pathways, especially neurorehabilitation and slower stream when system hits points of pressure reliance on key individual members of staff
- Insufficient level of capacity outside of acute hospitals meaning patients stay in acute beds longer than is necessary, creating bottlenecks and pressures elsewhere in the system i.e. A&E and acute medical wards
- Insufficient number of Elderly Mental Infirm (EMI) placement beds
- Delivering on 18 week referral to treatment time constitutional commitment

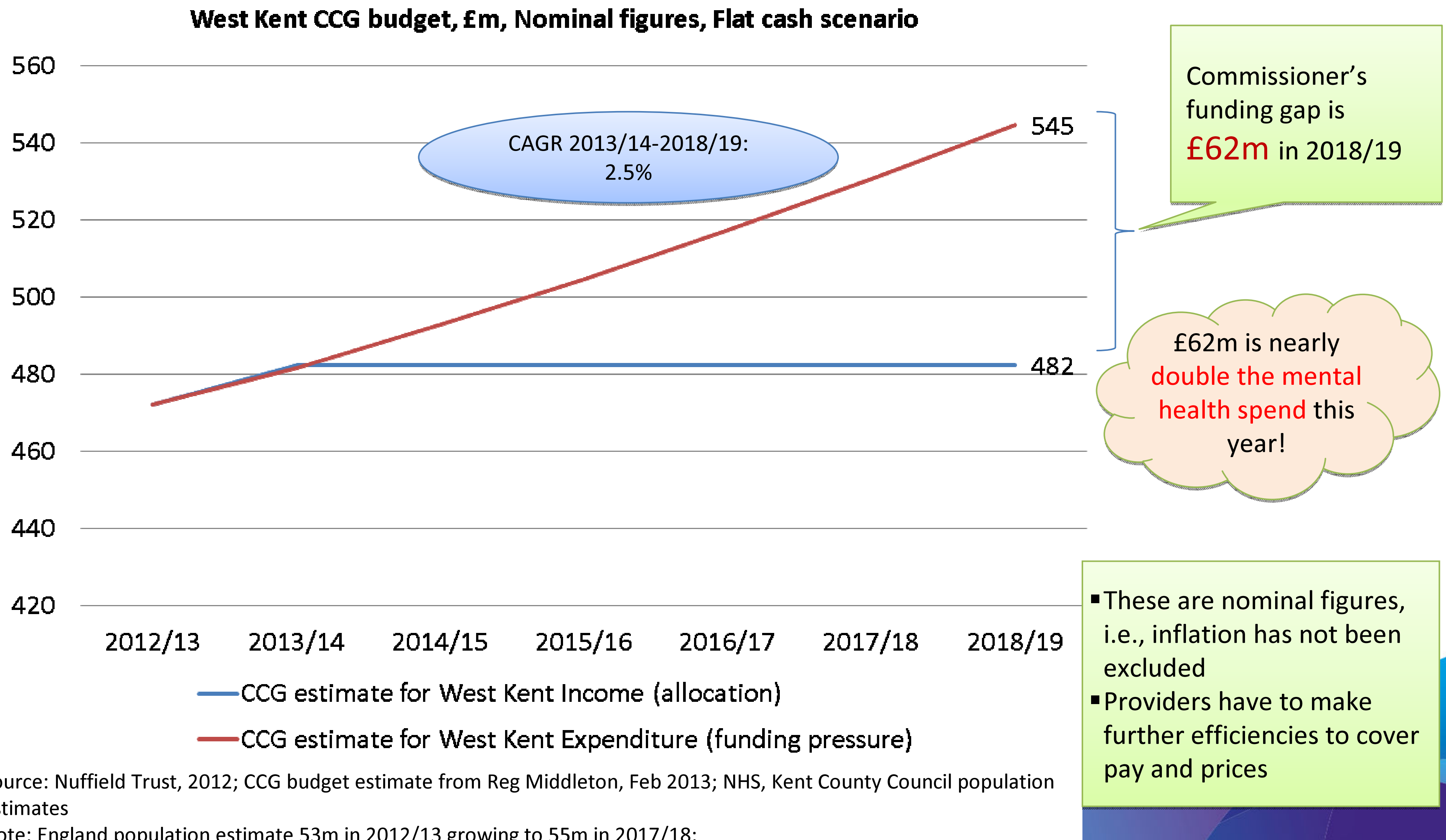
Current Health Challenges in West Kent

- Delivering timely reporting of diagnostic investigations, although the tests are achieved within the target time
- Higher than desired number of patients admitted to acute hospitals for end of life care
- Gaps in expected levels of detected disease leading to health inequalities
- Opportunity for patients with long term conditions to be more involved in their own condition management and for them to receive more of their necessary care in a planned way outside of hospitals
- Timely provision of equipment to keep patients at home
- Delivery of the desired ambulance response times
- Recruitment to specific specialist roles
- Timely access to Children and Adolescent Mental Health Services (CAMHS) services
- Timely access to Improving Access to Psychological Therapies (IAPT) services

Growth in demand for care has to be served without growth in resources

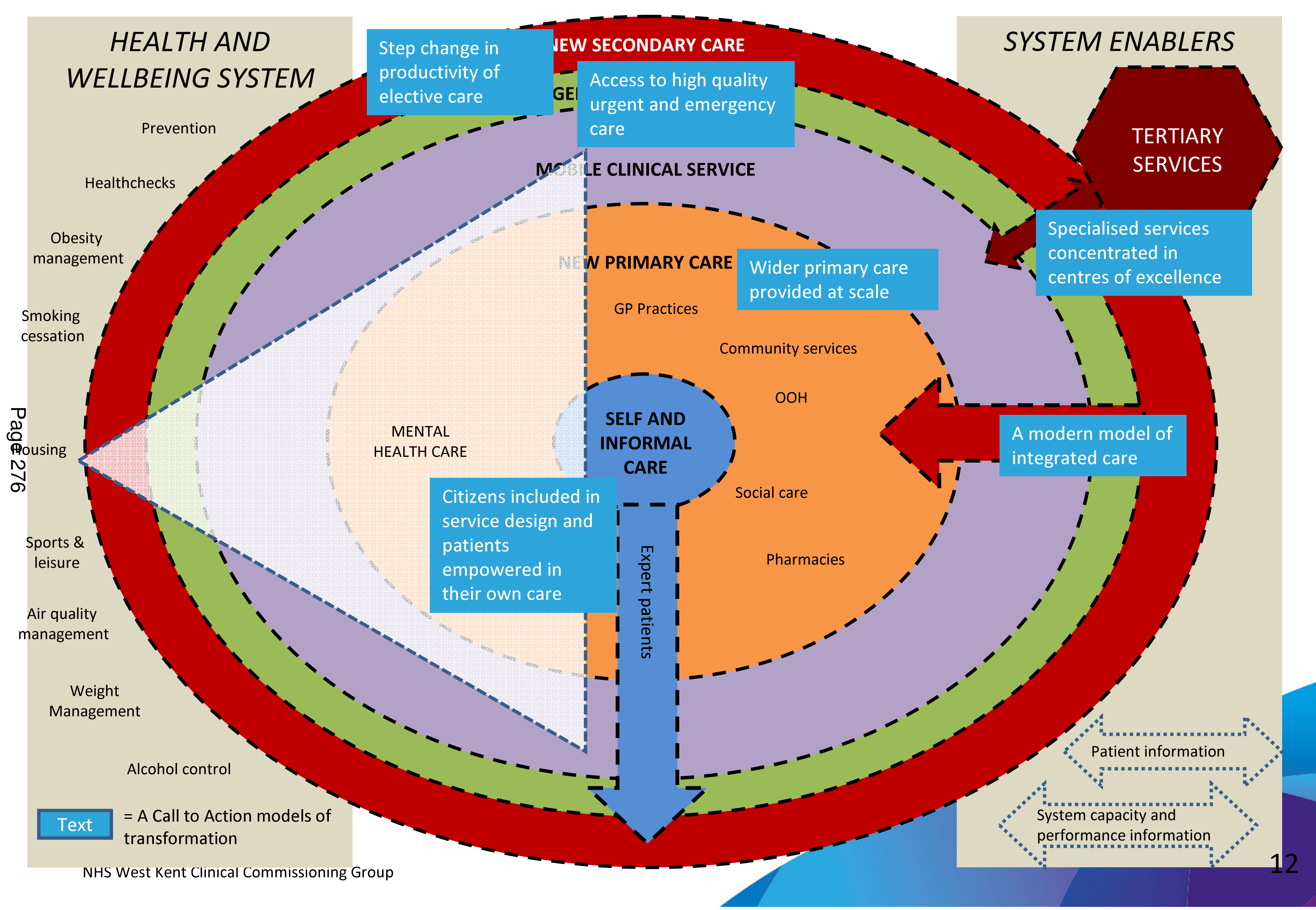
- CCG funding gap will increase every year, becoming ~£60m in 2018/19
  - In a ‘Flat Cash’ environment
- Our health care providers are already planning to make significant savings every year for next few years
- PCT and CCG has achieved financial duties by taking non-recurrent actions
- MTW needs to do even more to account for the gradual withdrawal of support for Pembury PFI
- West Kent has historically under-invested in community services and received a larger share of those services than it has paid for

If we do not change our health services there will be a widening gap between our income and spend



- These are nominal figures, i.e., inflation has not been excluded
- Providers have to make further efficiencies to cover pay and prices

Source: Nuffield Trust, 2012; CCG budget estimate from Reg Middleton, Feb 2013; NHS, Kent County Council population estimates
Note: England population estimate 53m in 2012/13 growing to 55m in 2017/18;
West Kent population estimate 0.466m in 2012/13 growing to 0.49m in 2017/18


HEALTH AND WELLBEING SYSTEM
Prevention
Healthchecks
Obesity management
Smoking cessation
Housing
Sports & leisure
Air quality management
Weight Management
Alcohol control
Text
= A Call to Action models of transformation
NEW SECONDARY CARE
Step change in productivity of elective care
Access to high quality urgent and emergency care
MOBILE CLINICAL SERVICE
NEW PRIMARY CARE
Wider primary care provided at scale
GP Practices
Community services
OOH
Social care
Pharmacies
MENTAL HEALTH CARE
SELF AND INFORMAL CARE
Citizens included in service design and patients empowered in their own care
Expert patients
A modern model of integrated care
SYSTEM ENABLERS
TERTIARY SERVICES
Specialised services concentrated in centres of excellence
Patient information
System capacity and performance information

Mapping the Future - The Blueprint

Health and Well-being	• Whole system approach with campaigns on alcohol, smoking and obesity • Communities and individuals with capacity to support themselves and each other • All levers used to tackle health determinants – e.g., Health education, environmental health, housing eligibility and maintenance, trading standards, standards and specifications of health and social care contracts
Self and Informal Care	• People are supported to take responsibility for their health and care • People fully informed and take part in discussions about future plans • People are supported to stay independent and at home for as long as possible • Local communities and voluntary organisations are encouraged to provide support
New Primary Care	• GP practices, community services, OOH, social work and mental health as integrated team that can respond round the clock, easily accessible, seamless service • Some services brought into community (e.g., diagnostics) • Pro-active care and prevention
Mobile Clinical Services	• Helpline for advice to patients and carers, supported by GPs and well supervised , aware of all available services real-time • Paramedics provide care to people at the point where they become ill, as part of integrated team with same similar pathways and protocols and access to information
Urgent Transfer	• Transfer patients with urgent care needs to best setting, not necessarily only to A%E • Provide a range of treatments and diagnostic tests to patients on the way • More use is made of transport services by voluntary and community organisations
New Secondary Care	• Urgent and planned care are managed as separate entities for optimum efficiency • Some services concentrated in larger centres • Urgent care as part of a total system connected with NPC and Mobile Services • Clear agreements between NPC and specialists about their responsibilities and risks
System Enablers	• Access to shared medical records and care plans for all care professionals anywhere • Improved communications and relationships between all care professionals • Risk management across the system contribute to more efficient and effective care (financial risk and clinical governance) • Financial and contractual levers aligned

Resource outlook

- West Kent CCG initial funding below target level
- NHSE England has confirmed firm intention to reduce inequalities in funding levels
- West Kent CCG will receive a higher than average funding uplift – confirmed for two years, indicative for further three years, as follows:

	Distance from target £m	Distance from target %	Actual per capita £	Target per capita £	Actual allocation £m	Target allocation £m	Base level growth %	Growth received by West Kent CCG %
2013-14	(39.828m)	(7.87)	1,000	1,085	466.024	505.852		
2014-15	(27.426m)	(5.48)	1,006	1,064	476.809	504.235	2.14	3.86
2015-16	(24.348m)	(4.76)	1,026	1,077	492.214	516.563	1.70	3.23
2016-17	Indicative planning assumptions only						1.80	2.72
2017-18							1.70	2.69
2018-19							1.70	2.68

West Kent CCG - Deployment of resources

- Resource consumption dominated by investment toward people aged over 60 who have between 1-5 Long Term Conditions
- High proportion of expenditure directed towards the cost of emergency care, community services and drug prescribing within the age cohorts over 60 years of age
- People over 65 and those with Long Term Conditions represent 25% of the population but consume 71% of the total CCG budget
- People over the age of 65 and those with LTCs represent 25% of the West Kent population but consume 71% of the total CCG budget. This is the group where integrated care is most beneficial

Age band	A&E	Emergency admissions	Maternity admissions	Outpatient	Day case	Elective inpatient	Other acute			Mental Health	Community	Prescribing	Continuing care	Other	Total health spend
							Ambulance	High cost drugs	Other acute						
0-4	304	1,594	0	1,166	463	718	311	317	1,114	0	1897	1925	0	425	10,234
5-9	218	1,094	0	1,400	730	670	215	307	1,079	69	1487	2313	0	415	9997
10-14	332	1,073	0	1,396	556	498	230	288	1,012	414	901	2307	0	390	9398
15-19	426	1,739	367	1,592	791	730	355	422	1,482	1,422	614	2631	0	545	13,116
20-24	423	1,877	1,592	1,258	691	507	376	474	1,665	1,739	470	2070	0	613	14,750
25-29	358	1,798	2,605	1,724	900	590	352	596	2,092	2,550	536	2848	0	734	17,677
30-34	337	1,920	3,928	2,000	972	727	367	744	2,612	2,570	562	3436	0	802	21,253
35-39	280	2,151	2,820	2,180	1,175	906	400	720	2,528	2,853	586	3607	0	881	21,206
40-44	345	2,680	922	2,384	1,622	1,485	495	705	2,477	3,181	569	3938	0	906	21,808
45-49	346	2,806	80	2,668	1,891	2,060	516	736	2,586	4,162	607	4408	0	991	23,857
50-54	296	3,108	3	2,787	1,963	2,475	558	795	2,792	3,233	856	4604	0	1017	24,490
55-59	266	3,308	0	2,815	1,945	2,427	586	804	2,826	2,108	334	4650	0	982	23,652
60-64	266	4,288	0	3,449	2,509	1,849	746	1,073	3,771	2,685	1,377	5697	0	1,287	31,002
65-69	294	6,004	0	4,232	2,980	4,942	1,041	1,380	4,849	2,644	2,133	6992	4,081	1,800	43,354
70-74	266	5,948	0	3,621	2,387	4,340	1,017	1,238	4,349	2,863	2,741	5984	3,964	1,678	40,399
75-79	280	7,107	0	3,580	2,308	4,208	1,350	1,306	4,588	2,343	4,517	6014	4,736	1,824	43,912
80-84	300	8,508	0	3,028	1,594	3,243	1,456	1,252	4,397	3,106	7,182	4990	5,726	1944	46,806
85-89	275	8,333	0	1,823	875	1,462	1,410	954	3,353	1,870	8,317	3012	5,553	1614	38,855
90-94	173	5,581	0	760	313	454	942	544	1,912	1,056	6,019	1,255	3,720	985	23,715
95+	54	1,899	0	141	51	74	320	166	583	191	2,222	133	1,266	312	7,515
Total	5,368	73,966	12,390	68,075	28,576	38,567	17,906	18,328	52,067	47,056	44,775	72,818	25,008	20,225	686,972

Age band	WLTC 0	1-5	6-10	11-15	16-20	21+	Total
0-4	8,751	1,432	51	0	0	0	10.234
5-9	8,040	1,944	13	0	0	0	9,997
10-14	7,770	1,533	96	0	0	0	9,398
15-19	9,734	2,696	686	0	0	0	13,116
20-24	9,753	2,291	2,639	67	0	0	14.750
25-29	11,802	2,952	2,854	69	0	0	17.677
30-34	14,635	3,784	2,768	46	0	0	21.253
35-39	14,126	4,097	2,904	79	0	0	21.206
40-44	12,601	5,623	3,127	441	15	0	21.808
45-49	11,730	6,749	4,547	643	189	0	23.857
50-54	11,108	9,188	3,692	416	86	0	24.490
55-59	10,003	9,945	3,187	475	43	0	23.652
60-64	9,916	14,902	4,800	1,136	248	0	31,002
65-69	10,954	24,006	6,136	1,971	287	0	43,354
70-74	8,348	22,207	6,574	2,544	709	17	40.399
75-79	6,821	24,263	9,569	2,659	507	93	43.912
80-84	5,923	24,177	12,047	3,971	678	9	46,806
85-89	3,950	18,993	11,598	3,520	766	28	38,855
90-94	2,348	10,951	7,942	2,056	361	56	23.715
95+	813	3,623	2,304	547	225	0	7,515
Total	179,126	195,357	87,532	20,640	4,154	203	[illegible]

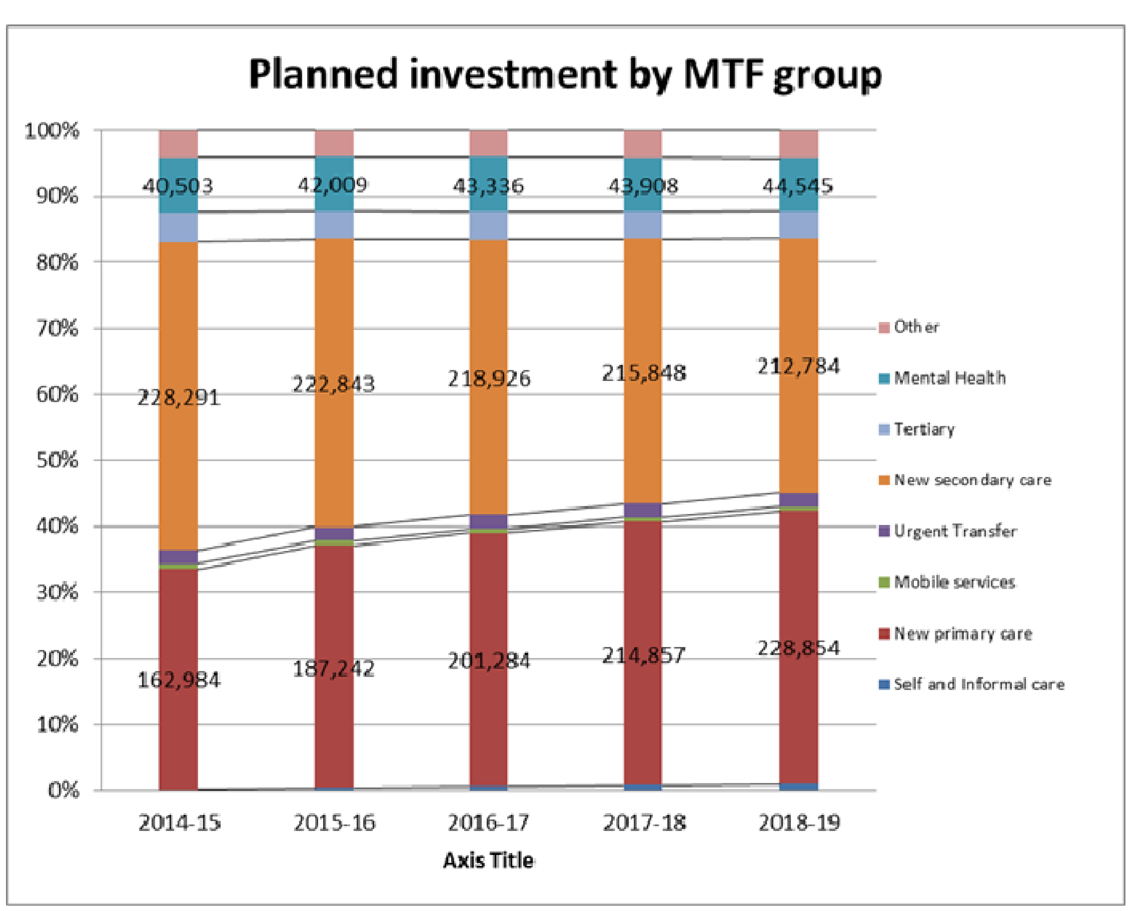
Finance – Strategic Goals

- To secure a sustainable financial future for the CCG
- To secure an appropriate balance between the achievement of financial duties and the achievement of high quality clinical services
- To secure the maximum benefit per £ invested, in terms of health outcomes, and quality of care
- To deploy resources in way that secures the vision of the CCG towards shifting the provision of care towards community based settings

Medium Term Financial Plan - draft

	2014-15	2015-16	2016-17	2017-18	2018-19
	£000	£000	£000	£000	£000
Resource Limit	493,169	516,383	530,241	544,220	558,521
Self and Informal care	619	2,304	3,322	4,382	5,484
New primary care	162,984	187,242	201,284	214,857	228,854
Mobile services	4,039	3,924	3,693	3,481	3,266
Urgent Transfer	9,892	10,468	10,918	11,420	11,931
New secondary care	228,291	222,843	218,926	215,848	212,784
Tertiary	21,585	21,693	21,975	22,348	22,728
Mental Health	40,503	42,009	43,336	43,908	44,545
Other	20,324	20,736	21,484	22,534	23,344
Total	488,237	511,219	524,938	538,778	552,936
Surplus 1%	4,932	5,164	5,302	5,442	5,585

Relative Movement in Investment Plans



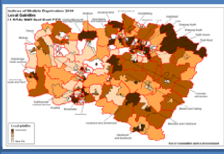
Mapping the Future Outcomes

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

Our Ambition is that by 2018/19 we will have:

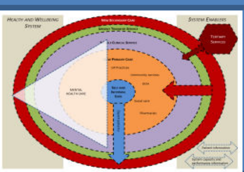
- Reduced years of life lost to under 75s for circulatory disease & cancer by 5%
- Increased the number of patients whose dementia is diagnosed to 60%
- Reduced the number of hospital admissions for respiratory disease by 20%
- Increased the take up of psychological therapies to 50% of those that are eligible
- Ensured that children & adolescents needing Mental Health services are assessed, when urgent within 48 hours and otherwise within 4 weeks and treated in 12 weeks
- Increased the number of outpatient appointments that are provided in the community not the acute hospital by 15%
- Reduced the number of urgent hospital admissions by 25%, by providing more care outside hospital in a planned way

West Kent Plan on a Page



West Kent is a prospering area in Southern England with above average health outcomes. The population of West Kent is 464,000 and although generally affluent there are hidden pockets experience of end of life care; improving health in the most disadvantaged communities; supporting people with mental ill health to live well; and giving children the best start in life

Working with local people, clinicians from all providers and the local authority we have produced 'Mapping the Future' describing what modernised health and care like in 18.19 to meet the challenges described above as well as the need to manage increasing need for care with reducing resources. We share a conviction that sig changes to how care is provided across health and social care are essential and that integration is key to success. West Kent is part of the Kent wide 'Integration Pio



Our Vision for 18/19 is to provide:

Self and Informal Care
People and local communities are supported to take responsibility for their own care

New Primary Care
General Practice is supported by a full range of 24/7 health and social care services to help manage individuals with, multiple long term conditions in the community and avoid the need for hospital admission

New Secondary Care
Specialist care is provided separately for planned and urgent care, by teams that work in the hospital and in the community supporting New Primary Care

Supported by:
Shared clinical records, care plans and contracts that support integrated working

Our ambition for 18/19 is that we will have:

- Reduced years of life lost to under 75s for circulatory disease & cancer by 5%
- Increased the number of patients whose dementia is diagnosed to 60%
- Reduced the number of hospital admissions for respiratory disease by 20%
- Increased the take up of psychological therapies to 50% of those that are eligible
- Ensured that children & adolescents needing Mental Health services are assessed, when urgent within 48 hours and otherwise within 4 weeks and treated in 12 weeks
- Increased the number of outpatient appointments that are provided in the community not the acute hospital by 15%
- Reduced the number of urgent hospital admissions by 25%, by providing more care outside hospital in a planned way

By March 2016 we will have introduced:

Proactive care
- Integrated community health, mental health, and social care teams, with GP leadership, working with groups of GP practices.
- Active support from integrated teams to the community to enable patients to look after themselves
- Increased support to help people at the end of their life to die in the place of their choice

Reactive Care
- An integrated 24/7 service that provides a full range of out of hospital urgent health and social care to support proactive care teams manage patients in the community and avoid hospital admission

Integrated prevention services
- Accessed through a single point of contact to support people live healthy lives

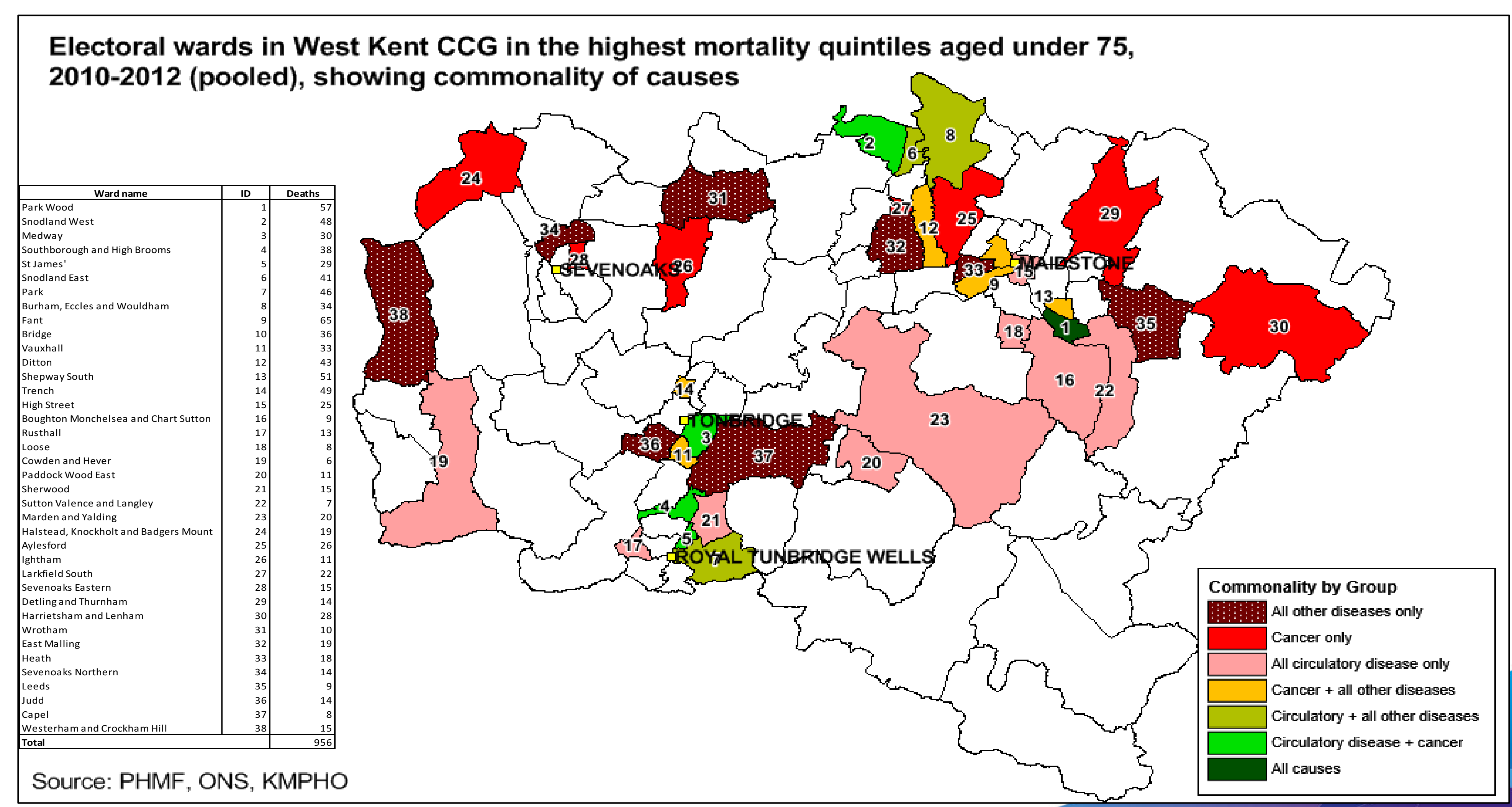
We will make sure we deliver the plan by:

Ensuring it is overseen through the following governance arrangements
- Overall leadership exercised by the West Kent Health and Wellbeing Board
- Participation in the Kent wide 'Integration Pioneer' programme
- Mapping the future programme board to oversee delivery

Measured using the following success criteria
- All providers achieving upper quartile performance on most quality indicators
- All organisations within the health economy report a financial surplus in 18/19
- Delivery of the system objectives.
- Improved citizen experience across the system

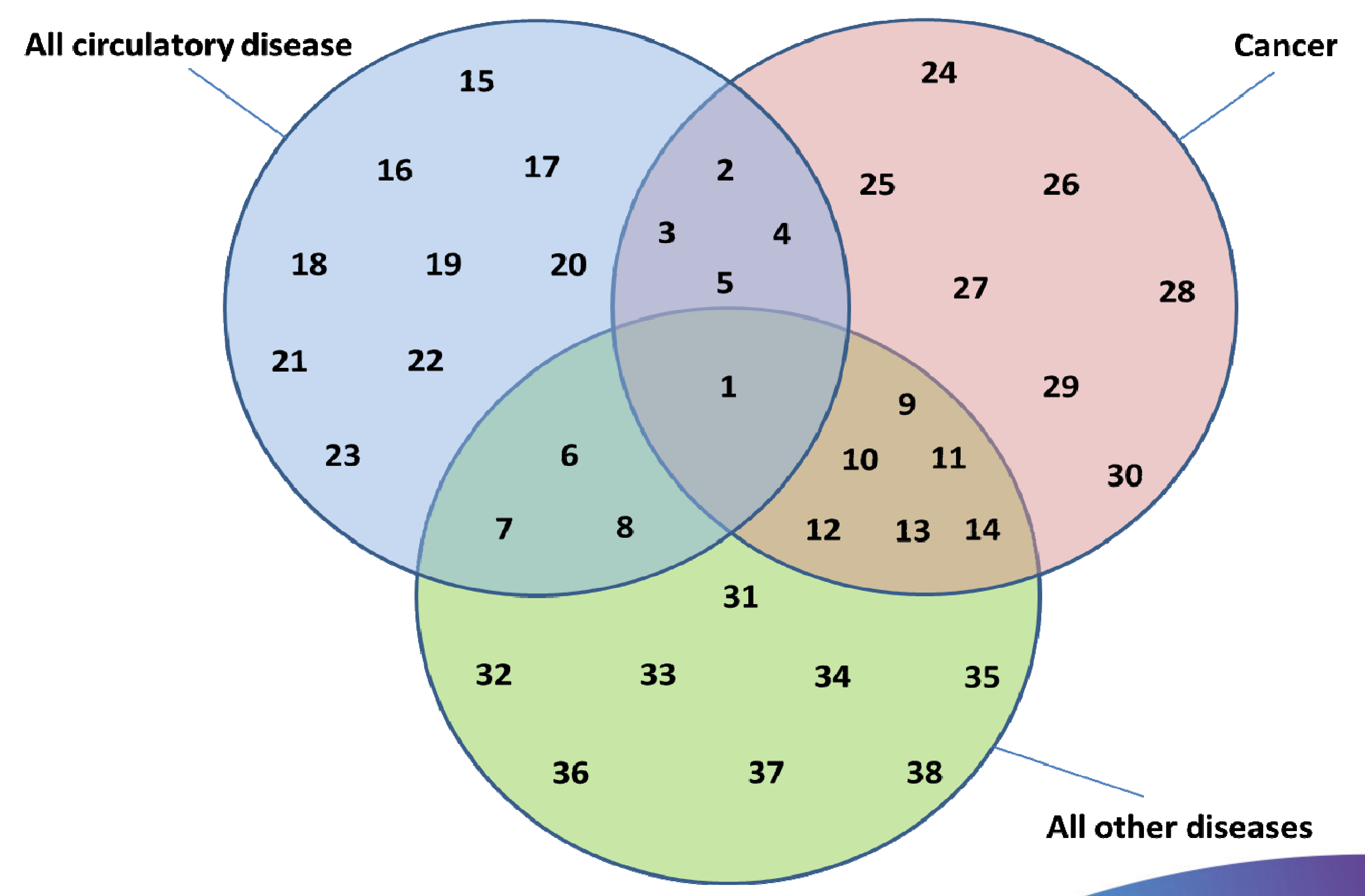
Basing all we do on these values and principles
- Patient focused
- Providing quality,
- Improving outcomes

Electoral wards in highest mortality quintiles – West Kent CCG, aged under 75, 2010-2012 (pooled)



Ward name	ID	Deaths
Park Wood	1	57
Snodland West	2	48
Medway	3	30
Southborough and High Brooms	4	38
St James'	5	29
Snodland East	6	41
Park	7	46
Burham, Eccles and Wouldham	8	34
Fant	9	65
Bridge	10	36
Vauxhall	11	33
Ditton	12	43
Shepway South	13	51
Trench	14	49
High Street	15	25
Boughton Monchelsea and Chart Sutton	16	9
Rusthall	17	13
Loose	18	8
Cowden and Hever	19	6
Paddock Wood East	20	11
Sherwood	21	15
Sutton Valence and Langley	22	7
Marden and Yalding	23	20
Halstead, Knockholt and Badgers Mount	24	19
Aylesford	25	26
Ightham	26	11
Larkfield South	27	22
Sevenoaks Eastern	28	15
Detling and Thurnham	29	14
Harrietsham and Lenham	30	28
Wrotham	31	10
East Malling	32	19
Heath	33	18
Sevenoaks Northern	34	14
Leeds	35	9
Judd	36	14
Capel	37	8
Westerham and Crockham Hill	38	15
Total		956

Electoral wards[1] in West Kent CCG in the highest mortality quintiles aged under 75, 2010-2012 (pooled), showing commonality of causes



[1] –Numerals on Venn diagram refer to labels on map
Source: PHMF, ONS, KMPHO

Electoral wards in West Kent CCG in the highest mortality quintiles, aged under 75, 2011-2012 (pooled), showing commonality by cause of death

■ - ward is in highest mortality quintile for this disease

Map ID	Ward code	Ward name	Circulatory disease	Cancer	All other diseases
1	29UHHC	Park Wood	■	■	■
2	29UPJF	Snodland West	■	■	
3	29UPJD	Medway	■	■	
4	29UQGU	Southborough and High Brooms	■	■	
5	29UQGR	St James'	■	■	
6	29UPJE	Snodland East	■		■
7	29UQGN	Park	■		■
8	29UPHM	Burham, Eccles and Wouldham	■		■
9	29UHGR	Fant		■	■
10	29UHGL	Bridge		■	■
11	29UPJH	Vauxhall		■	■
12	29UPHQ	Ditton		■	■
13	29UHHE	Shepway South		■	■
14	29UPJG	Trench		■	■
15	29UHGW	High Street	■		
16	29UHGJ	Boughton Monchelsea and Chart Sutton	■		
17	29UQGQ	Rusthall	■		
18	29UHGY	Loose	■		
19	29UKGM	Cowden and Hever	■		
20	29UQGK	Paddock Wood East	■		
21	29UQGT	Sherwood	■		
22	29UHHH	Sutton Valence and Langley	■		
23	29UHGZ	Marden and Yalding	■		
24	29UKGW	Halstead, Knockholt and Badgers Mount		■	
25	29UPHJ	Aylesford		■	
26	29UPHY	Ightham		■	
27	29UPJC	Larkfield South		■	
28	29UKHE	Sevenoaks Eastern		■	
29	29UHGN	Detling and Thurnham		■	
30	29UHGS	Harrietsham and Lenham		■	
31	29UPJL	Wrotham			■
32	29UPHS	East Malling			■
33	29UHGU	Heath			■
34	29UKHG	Sevenoaks Northern			■
35	29UHGX	Leeds			■
36	29UPHZ	Judd			■
37	29UQGE	Capel			■
38	29UKHM	Westerham and Crockham Hill			■

Source: PHMF, ONS, KMPHO

Collective Challenge

	CIRCULATORY	RESPIRATORY	CANCER	LEAD RESPONSIBILITY
Smoking	✓	✓	✓	Public Health
Health Checks	✓			Public Health
Obesity Management	✓			Public Health
Diet	✓			
Weight Management			✓	
Sports and Leisure	✓			District Councils
Alcohol control	✓	✓	✓	Community Safety Partnership
Air Quality Management	✓	✓	✓	District Councils
Industrial / Occupational Hazards		✓		(Local Employers)
Housing / heating & damp		✓		Housing Associations/District Councils
Excess winter deaths		✓		
Primary Care input	✓			NHS England Kent & Medway Local Area Team
Management of AF & CHD	✓			NHS England Kent & Medway Local Area Team
Diabetes	✓			Health (various providers)
Thrombosis	✓			
Cardiac Medical procedures (PPCI/STEM1)	✓			
Cardiac Rehab	✓			
Medicines Management issues	✓			
Finding the unknown 'closing the gap'	✓	✓		
Primary Care input to optimise management		✓		
Pulmonary Rehab		✓		
Hidden circulatory problems		✓		
Asthma diagnosis & management especially children		✓		
Practice prevalence of smokers		✓		
Use of services to mortality		✓		
Screening - breast/cervical/bowel			✓	
Early diagnosis			✓	
2/52 referrals			✓	
Reducing variation in optimal therapy			✓	

Planning Timetable

	SCP	BCF
14 February 2014	1st submission of plans	1st Draft
28 February 2014	Contracts signed off	
4 March 2014	Refresh of plans post contract sign off	
5 March 2014	Reconciliation process begins with NHS TDA and Monitor	
18 March 2014	West Kent Health & Well Being Board	
25 March 2014	Governing Body sign of plans	
26 March 2014	Kent Health & Well Being Board	
4 April 2014	Submission of final 2 year plan and draft 5 year	Submission of final proposal
20 June 2014	Submission of 5 year strategic plan (years 1 & 2 will be fixed as per 4 April submission)	
NHS England will work closely with Monitor, NHS Trust Development Authority and Health Education England throughout this process to provide feedback to CCGs and providers and to ensure alignment and deliverability. This will be an iterative process as providers respond to commissioner plans.		

Ashford Clinical Commissioning Group

Operational Plan

April 2014- March 2016

v0.2

Integrated Urgent Care Centre	**Urgent Care**

Description

Evidence Base

- East Kent Integrated Care Pilot 2009
- ECIST review of the Urgent Care System 2010
- Clinical Systems Model for Integrated Urgent Care and Long Term Conditions 2012
- Kings Fund review of Urgent and Emergency Care NHS South of England 2013.

Key Changes

- enhanced GP out of hours service to replicate what is provided in hours;
- enhanced input to review and treat patients within care homes, reducing the need to access acute hospital services;
- consistently responsive and reliable service 24/7;
- integration of the out of hours service with other care providers;
- clear discharge processes from urgent care to planned or primary care, to maintain capacity within the system; and
- proactive case management.

High Level Benefit Assessment

- Provide a rapid multi-disciplinary assessment of patients quickly
- Provide rapid access to a range of services that will ensure that patients are managed seamlessly and are better supported to cope within their local community.

Key Risks

- Quality / complaints
- Human resources / organisational development / staffing / competence
- Adverse publicity / reputation

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Securing additional years of life for people with treatable mental and physical health conditions.	Improving the health related quality of people with one or more long-term condition, including mental health conditions.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	Increasing the proportion of older people living independently at home following discharge from hospital.	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

<table>
<tr><th colspan="4">Project Accountability</th></tr>
<tr><td>Clinical Lead</td><td></td><td>Managerial Lead</td><td>Alastair Martin</td></tr>
<tr><td>Key Partners</td><td colspan="3">East Kent Hospitals University NHS Foundation Trust
Kent Community Health NHS Trust
Kent County Council
Local CCGs</td></tr>
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<tr><td rowspan="2">Key Measures</td><td></td><td colspan="2"></td></tr>
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Transformation of Outpatient Services	**Planned Care**
Description	Key Changes • Pre-Referral Advice and Guidance Service • One-Stop Clinics • Improved Triage High Level Benefit Assessment For patients • Appropriate referral to the right clinician • Management of their condition by local clinicians • Reduced attendances in acute settings For GPs • Education resource • Reduces redirection/rejected referrals • Reduction in overall referrals For provider • Only those patients that need to be in clinic are seen • More diagnostic tests, where appropriate, can be completed prior to referral • Improves RTT timelines where redirection of referrals has added delays in the past For CCG's • Confidence that referrals to secondary care are appropriate • Potential for savings where patients are not referred and managed in primary/community care Key Risks • Potential for provider to miscode response and therefore output data maybe of questionable quality • Percentage of referrals avoided provides minimal savings • Engagement with GPs

NHS Outcomes Framework

1		2	3	4		5
Preventing people from dying prematurely		**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**		**Treating and caring for people in a safe environment and protecting them from avoidable harm**
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<tr><th colspan="4">Project Accountability</th></tr>
<tr><td>Clinical Lead</td><td></td><td>Managerial Leads</td><td>Paula Smith
Sue Luff
Felix Robinson</td></tr>
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Local CCGs</td></tr>
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Macula Oedema	Planned Care

Description

Evidence Base

- NICE Technology Appraisal Guidance
- Diabetic Macular Oedema (DMO; TA274)
- Wet Age-Related Macular Degeneration (WAMD; TA155)

Key Changes

- A hub and spoke type service model to provide patients with community monitoring facilities and a central acute site(s) for the treatment/drug administration

High Level Benefit Assessment

- Patients would not need to attend acute hospital sites for every appointment.
- Patients seen in a timely fashion and impact on their vision is minimised
- Improved delivery of high quality and value for money monitoring service that will also provide the maintenance a patient requires between injections
- Improved access and choice
- Delivers greater consistency of treatments
- Equity of services across the localities which enhances patient experience and reduces wait times

Key Risks

- Fragmentation of service
- Patients confused where their next treatment will be provided
- Community provider monitoring patients fails to identify developing problems
- Agreed tariff too low to be viable & attract providers

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	Enhancing quality of life for people with long-term conditions	Helping people to recover from episodes of ill health or following injury	Ensuring that people have a positive experience of care	Treating and caring for people in a safe environment and protecting them from avoidable harm

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<tr><td>Clinical Lead</td><td></td><td>Managerial Lead</td><td>Paula Smith</td></tr>
<tr><td>Key Partners</td><td colspan="3">East Kent Hospitals University NHS Foundation Trust
Local Optometrist Committee
Local CCGs</td></tr>
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Dermatology	Planned Care

Description

Key Changes

- Prime contractor will be responsible for developing and implementing an integrated and coordinated programme of Dermatology care
- Services will be commissioned on the basis of "outcome" rather than separate services for each condition.

High Level Benefit Assessment

- Reducing fragmentation in the patient pathway.
- Reducing confusion for GPs with regard to where to refer.
- The patient being seen by the right clinician in the right place first time.
- Ensuring the right investigations is undertaken.
- Creating efficiencies and financial savings.
- Better clinical effectiveness and increase quality of service.
- Monitoring based on outcomes.
- Supports education in primary care.

Key Risks

- Conflicts of interest from current providers engaged within the Task and Finish Group
- Destabilisation of the Trusts Cancer services
- Inability to procure a new service by October.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	Enhancing quality of life for people with long-term conditions	Helping people to recover from episodes of ill health or following injury	Ensuring that people have a positive experience of care	Treating and caring for people in a safe environment and protecting them from avoidable harm

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Project Accountability			
Clinical Lead		**Managerial Lead**	Laura Counter
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent Community Health NHS Trust Local CCGs		

Delivery in 2014-16		
Key Measures		
Key Milestones	February 2014	Service Review
	March 2014	Redesign
	October 2014	Implement changes

Transformation of ADHD Service	**Mental Health**
Description	Evidence Base • NICE Guideline CG72 Attention Deficit Hyperactivity Disorder (ADHD) 2008 Key Changes • Integrated all-age pathway, reducing need to transition across paediatric and adult services • Increased community based service provision • Shared care between GPs and specialist services High Level Benefit Assessment • Improve the recognition, accurate diagnosis and treatment of ADHD in children, young people and adults • Limit the impact of late initiation of treatment • Improve the quality of care and may reduce the number of mental health contacts, with the associated costs Key Risks • Lack of engagement and buy in to the transformation of services from stakeholders particularly at the early stages of the children's pathway • GPs unwilling to sign up to an ADHD shared care and prescribing protocol

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	Enhancing quality of life for people with long-term conditions	Helping people to recover from episodes of ill health or following injury	Ensuring that people have a positive experience of care	Treating and caring for people in a safe environment and protecting them from avoidable harm

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<tr><td>Clinical Lead</td><td></td><td>Managerial Lead</td><td>Jacqui Davis</td></tr>
<tr><td>Key Partners</td><td colspan="3">Kent and Medway Partnership Trust
Sussex Partnership NHS Trust
East Kent Hospitals University NHS Foundation Trust
Medway NHS Foundation Trust
Kent Community Health NHS Trust
Local CCGs</td></tr>
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<tr><td colspan="3"></td></tr>
<tr><td rowspan="7">Key Milestones</td><td>March 2014</td><td colspan="2">Determine the level of service required</td></tr>
<tr><td>June 2014</td><td colspan="2">Service design (including prescribing arrangements)</td></tr>
<tr><td>September 2014</td><td colspan="2">Development of shared care and prescribing protocol</td></tr>
<tr><td>March 2015</td><td colspan="2">Procurement process and implementation of new service</td></tr>
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<tr><td></td><td colspan="2"></td></tr>
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Eating Disorders Service	**Mental Health**

Description

Strategic Fit

- Kent Health and Wellbeing Strategy

Evidence Base

- NICE guidelines for Borderline Personality Disorder

Key Changes

- TBA

High Level Benefit Assessment

- To improve the condition of patients with eating difficulties or disorders, whereby they are able to maintain their physical and psychological health either with no or less specialist assistance
- To improve the nutritional health of patients with eating difficulties or disorders
- A reduction in subjective distress of patients
- To liaise with secondary and tertiary care providers to provide appropriate and timely care for patients identified as needing more intensive treatment or admission

Key Risks

- Derogation of funds from NHSE to CCGs – no agreement in place between CCGs regarding fair share of funding and resources

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

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Project Accountability			
Clinical Lead		**Managerial Lead**	Jacqui Davies
Key Partners	Kent and Medway Partnership Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			

Autistic Spectrum Conditions Diagnostic Assessment Service	**Learning Disabilities**

Description

Strategic Fit

- It was identified in 2010 that there was no clear diagnostic or care pathway for adults with high functioning autism and Aspergers syndrome in Kent
- The current capacity of the service is 60 diagnostic assessments a year, and the waiting list as of July was 280 patients

Evidence Base

- NICE quality standards

Key Changes

- Increase capacity for assessment service

High Level Benefit Assessment

- The backlog of people waiting for diagnostic assessment will be addressed
- There will be improved multi disciplinary working including the provision of joint health and social care assessment meetings and specialist interventions
- Formal diagnosis ensures individuals are not referred to inappropriate health, social care and community and voluntary services.
- Carers and families will have a greater understanding of autism as a result of the development of this service.
- The service would meet key requirements of national policy and guidance.

Key Risks

- Risk that current level of referrals may not be a true representation of future demand for service – the prevalence data suggests referrals could continue to increase
- Risk that current provider cannot sustain current service which may pre-empt closure of the current service.

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	Helping people to recover from episodes of ill health or following injury	**Ensuring that people have a positive experience of care**	Treating and caring for people in a safe environment and protecting them from avoidable harm

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<tr><td>Clinical Lead</td><td></td><td>Managerial Lead</td><td>Sue Gratton</td></tr>
<tr><td>Key Partners</td><td colspan="3">Kent County Council
Local CCGs</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="3">Key Measures</td><td colspan="3">Service meeting NICE guidelines</td></tr>
<tr><td colspan="3">Reduced waits for diagnosis</td></tr>
<tr><td colspan="3">Increased referrals</td></tr>
<tr><td rowspan="3">Key Milestones</td><td>October 2014</td><td colspan="2">Additional staff recruited</td></tr>
<tr><td>January 2015</td><td colspan="2">New capacity available</td></tr>
<tr><td></td><td colspan="2"></td></tr>
</table>

Winterbourne Joint Plan	**Learning Disabilities**
Description	Evidence Base • The *Winterbourne Concordat: Programme of Action* (DH 2012) Key Changes • Agree a personal plan for each individual that is inappropriately placed in CCG or NHS England commissioned learning disability or autism in-patient services and put the plans into action so that all individuals receive personalised care and support in the community no later than 1 June 2014 • Put in place a locally agreed joint plan for high quality care and support services by April 2014, which accords with the model of good care to ensure that a new generation of inpatients do not take the place of people currently in hospital. High Level Benefit Assessment • People with learning disability and autism who have complex mental health or behaviour problems will experience more integrated care and support in the community • There will be improved multi-disciplinary working including the provision of joint health and social care assessment meetings and specialist interventions • There will be reduced reliance on the use of high cost in-patient services • Clinical consultancy and support would be available for other professionals in mainstream services to enable them to make reasonable adjustments. • The service would meet key requirements of national policy and guidance. Key Risks • Lack of funding from NHSE Specialised Commissioning renders commissioning recommendations unaffordable for CCGs and Local Authority • June 2014 deadline for discharges of current in-patients not met due to requirement to undertake procurement process for new services

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

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<tr><th colspan="4">Project Accountability</th></tr>
<tr><td>Clinical Lead</td><td>Bethan Haskins</td><td>Managerial Lead</td><td>Sue Gratton</td></tr>
<tr><td>Key Partners</td><td colspan="3">Local CCGs</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="2">Key Measures</td><td colspan="3">Reduced number of hospital admissions</td></tr>
<tr><td colspan="3">Reduced length of stay for hospital admissions</td></tr>
<tr><td rowspan="7">Key Milestones</td><td>Completed</td><td colspan="2">Identify current in-patients for discharge</td></tr>
<tr><td>February 2014</td><td colspan="2">Details of each patients support and accommodation needs</td></tr>
<tr><td>March 2014</td><td colspan="2">Consult on new care pathway and models of care</td></tr>
<tr><td>April 2014</td><td colspan="2">Final Joint Plan</td></tr>
<tr><td>June 2014</td><td colspan="2">All current in-patients discharged or agreed discharge plan / procurement being implemented.</td></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><td></td><td colspan="2"></td></tr>
</table>

Multi-agency whole system approach for supporting disabled children and young people with challenging behaviour	**Child Health and Maternity**
Description	Strategic Fit • Kent Health and Wellbeing Strategy Evidence Base • Department of Health's Report into Winterbourne View • Children and Families Bill • Kent Sufficiency Strategy (2013) Key Changes • A new multi-agency integrated pathway involving professionals working at universal, targeted, specialist and highly specialist levels Integrated assessments and care planning process aligned to the new Education Health and Care plans High Level Benefit Assessment • Children and young people are able to remain living at home with their families. • Children and young people are educated in a Kent school. • Children and young people are able to maintain or develop friendships and access local community services. • Families feel confident in managing their son or daughter's challenging behaviour and are able to participate in everyday activities. Key Risks • Delay in recruiting the right staff with the right level of training and experience. • Unable to agree contract variation to support the implementation of the transformation programme. • Decision by any partner not to invest in this transformation programme.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Securing additional years of life for people with treatable mental and physical health conditions.	Improving the health related quality of people with one or more long-term condition, including mental health conditions.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	Increasing the proportion of older people living independently at home following discharge from hospital.	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

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<tr><td>Clinical Lead</td><td></td><td>Managerial Lead</td><td>Martin Cunnington</td></tr>
<tr><td>Key Partners</td><td colspan="3">East Kent Hospitals University NHS Foundation Trust
Kent County Council
Sussex Partnership NHS Trust
Local CCGs</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="2">Key Measures</td><td colspan="3">Reduce the number of out of county placements for children with severe autism and challenging behaviour.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td rowspan="7">Key Milestones</td><td>June 2014</td><td colspan="2">Baseline data and scope of the evaluation agreed.</td></tr>
<tr><td>September 2014</td><td colspan="2">New outcome measures and KPIs included in a range of contracts and a central data collection system agreed.</td></tr>
<tr><td>December 2014</td><td colspan="2">Remodelling and training within CAMHS, social care and education to implement new integrated pathway across universal, targeted and specialist services</td></tr>
<tr><td></td><td colspan="2"></td></tr>
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</table>

Early Pregnancy Assessment Unit	**Child Health and Maternity**

Description

Strategic Fit

- Kent Health and Wellbeing Strategy
- Kent's Children and Young People's plan 'Every Day Matters'
- Kent Health Inequalities Action Plan "Mind the Gap"

Evidence Base

- NICE Guidelines for Ectopic pregnancy and miscarriage

Key Changes

- Ensure pathways are transparent, equitable and clearly communicated
- Single Point of Access (SPA) led by a clinician who will feed into primary care and OOH services that link to the A&E pathways.
- Improved access to scanning appointments, or explore having a scanner available in primary care

High Level Benefit Assessment

- Ensure the right care is given at the right time, at the right place and by the right professional
- Deliver the best, proactive care to prevent avoidable complications and interventions. Supporting the reduction of adverse outcomes of pregnancy
- Enable and empower women and GPs to use appropriate access routes to the services
- Improve transparency and accuracy of coding to result in more efficient use of resources
- Continued reduction of A&E attendances – improve pathways and reduce activity though this route

Key Risks

- Destabilisation of services
- Lack of engagement
- Projected benefits are not fully realised.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

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Project Accountability			
Clinical Lead		**Managerial Lead**	Adam Warmington
Key Partners	East Kent Hospitals University NHS Foundation Trust Local CCGs		

Delivery in 2014-16		
Key Measures	Reduced attendance at A&E for pregnancy complications	
	Waiting times following GP referral	
	Proportion of scans undertaken on same day	
Key Milestones	June 2014	Research and understand best practice
	July 2014	Implement new EPAU pathway

Transformational of Urgent Care for Children and Young People	**Child Health and Maternity**

Description

Evidence Base

- DH and DfE, Improving Children and Young People's Health Outcomes – a system wide response (2013)
- DH, Report of Children and Young People's Health Outcomes Forum (2012)
- RCGP in partnership with RCPCH and RCN, Commissioning a good child health service (2013)
- Standards for children and young people in emergency care settings (2012)
- NHS Institute for Innovation and Improvement, Focus on: Children and Young People Emergency and Urgent Care (2010)

Key Changes

- New urgent and emergency care clinical network for children and young people
- Use of assistive technology
- Working with Public Health and the School Nursing Service to deliver key messages in schools.
- Develop lesson plans for use in schools around PSHE.

High Level Benefit Assessment

- Parents have an increased level of awareness and confidence in being able to support their children with common illnesses which may require urgent or emergency care.
- Children and young people, where it is clinically safe are treated and supported outside of hospital in their local community.
- Increase in confidence to manage their condition.

Key Risks

- Destabilisation of services
- Lack of engagement
- Services not streamlined
- Efficiencies and quality not meeting expectations

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

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<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="3">Key Measures</td><td colspan="3">Reduction in A&E attendances</td></tr>
<tr><td colspan="3">Reduce short stay admissions</td></tr>
<tr><td colspan="3">Increased community based support</td></tr>
<tr><td rowspan="3">Key Milestones</td><td>December 2014</td><td colspan="2">Reviews of existing services complete</td></tr>
<tr><td>June 2015</td><td colspan="2">New system design complete</td></tr>
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</table>

Admiral Nursing	Long Term Conditions

Description

Strategic Fit

- Dementia has been identified as a priority for the Kent HWB as well as the CCG.
- The provision of good community support for people with dementia is identified as an objective in the National Dementia Strategy 2009 and the Prime Ministers Dementia Challenge 2012.

Evidence Base

- NICE QS30 Supporting people to live well with Dementia. Quality Standard 30 (NICE 2012)
- NICE CG42 Dementia Support people with dementia and their carers in health & social care (NICE 2005)

Key Changes

- The existing Admiral Nurse be integrated into the Neighbourhood Care Teams
- The service will need to develop stronger working links with Age UK (who currently hold the contract for Dementia Café in Canterbury).
- A combination of clinic and home visit approach is explored and adopted to create capacity, utilising existing voluntary sector accommodation where appropriate (Age UK etc.)
- Improve links with carers rapid response and other jointly commissioned services i.e. Crossroads crisis service.

High Level Benefit Assessment

- Reduced carer admissions
- Improved access for carers/families to support them in caring role.
- Integrated working between Neighbourhood Care Teams/admiral nursing/voluntary sector
- Capacity for service to educate other professionals.

Key Risks

- Capacity of the team across other parts of East Kent means that the administrative post is diluted

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	Enhancing quality of life for people with long-term conditions	Helping people to recover from episodes of ill health or following injury	Ensuring that people have a positive experience of care	Treating and caring for people in a safe environment and protecting them from avoidable harm

Securing additional years of life for people with treatable mental and physical health conditions.	Improving the health related quality of people with one or more long-term condition, including mental health conditions.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	Increasing the proportion of older people living independently at home following discharge from hospital.	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Project Accountability			
Clinical Lead		**Managerial Lead**	Lisa Barclay
Key Partners	Kent Community Health NHS Trust Kent County Council Local CCGs		

Delivery in 2014-16		
Key Measures	Reduced admissions due to carer breakdown	
Key Milestones		

Cardiology	Long Term Conditions

Description

Key Changes

- Review all of the existing services
- Develop an integrated service model
- Services commissioned on the basis of "outcome" rather than separate services for each condition
- Care delivered in a community setting
- Clear and responsive referral routes into secondary care services.

High Level Benefit Assessment

- Reducing fragmentation in the patient pathway.
- Ensuring the patients are seen by the right clinician in the right place first time.
- Creating efficiencies and financial savings, providing value for money against existing services
- Better clinical effectiveness and increase quality of service.
- To improve health outcomes through earlier diagnosis and treatment of common cardiology conditions
- To reduce the number of referrals, so far as clinically appropriate, to secondary care
- To establish a robust communication mechanism between all parties providing and receiving the service.

Key Risks

- KCHT may not wish to support the continuation of the GPwSI service on an interim basis
- Lack of data on the GPwSI service to review effectiveness
- Clinicians ability to dedicate time to the Task and Finish Groups

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

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Project Accountability			
Clinical Lead		**Managerial Lead**	Rachel Grout
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent Community Health NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures	Reduction in GP referrals		
	Reduced admissions		
	Improved life expectancy		
Key Milestones	February 2014	Service review completed	
	April 2014	Full Business Case	
	October 2014	Implementation	

Memory Assessment	**Long Term Conditions**

Description

Strategic Fit
- The provision of early diagnosis for people with dementia is identified as an objective in the National Dementia Strategy 2009
- Prime Minister's Dementia Challenge, 2012 which sets a target diagnosis rate of 66% by 2015 (against expected prevalence).

Key Changes
- The pathway envisages in future that the majority of people with dementia will be reviewed and monitored in primary care.
- Dementia screening should be undertaken in primary care to exclude other reasons for the cognitive impairment
- Magnetic resonance imaging (MRI) is suggested as the preferred modality to assist with early diagnosis and detect subcortical vascular changes, the suggestion would be that the scan should be ordered in primary care.

High Level Benefit Assessment
- Care closer to home by increasing the assessment and treatment available in primary care.
- A more multi disciplinary approach to patients will also help to support the integration of services
- Free up capacity in the memory assessment service for those people who need more specialist input

Key Risks
- Redesign of pathway does not increase capacity in memory assessment services leading to delays in assessment.
- Future modelling of local tariffs and activity indicate current budget is insufficient.
- Prescribing will continue to be a cost pressure unless appropriate agreements are reached.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	Enhancing quality of life for people with long-term conditions	Helping people to recover from episodes of ill health or following injury	Ensuring that people have a positive experience of care	Treating and caring for people in a safe environment and protecting them from avoidable harm

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<tr><td>Key Partners</td><td colspan="3">Kent and Medway Partnership NHS Trust
Local CCGs</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="2">Key Measures</td><td colspan="3">Reduction in admission to acute hospital beds</td></tr>
<tr><td colspan="3">Time of referral to the service.</td></tr>
<tr><td rowspan="7">Key Milestones</td><td>January 2014</td><td colspan="2">Review additional data, eg scanning data, number of referrals converted to diagnosis.</td></tr>
<tr><td>February 2014</td><td colspan="2">Second workshop for dementia leads</td></tr>
<tr><td>Mid February 2014</td><td colspan="2">Agree specification for cluster 18</td></tr>
<tr><td>April 2014</td><td colspan="2">Initial evaluation of Cantabmobile pilot</td></tr>
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Dementia Out Of Hours Crisis Support	**Long Term Conditions**

Description

Strategic Fit

- Dementia has been identified as a priority for the Kent HWB as well as the CCG. The business supports the desire to deliver care as close to home as possible.
- The provision of good community support for people with dementia is identified as an objective in the National Dementia Strategy,2009 and the Prime Ministers Dementia Challenge, 2012.

Key Changes

- The proposal is to develop existing community services
- This enhanced service would provide an out of hours response for both older people with functional problems as well as people with dementia
- The service would be available to both patients known to the secondary mental health services and new referrals and would deliver a service to individuals in their own homes, including care homes
- The service will be targeted at those patients requiring an urgent response from mental health services and those patients who needs may require a joint response between community nursing and mental health services because a physical problem has enhanced their level of confusion.

High Level Benefit Assessment

- Enable older people to remain in their own home (which could be a care home) at times of crisis.
- Avoid unnecessary hospital attendances and admissions.
- Facilitate hospital discharge

Key Risks

- Inability recruit to additional posts will impact on service delivery
- Service does not ultimately deliver savings.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	Helping people to recover from episodes of ill health or following injury	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

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Project Accountability			
Clinical Lead		**Managerial Lead**	Linda Caldwell
Key Partners	Kent and Medway Partnership Trust Local CCGs		

Delivery in 2014-16		
Key Measures	Reduction in admission to acute hospital beds	
	Time of referral to the service.	
Key Milestones	January 2014	Undertake modelling to identify hours service needed.
	February 2014	Agree activity and KPIs for inclusion in KMPT contract
	Mid February 2014	Advertise for posts
	May 2014	Service fully implemented

Falls Strategy	Long Term Conditions

Description

Strategic Fit

- Kent has an aging population, the over 65 population is expected to rise by at least 15% over the next 5 years (more than 20% for over 85 years).

Evidence Base

- One in three people aged 65+ will fall each year and one in two people aged 80+ will fall each year (NHS Confederation, April 2012)
- Falls account for approx. 10 to 25% of ambulance callout (NHS Confederation).
- NICE and National Service Framework (NSF) for older people recommend the prompt delivery of multifactorial assessment and interventions

Key Changes

- Screening of adults who are at a higher risk of falls
- Integrated multi-disciplinary assessment for the secondary prevention of
- falls and fractures
- Use of standardised Multifactorial Falls Assessment and Evaluation tool
- across Kent
- Availability of community based postural stability exercise classes
- Follow on community support for on-going maintenance closer to home

High Level Benefit Assessment

- Improve access to services
- Reduce hospital admissions related to falls by preventing the patient from having a second fall
- To reduce the number of health and social care activity related to falls and fracture in older people
- Improve patient experience of services
- Improve outcomes for patients

Key Risks

- Public Health timescales for the training and delivery of Postural Stability Instructors may not align with the delivery of the integrated pathway.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	Enhancing quality of life for people with long-term conditions	Helping people to recover from episodes of ill health or following injury	Ensuring that people have a positive experience of care	Treating and caring for people in a safe environment and protecting them from avoidable harm

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<tr><td>Key Partners</td><td colspan="3">Kent Community Health NHS Trust
Kent County Council
Local CCGs
Kent Fire and Rescue Service</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="2">Key Measures</td><td colspan="3">Reduced falls related admissions</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td rowspan="7">Key Milestones</td><td>March 2014</td><td colspan="2">Scoping exercise complete</td></tr>
<tr><td>April 2014</td><td colspan="2">Full Business Case</td></tr>
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Community Equipment Loan Store	**Long Term Conditions**

Description

Key Changes

- Procure joint social and health care loan store service
- Implement seven day working
- Faster, more responsive, service appropriate to patient need

High Level Benefit Assessment

- Creating efficiencies and financial savings, providing value for money against existing services
- Reduction in admissions by ensuring patients have access to necessary equipment allowing them to remain living in their own homes

Key Risks

- Significant investment required
- Unable to identify provider through procurement process
- Implementation of new service does not meet objectives
- Unable to gain support across health and social care for new service specification

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

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<tr><td rowspan="2">Key Measures</td><td colspan="3">Reduced admissions</td></tr>
<tr><td colspan="3">Reduction in length of stay and delayed discharges</td></tr>
<tr><td rowspan="7">Key Milestones</td><td>October 2014</td><td colspan="2">Commence tender exercise</td></tr>
<tr><td>April 2015</td><td colspan="2">Implement new service</td></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><td></td><td colspan="2"></td></tr>
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Expansion of Health and Social Care Team	**Long Term Conditions**

Description

Evidence Base

- Neighbourhood Care Team was implemented in February 2013, A&E attendance and admission avoidance achieved in line with plans

Key Changes

- Make the current H&SCC roles substantive within NCT, recognising the role functions as a central point of access and service navigation for practices.
- Review measurement of savings and test cost assumptions on patient cohort where admission avoidance achieved.
- Increase the H&SCC roles to cover Sunday between 10-2pm
- Extend current NCT team cover for long term conditions, to allow service cover until 8pm at night (currently 5pm), with an on call service being available for care homes 8-8, Mon-Sun
- Improve working relationships between Discharge Referral Service and community care to reduce LoS
- Encourage use of integrated team through H&SCC, by Out of Hours GP Provider.
- Embed use of Share My Care across EKHUFT/KCHT/IC24 and Secamb to reduce A&E attendances and admissions.

High Level Benefit Assessment

- Continue to reduce A&E attendances in 65+ age group – absorb growth in population attendances
- Improve provider integration

Key Risks

- Unable to recruit additional staff
- Service does not meet expected outcomes

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

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Local CCGs</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="2">Key Measures</td><td colspan="3">Reduced admissions</td></tr>
<tr><td colspan="3">Reduction in length of stay and delays in discharges</td></tr>
<tr><td rowspan="7">Key Milestones</td><td>March 2014</td><td colspan="2">Trial extended hours</td></tr>
<tr><td>June 2014</td><td colspan="2">Review outcome of trial peroid</td></tr>
<tr><td></td><td colspan="2"></td></tr>
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Personal Health Budgets	Long Term Conditions
Description	Strategic Fit • From 1st April 2014 everyone eligible for NHS Continuing Healthcare funding will have a right to ask for a personal health budget Evidence Base The final national evaluation of the personal health budget pilot programme was released in May 2013. The key findings of the evaluation were: • 72.6% of budget holders reported their budget having a positive impact on their independence • 67.9% reported a positive impact on being supported with dignity and respect • 67.7% reported a positive impact on being in control of their support • 63.9% reported a positive impact on their mental wellbeing Key Changes • Implement a robust governance system for assessment and planning linked to the SE7 SEN and Disabled Children Pathfinder and the establishment of the new Education, Health and Care Plans. • Implement a multi-agency joint commissioning approach to the provision and monitoring of a personal budget. High Level Benefit Assessment *Benefits to budget holders and carers* • Greater choice and control • Improved alignment with patients personal life and circumstances *Wider system benefits* • Greater transparency in the allocation of NHS funds • Greater integration • Greater innovation and service development Key Risks • Section 75 agreement not completed by April 2014 • Inability to recruit broker resources • Unable to agree clinical quality monitoring and support with existing providers

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	Helping people to recover from episodes of ill health or following injury	**Ensuring that people have a positive experience of care**	Treating and caring for people in a safe environment and protecting them from avoidable harm

Securing additional years of life for people with treatable mental and physical health conditions.	Improving the health related quality of people with one or more long-term condition, including mental health conditions.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	Increasing the proportion of older people living independently at home following discharge from hospital.	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

<table>
<tr><th colspan="4">Project Accountability</th></tr>
<tr><td>Clinical Lead</td><td></td><td>Managerial Lead</td><td>Marie Reynolds</td></tr>
<tr><td>Key Partners</td><td colspan="3">Kent County Council
Local CCGs</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="5">Key Measures</td><td colspan="3">Satisfactory levels of positive patient feedback.</td></tr>
<tr><td colspan="3">All PHB referrals are processed following agreed procedures within agreed timeframes.</td></tr>
<tr><td colspan="3">Tracking and comparison of PHB costs against traditional care package cost baseline provided through Decision Support Tool (for CHC).</td></tr>
<tr><td colspan="3">Reduced acute admissions and re-admissions and reduced A&E attendances, ICT referrals.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td rowspan="7">Key Milestones</td><td>Mar 2014</td><td colspan="2">Completion of Section 75 agreement</td></tr>
<tr><td>Jul 2014</td><td colspan="2">Broker recruitment and training completed</td></tr>
<tr><td>Aug 2014</td><td colspan="2">Development and approval of joint assessment processes for children with SEN and Disabilities</td></tr>
<tr><td></td><td colspan="2"></td></tr>
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Pulmonary Rehabilitation Service	**Long Term Conditions**

Description

Strategic Fit

- Respiratory disease is the third most common cause of chronic ill health in the UK, (Thorax Journal)
- 21% of adults recorded as “smokers”

Key Changes

- Increase capacity in the Pulmonary Rehabilitation Service
- Encourage and facilitate patient self-management exercise groups
- Ensure consistency in acute sites operate across East Kent

High Level Benefit Assessment

- Reduced duplication and meet existing gaps in provision – clear patient pathway
- Reduced unnecessary appointments by improving patient self-management
- Equitable service across East Kent
- Closer working relationships between the acute trust and community clinicians
- Accurate Asthma and COPD registers, and achievement of respiratory QoF points

Key Risks

- Workforce development
- No increase in referrals

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Securing additional years of life for people with treatable mental and physical health conditions.	Improving the health related quality of people with one or more long-term condition, including mental health conditions.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	Increasing the proportion of older people living independently at home following discharge from hospital.	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

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<tr><td>**Clinical Lead**</td><td></td><td>**Managerial Lead**</td><td>Kim Eaglestone</td></tr>
<tr><td>**Key Partners**</td><td colspan="3">East Kent Hospitals University NHS Foundation Trust
Kent Community Health NHS Trust
Local CCGs</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="2">**Key Measures**</td><td colspan="3">Reduction of A&E attendances and re-admissions for those patients that have experienced the Pulmonary Rehabilitation service;</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td rowspan="7">**Key Milestones**</td><td>March 2014</td><td colspan="2">Task and Finish Group Commences</td></tr>
<tr><td>July 2014</td><td colspan="2">Service Specification Complete</td></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><td></td><td colspan="2"></td></tr>
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Ashford Clinical Commissioning Group

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Strategic Commissioning Plan

April 2014- March 2019

(Incl. Operational Plan April 2014-March 2016)

v0.5

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Introduction

The NHS has changed, with responsibility for planning and paying for local health services being transferred from Primary Care Trusts (PCT) to Clinical Commissioning Groups (CCGs). We have thought long and hard about how we can use these reforms to improve the health of the community we serve, by capitalising on our knowledge and understanding of the local population. We have concluded that there are two key components to ensuring that Ashford Clinical Commissioning Group (CCG) achieves its objective – putting patients at the centre of our decisions, and working in partnership with other agencies, such as the borough council and Public Health.

Ashford Clinical Commissioning Group (ACCG) has a membership of 15 practices covering the whole of the Ashford district and is led by local GPs and senior healthcare managers. We inherited a local NHS which offers good services, in good facilities and delivers good outcomes for most people, but is often uncoordinated and this means that the right things for patients are not always the easiest things to do. We will continue to work with residents and organisations, including Kent County Council, Ashford Borough Council, providers of health and social care, and the voluntary and community sector.

The aim of our Strategic Commissioning Plan is to tell the end-to-end story about how we will move from assessing the needs of our population to delivering services that will drive improvements in health outcomes. This document also sets out how ACCG will inform and involve residents, partners, health and social care professionals, and voluntary and community sector groups to ensure we champion their needs, and ensure their thoughts shape our decisions.

Some of the decisions we will have to make this year and next will be tough, but we know that together with local doctors, nurses, NHS staff and you, our patients and our public, we can make a real difference to the quality of services you receive and the NHS is able to offer. In all we do, we want to ensure patients are involved and can have their say. In establishing our channels for engaging the public we are taking the best of the past and incorporating it into exciting new engagement models, including using new technologies to help us create a social movement for improved healthcare.

Within the Ashford area I believe will have a healthcare partnership to be proud of, and I look forward to continuing the progress we have already begun to make.

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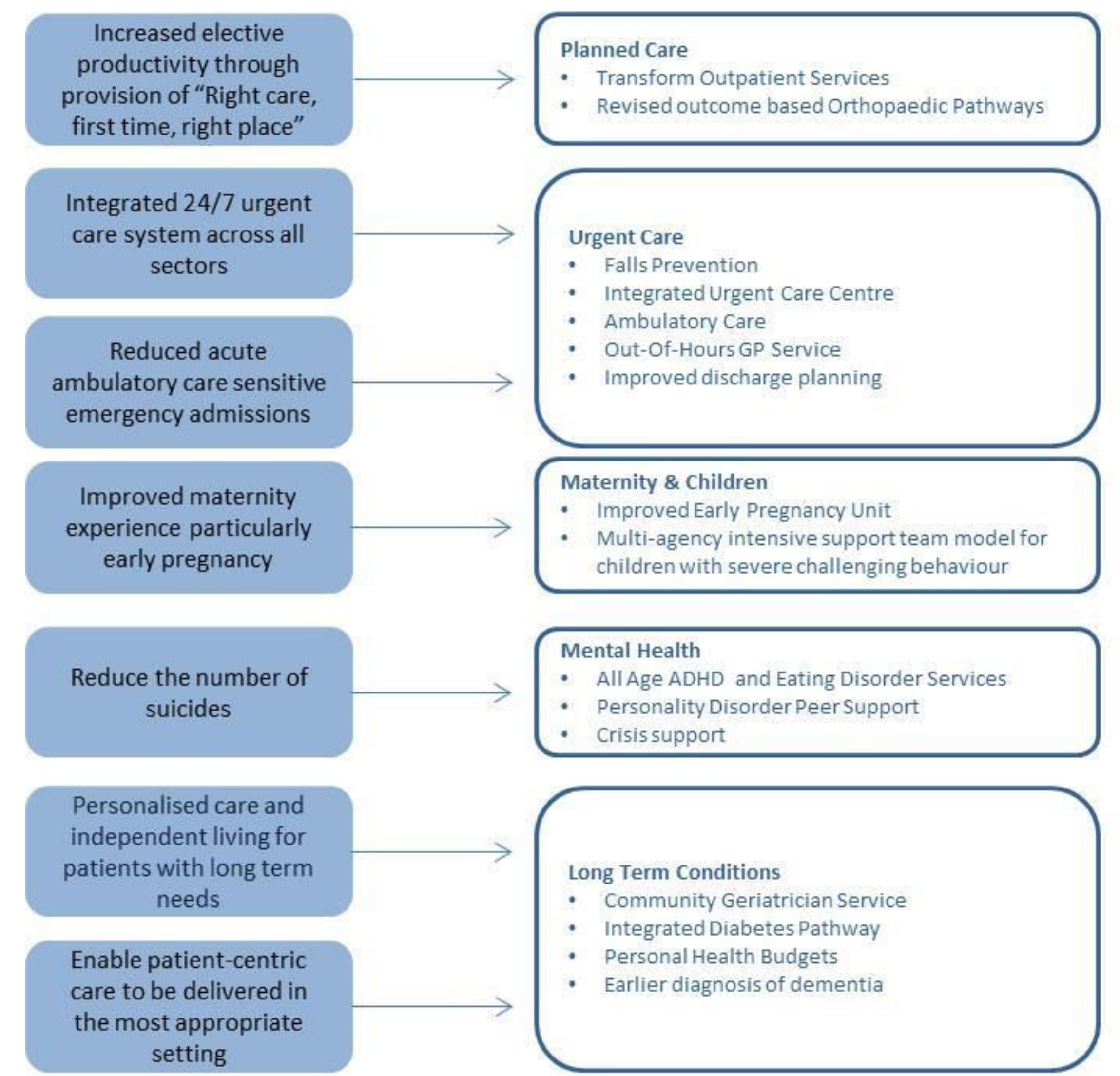
We want a health economy that is sustainable for the future with primary and community care services working closer together, along with voluntary organisations and other independent sector organisations able to forge common goals for improving the health and well-being of local people and communities



Governance

- Kent Health and Wellbeing Board
- Programme Boards for Urgent and Planned Care
- Corporate Governance Structure
- Monthly review of programme or project progress at CCG Clinical Strategy and Investment Committee meetings
- Identified Leads CCG for specific projects

Success Criteria

- Primary and community care services will work closer together, along with voluntary organisations and other independent sector organisations reducing the time people currently spend waiting for a service.
- We will see less acute admissions and reduced length of stay.
- We will see more people remaining in their own homes and a reduction in the proportion of the population living in care homes.
- More people will be living independently following reablement/intermediate care

Values and Principles

- People are supported to live in their own homes or communities.
- We have a workforce with skills to deliver integrated care.
- Our integrated teams respond rapidly to people at risk of admission
- Carers are be supported and have access to services as appropriate.
- We will have systematised self-care so that people can to manage their own health and social care needs

About the CCG

Background and Context
Health Profile
Working Together
Health and Wellbeing Board

Background and Context

The Health and Social Care Act (2012) gave more power and responsibility to front-line professionals to commission safe, high-quality and compassionate care and to make decisions about the use of resources through Clinical Commissioning Groups. This comes at a time when, across England, the NHS must continue its QIPP programme to deliver £30bn of savings by 2020. We have started to build a track record of delivering change and have established a strong partnership approach in our local health and social care economy

This means that the next five years (2014-19) will be another challenging period for the NHS and your local CCG who will be supporting the delivery of the improvements and standards set out in the NHS Constitution, the NHS Mandate and the NHS Outcomes Framework.

In support of the 2014/19 planning and delivery process the CCG has produced this document to:

- Provide the context in which the CCG operates
- Communicate our plan to our patients and local population
- Mobilise commissioners, providers, partners, voluntary organisations and members around a common set of objectives and plans
- Provide assurance on how we will deliver what the CCG aims to achieve

The document and content within it is generated from, amongst other inputs, demographic information, performance data, national guidance and recent health inquiries. However, one of our most important sources of information is that which our patients and public provide us directly. We have used a number of stakeholder events, feedback given to our practices and our formalised patient participation groups to inform this plan and we will continue to refine and update our plans based on what our patients and public are telling us.

We believe that these steps will deliver ambitious improvements to the local NHS in line with the needs of local people as set out in our Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy as well as against the 5 Domains of the NHS Outcomes Framework:

Domain	
Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring that people have a positive experience of care
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm

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This plan is owned and sponsored by our governing body and member practices and represents our commissioning and delivery intentions.

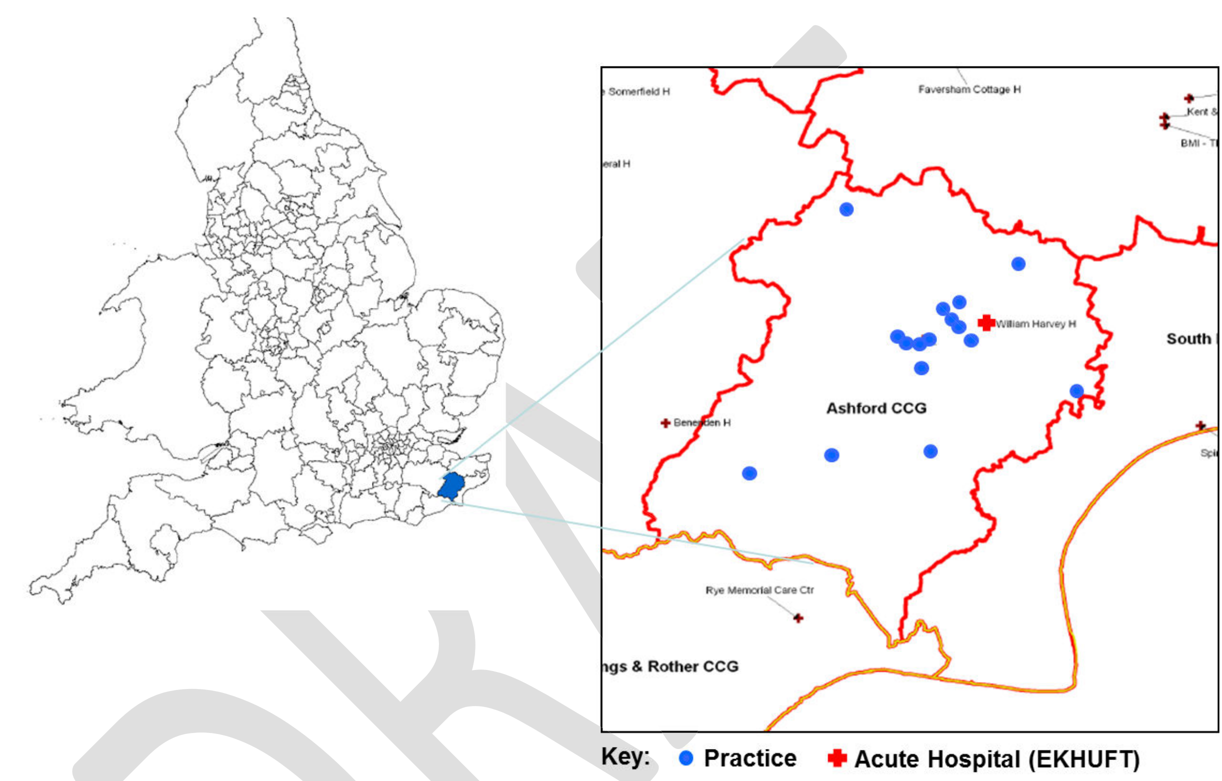
Joint Strategic Needs Assessment

SUMMARY – OUR POPULATION HEALTH CHALLENGES	
Inequalities	The average life expectancy in Ashford is 83.4 years for females compared to males at 80.7 The lowest life expectancy figures are in the wards of St Michaels and Weald East and Weald North, with the highest figures in Park Farm North and Washford. The difference in the number of years between the highest and lowest life expectancy at birth is 15.7 years.
Population	The resident population of Ashford comprises approximately 120,116 (ONS, mid-year estimates 2012). In comparison to England, Ashford has a considerably smaller proportion of 20 to 34 year olds and a larger proportion of 40-49 and 60+ year olds. The distribution of the Ashford CCG population means that there are lower numbers of young people and larger numbers in the age ranges between 40 and 69. This type of age structure is often referred to as the “ageing population time bomb”. The shift in age structure towards older people with a simultaneous reduction in working-aged adults has implications on future pensions, provision of health and social care and economic growth.
Cause of Death	Circulatory Disease is now the main cause of death (34% of deaths), followed by Cancer (26%), and respiratory disease (15%).
Lifestyles	Smoking leads to cardiovascular disease, respiratory disease and cancer. NICE highlight that smoking is the “leading cause of health inequalities in the UK today and the principal reason for inequalities in death rates between rich and poor.” In Ashford, almost 35% of people in the most deprived wards are smokers which compares to less than 20% in more affluent wards. The prevalence of adult obesity has been mapped across electoral wards in Ashford. The wards with the highest prevalence (estimated to be between 26% and 30%) are Beaver, Stanhope, Norman and Aylesford Green. All these four wards are found in the south of Ashford town and have a relatively high level of deprivation.
Long-Term Conditions	There will be increasing numbers of people who have long-term conditions and this will further increase with the ageing population, particularly the likelihood of having more than two conditions.
Mental health	Age specific adult mental health rates are seen to correlate with areas of deprivation, with high rates seen in Stanhope, Beaver, Norman, South Willesborough, Aylesford Green and Victoria Wards. Lowest rates are seem in Weald North.
Dementia	Dementia - with the increasing age of the population the number of dementia cases will rise; prevalence increases particularly in the population older than 65.

The information in this section provides the geographical, socio-economical, regulatory and financial context in which NHS Ashford CCG will commission services in 2013/14. It directly informs what NHS Ashford CCG will prioritise within the context of limited resources.

Location

The geographical area covered by NHS Ashford Clinical Commissioning Group is fully coterminous with Ashford Borough Council:



Key High-Level Data

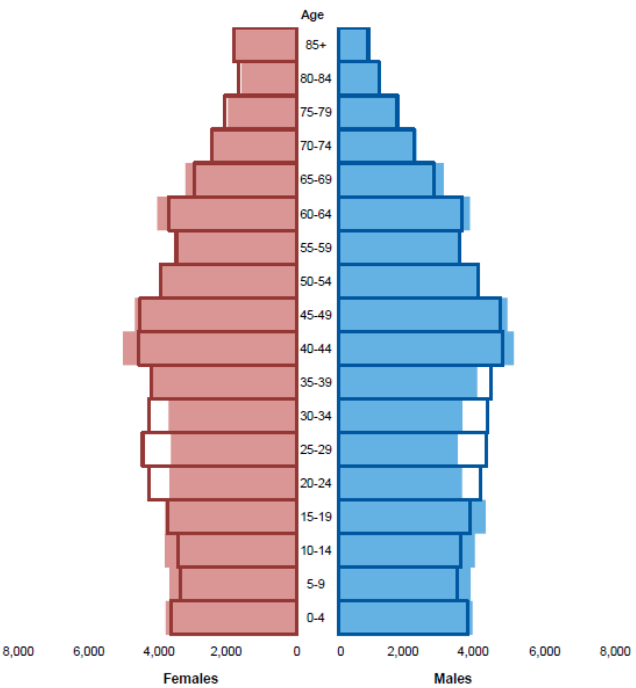
Below are some high-level data points which are relevant to this CCG and its commissioning activity:

Data Point	Data
Registered patient population:	122,000
Number of GP practices:	15
Neighbouring CCGs	4
Acute Hospital	1
Commissioning budget:	£134.5M

High-level demographic information

The chart below shows the number of people registered with this CCG's practices by sex and 5-year age band. The darker outline shows the profile of England's population.

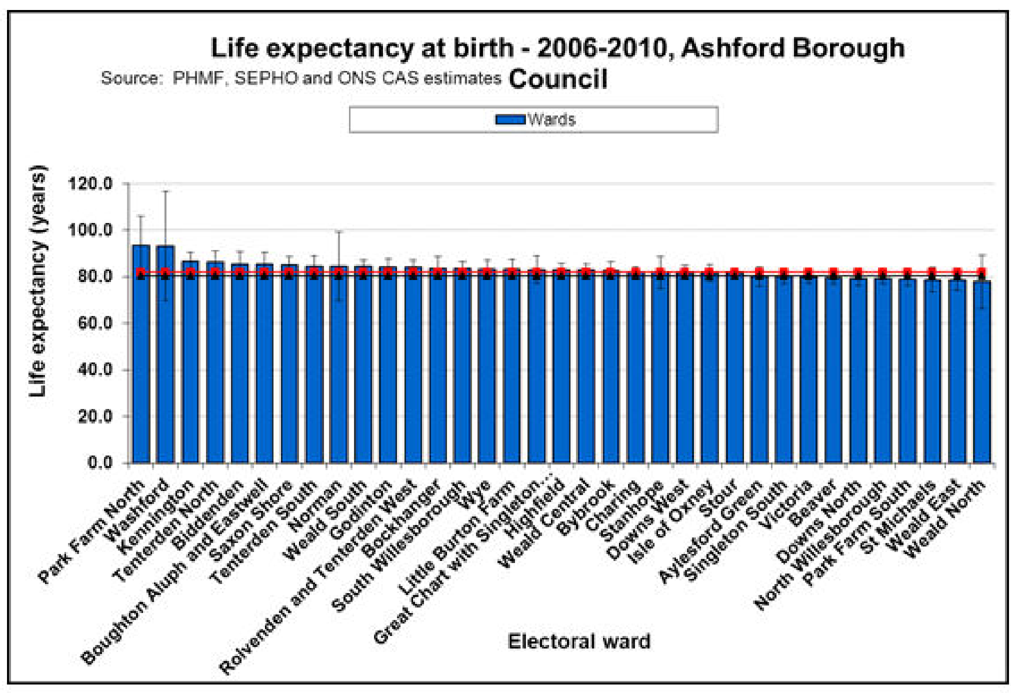
Compared to the rest of England, Ashford has a higher than average population between the ages of 5-14, 40-49 and 60-69. Alongside the importance of health promotion and prevention for the younger generation ACCG must also plan for a 16% rise in 65+ age groups.



More generally, the town of Ashford is set to double in size over the next 25 years. As new housing developments emerge, ACCG will work with Ashford Borough Council to ensure that these new populations benefit from high quality, local integrated health and social care services.

Life Expectancy

Compared to the eastern and coastal Kent average (the line in black), the average life expectancy for Ashford (the line in red) is high i.e. 80 vs 82:

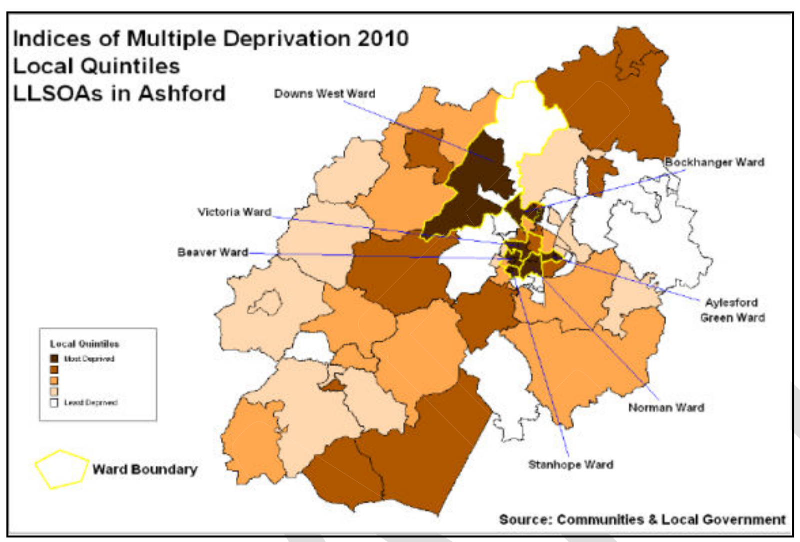


However, whilst ACCG is proud of its current health outcomes it recognises it will need to work hard to maintain the health status and clinical effectiveness of its population particularly with the

expected growth in the 65+ population. Additionally, whilst the life expectancy is higher than local averages, Ashford also contains the biggest variation in life expectancy across its wards in Kent and Medway. All of our project and programmes must therefore include, as an objective, the targeting of those communities which do not benefit from the outcomes that the majority of our population currently experience. This includes educative elements across all of our projects and programmes.

Deprivation

Whilst the ACCG benefits from relatively good health outcomes and life expectancy it does include some relatively deprived wards denoted by the dark brown areas on the map below.



The 20% most deprived areas of Ashford are in the central and southern parts of the town (Stanhope, Aylesford Green, Norman, and Beaver), although the village of Hothfield in the Downs West ward and Bockhanger were also in the worst quintile for deprivation.

Inequalities in health are primarily a socio-economic relationship. The poorer people are, the greater the likelihood of early onset disability and chronic disease and shorter life span. In contrast, those who are of high status have expectations of a much greater disability free life span and of a good old age.

People with low socio-economic status are at greater risk of behaviours causing ill health. They will have higher smoking rates, have a poorer diet, have less opportunity to take part in social activities, have poor mental health. Whilst it is undeniable that individual behaviour is a significant driver of ill health, it is wrong to attribute all causes of premature poor health and early death to personal behaviour. If such behaviour was eliminated, people with the lowest socio-economic status would certainly live longer, but would continue to die prematurely relative to the mainstream society.

Addressing health inequalities as a strategic response requires CCGs to commit to partnership working with other statutory agencies whose capacity to address the wider determinants of health is core to their purpose. Accordingly ACCG must support the actions of Public Health working with local authorities to address the root causes of disadvantage through the Kent Health Inequalities Strategy and more locally through the work of Ashford's local Health and Wellbeing Board. All pathways must include education as a key step to mitigate the risk of individual's behaviours affecting their health.

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Working across CCGs

In some instances, CCGs need to work together to create a bigger footprint as a "unit of planning" in order to effectively commission some of the services for which they are responsible, but also to share risk safely, transfer skills and secure commissioning support. The CCGs in east Kent have agreed to collaborate in a range of areas where working together will;

- **Support Clinical Improvement –** through consistent, evidence based pathway development and effective and consistent performance management
- **Drive greater efficiency –** by ensuring leverage with providers; keeping transaction costs low; and sharing (potentially scarce) expertise and capacity
- **Provide greater resilience –** by managing financial risks together; improving risk management and sustaining more effective business continuity arrangements

A range of initiatives have been agreed which will ensure that CCGs are able to work together across east Kent to both deliver transformation in areas where a greater critical mass must be achieved to make change sustainable and where wider approaches are key levers to improvements in individual CCGs.

As illustrated in the diagram below the projects will be planned and delivered at either an East Kent-level, as joint projects with Canterbury and Coastal CCG or as a local project only to serve Ashford CCG's needs:

Ashford Health and Wellbeing Board

The Ashford Health and Wellbeing Board brings together the statutory and voluntary organisations which are involved in healthcare, social care and public health to champion the delivery of better, more efficient and integrated services in the area. It is a forum where partners can share their respective objectives, performance requirements and proposed plans with a view to identifying areas of mutual interest and support. Although formally a sub-committee of the Kent board, the local board is closer to local citizens/patients and has a more detailed insight into their needs and preferences which therefore complements the county-wide overview and is able to inform and influence County priorities and actions

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

System Vision

Our Vision
Community Based Care
Primary Care
Urgent Care
Long Term Conditions
Children and Young People
Planned Care
Mental Health
Working with Social Care – The Better Care Fund
Centres of Excellence
Cancer Services
Cardiovascular

Our Vision

Our vision and goals within our plan have not been developed in isolation and reflect the broader strategic context in which we operate as a statutory body. There are a number of external factors and influences, plus national requirements on which we are mandated to deliver. These can be broadly encapsulated in the following analysis.

Political	Economic
• National policy implementation • Changing NHS landscape • Secretary of States mandate • Public Health Transition • Legislative changes • Regulatory bodies • Market development • NHS England • Healthwatch • Health & Wellbeing Board • Professional preferences and resistance	• Financial sustainability • Financial Accountability • QIPP Challenge • Financial climate • Patient choice • NHS Cooperation and Competition • Foundation Trust pipeline
Social	**Technological**
• Health inequalities • Deprivation factors • Equity of Access • Lifestyle choices • Ethical decisions • Protected characteristics	• NICE guidance • Evidence based decisions • IMT providers and suppliers • Emerging technology • Introduction of new drugs • Use of social media and internet

ACCG worked on our mission, vision and strategic priorities as it went through its authorisation process to become a statutory commissioning body. They were arrived at through consultation with our patients, members and Governing Body. They are also aligned to, and informed by, the Kent Health and Wellbeing Strategy.

"A Healthcare Partnership to be proud of"

To improve the health and well-being of the population of Ashford by successfully engaging local GPs to lead our work and working in partnership with patients, Ashford Borough Council, Public Health and other key stakeholders, to develop plans to improve outcomes.

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Community Based Care

There is no lack of ambition to deliver the right outcomes for our patients and the wider population but we recognise the unprecedented scale of the challenge that faces the NHS nationally and locally. However, we believe that our developing plans give us the building blocks for a sustainable health economy in east Kent.

We have sufficient evidence for us to adopt radical change across the local health economy, drive improvements in medicines use and by working in partnership with our members, improve Primary Care infrastructure, workforce and services for patients.

We are confident that we are doing the right things for both patient care and for the delivery of a sustainable, viable and vibrant health economy, where we will actively seek and support opportunities for integrated care and integration between health and social care.

We are convinced that maintaining and driving the types of improvement to the quality of services set out in this plan will drive the productivity which delivers long term sustainability.

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

Our patients and carers should expect a high quality, compassionate, safe and personal service based around their needs, present and future. They should be enabled to take ownership of their health and social care and with that accept responsibility for their health behaviour and use of health and social care services.

The focus on quality must be our first consideration. Patients should not come to harm as a result of accessing and receiving care and we will commission services which deliver the best possible clinical outcomes within the available resources.

As part of this, we will move towards affordable 24/7 services, which are integrated across health service providers with voluntary and social services incorporated into community-based contracts. To enable this we will use new contract mechanisms (e.g.: alliance, lead provider), for defined geographical locations and which have clear, explicit, measurable outcomes for defined cohorts of patients

Primary Care

Whilst NHS England have responsibility for commissioning GP services through the national GMS and PMS contracts, general practice delivers significantly more services than ten years ago and this trend will continue with a proportion of this additional work transferred from traditional community or hospital bases. Excellent General Practice is core to the delivery of Ashford CCGs strategic vision.

In order for this is be possible a number of changes in the way which general practice operates will need to occur. NHS England has set out a call to action to staff, public and politicians to help the NHS meet future demands, including those faced by GPs. As a CCG we are supporting our practices as they endeavour to reconfigure their approach in response to this call.

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

Urgent Care

People using services and their carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need. Many patients, through better preventative care, should not need to access urgent care services. In addition patients often experience issues in identifying the best urgent care option to suit their needs. Furthermore, once they access urgent care services they may find it difficult to be discharged quickly and effectively due to sub-optimal integration of care services.

Traditional models of Urgent Care services have often been described as being highly fragmented and generate confusion among patients about how and when to access care. The Kings Fund report "Transforming our health care system" identifies a number of common issues across Urgent Care:

- Patients are frequently admitted to Hospital when it is not clinically justified because of a lack of alternative available options
- Poor sharing of information as patients move between different providers is a cause of significant failures of care (Ghandi, 2005)
- The growth of new forms of Urgent Care, such as walk in centres has failed to reduce A&E attendances (Cooke et al, 2004)
- New forms of urgent care have also failed to reduce Emergency Admissions, which continue to grow, rising by 5% between 2008/9 and 2011/12 (Department of Health 2011d; 2012).

An activity analysis of the patients who attend A&E has suggested locally that 38% of patients attend A&E present with Primary Care conditions. Provider organisations across East Kent recognise that patients attend A&E for a variety of reasons including:

- Health care Services are fragmented and difficult to understand
- Services in and out of hours offer different levels of cover
- A&E is recognised as a one stop shop service

It has long been recognised within east Kent that integrating services will reduce the amount of duplication and improve speed and ease of access for patients. Following the integration and roll out of several significant initiatives within the area, the east Kent health economy is proposing a fully integrated Urgent Care service. This has been designed by all providers in East Kent as one project.

The proposed model will bring services together to ensure that care will achieve a number of goals including a rapid multi-disciplinary assessment with rapid access to a range of services that will ensure that patients are managed seamlessly and are better supported to cope within their local community. This service will prevent a significant cohort of patients from having to attend hospital , improve recovery following an event and ensure that patients retain independence.

It will achieve this by providing rapid access to key health economy services which include:

- General Practitioners
- Community Support Services
- Social Services
- Psychiatric Services
- Secondary Care Consultants (including Geriatricians)

A variety of apparently isolated service developments are in fact drawn together leading to the colocation of a number of key services within hubs across East Kent under a single command and control structure to create a multi-disciplinary team working as an Integrated Urgent Care Centre (IUCC).

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These centres are about the colocation of services around specific buildings to provide an immediate multi-disciplinary response to self-presenting patients and also the coordination of a number of services which together form east Kent response to increasing demands. Our collective vision provides rapid access to care for a greater cohort of patients complimented with enhanced local support services for patients on a 24/7 basis. This will significantly reduce conveyances to hospital and provide enhanced care and support for patients to help them recover in their own home or place of residence.

Long Term Conditions

Our approach to the management of patients with long term health and social needs, also links with our vision for urgent care and our community based approach. The number of patients with long term needs is expected to rise due to an ageing population and certain lifestyle choices that people make.

We will continue our current approach of identifying patients requiring additional support through risk profiling. Risk stratification tools are utilised to support the identification of patients at risk and GPs are working locally with community nurses and members of the integrated health and social care teams (locally referred to as Cluster Teams) to ensure Management Care Plans are developed to support and educate patients to manage their own conditions.

Previously, a patient may have received visits from a number of community teams and GPs would have to refer patients to a variety of organisations depending on the patients' needs. The approach means patients only have to tell their health story once, and GPs only need to refer a patient to one team through a health and social care coordinator. As previously stated a key component of this is to ensure that the cluster teams are based in and around towns in the area, and aim to provide a more integrated health and social care service and work closely with the patient's GP to ensure patients receive the right services and support quickly to avoid an unnecessary admission to hospital.

Children and Young People

As our health profile demonstrates, Ashford CCG will see significant growth in the child population during the next 7 years, however some of the largest increases will fall within the 0-4 age range, creating significant demands on paediatric services.

National research states that the use of A&E departments by children is often not for emergency care but the default position for concerned parents, or just sometimes the nearest centre of care. In essence this demonstrates a need for us to improve access to paediatric services that can be provided in primary care, children's centres and other community settings to reduce unnecessary and avoidable admissions to Secondary Care and to ensure that parents are supported within their own communities.

We will ensure that vertical and horizontal integration of all paediatric services, including health, social and voluntary sectors, to reduce inequalities in care, narrow the gaps, avoid duplication and reduce clinical variation. This approach is supported by national research and best practice in relation to developing a whole system approach to improving emergency and urgent care for children, young people and their families.

The current system within Ashford CCG area is disjointed and parent carers have also stated that it is confusing and difficult to navigate. There are a range of access points within the health system for children, young people and their families including GP practice, minor injuries, A&E, Short Stay Paediatric Assessment Unit and out of hours, community children's nursing service, health visiting service and school nursing service. Through Ashford CCG patient and public engagement events there is also a demand to access services closer to home in the community, rather than always in a

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hospital setting. A new whole system approach between providers of healthcare (and for those with more complex needs providers of health, education and social care) is required to ensure services are more streamlined and provide seamless care which will lead to better outcomes.

We will align our paediatric transformation programme, and whole system approach for urgent and emergency care for children and young people, with the wider transformation programmes outlined above to maximise impact and promote effective transition to adult services.

Planned Care

Referral rates from GPs have reduced in the past number of years, with waiting times also consistently reducing. In order to ensure that waiting times reduction is maintained, as demands increase, we need to continue to consider alternative approaches to GP referral.

With this in mind analysis has shown that a number of patients are discharged from secondary care immediately following their first outpatient appointment. One of the reasons for this is that the GP is seeking additional advice on the management of a patient's condition, and for a number of these patients attending the outpatient department offers little real value.

GP's and other health professionals who refer patients to acute services will have access to acute care consultants via a mechanism that will be fast and easy to access by all involved. Currently there are schemes in place, and have been piloted previously, that utilise either Choose & Book (eBooking) or secure email (Nhs.net)

The objective is to formulate the exact mechanism which is acceptable to all uses and will provide outcomes of appropriate referral, first time for patients which will in turn also result in reduced referrals as some patients disease management will be better undertaken in primary/community care

Our patients also tell us that they are inconvenienced by a system which requires them to attend for outpatients, then separately for diagnostics, then again for follow-up. Not only is this inconvenience for them but it's not effective use of resources. Repeated visits are often clinically unnecessary and lead to increased anxiety for patients. In addition the capacity used leads to delays in the system for the delivery of 18 weeks.

Nationally 37 million follow up appointments where patients are asked to return to hospital to have their progress checked, to undergo tests, or to get test results. 75% of all out patient 'Did Not Attends' (DNA) are for follow-up appointments. The follow-up DNA rate varies between specialties and locations but a range of 10-40% is common. There are more than four million follow-up DNA's per annum, which cost the NHS more than £100 million a year.

With waiting times for diagnostics dropping significantly over the past few years, there is no longer the requirement for patients to attend outpatients, return for a diagnostic test and then return to outpatients for the results and treatment plan.

One Stop Services facilitate the assessment, diagnosis and commencement of treatment plan within one visit. Across our local health providers there are limited services where a one stop approach is undertaken. This results in the need for patients to make several visits to the provider before they commence treatment.

In order to ensure that providers are able to deliver one stop services it will be necessary to support the redesign of outpatient services particularly in relation to provision of same day diagnostics. Therefore it is anticipated that this project will take at least 15 months from commencement to completion across all specialties

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Whilst East Kent Hospitals University NHS Foundation Trust undertake the majority of outpatient services the project will require working with all providers to ensure that there is consistent approach and therefore equity of care. The CCG is committed to working with the organisations who provide planned care services to improve care and to look at different ways of ensuring high quality services that are centred on the patient and are available as close to their home as possible.

Mental Health

The majority of people with mental health needs in the Ashford CCG area are looked after by their GP. Where patients need more intensive support, they are predominantly treated in services provided by Kent and Medway NHS and Social Care Partnership Trust (KMPT).

We will continue to promote good mental health and wellbeing in the community, reduce the number of people who get common mental health problems, and lessen the stigma and discrimination associated with mental ill-health. We will ensure that prevention is targeted at those at higher risk but also that the right services are there when people need them.

Public services, the voluntary sector, and the independent sector will work together to improve mental health and wellbeing. Services will be personalised, will involve service users and their families in equal partnership, will aid recovery and will help people to reintegrate into their communities. They will promote the best care and promote accessible, supportive and empowering relationships. As with the CCG's underlying principle, wherever possible, services will be community-based and close to where people live.

We will improve the life expectancy and the physical health of those with severe mental illness, and improve the recognition of mental health needs in the treatment of all those with physical conditions and disabilities. We will reduce the number of suicides. We will ensure that all people with a significant mental health concern, or their carers, can access a local crisis response service at any time and an urgent response within 24 hours. We will ensure that all people using services are offered a service personal to them, giving them more choice and control. We will deliver better recovery outcomes for more people using services with care at home as the norm. We will ensure that more people with both mental health needs and drug and/or alcohol dependency (dual diagnosis) are receiving an effective service.

Working with Social Care – The Better Care Fund

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

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

- Together we will design and commission new systems and models of care that ensures the financial sustainability of health and social care services in Kent. These services will give people every opportunity to receive personalised care at, or closer to home to avoid hospital and care home admissions.
- We will use an integrated commissioning approach to buy integrated health and social care services where this makes sense.

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- The Kent Health and Wellbeing Board will be an established systems leader, supported by clinical co-design and strong links to innovation, evaluation and research networks. Integrated Commissioning will be achieving the shift from spend and activity in acute and residential care to community services, underpinned by JSNA, Year of Care financial model and risk stratification. We will have a locally agreed tariff system across health and social care commissioning.

- A proactive model of 24/7 community based care, with fully integrated multi-disciplinary teams across acute and community services with primary care playing a key co-ordination role. The community / primary / secondary care interfaces will become integrated.

- We will have a workforce fit for purpose to deliver integrated health and social care services. To have this, we need to start planning now and deliver training right across health, social care and voluntary sectors. We will also need to ensure that we link in with our partners within education

- An IT integration platform will enable clinicians and others involved in someone's care, including the person themselves, to view and input information so that care records are joined up and seamless. We will have overcome information governance issues. Patient held records and shared care plans will be commonplace.

- We will systematise self-care/self-management through assistive technologies, care navigation, the development of Dementia Friendly Communities and other support provided by the voluntary sector.

- New kinds of services that bridge current silos of working where health and social care staff can "follow" the citizen, providing the right care in the right place.

The Kent Health and Wellbeing Strategy has identified key performance measures, these are currently being updated and will include measures for integration. In addition there are local measures in place against existing projects which will support the BCF projects. As a Pioneer Kent will be undertaking a baseline assessment and delivering against the performance measures set out by the Programme. These will be combined with the metrics as outlined in the Better Care Fund plan to produce a robust performance and outcomes framework.

Centres of Excellence

To be completed with detail from NHS England Specialised Commissioning

Cancer Services

To be completed with input from NHS England Specialised Commissioning

Cardiovascular

To be completed with input from NHS England Specialised Commissioning

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Delivering Harm Free Care

Berwick, Francis and Winterbourne
Quality Monitoring
Hospital Acquired Infections
Never Events
Whistleblowing
Safeguarding
Patient Experience
Additional Quality Priorities

Berwick, Francis and Winterbourne Reviews

We will ensure that the recommendations from the Winterbourne View, Berwick and Francis reports are implemented within all local health providers and for ourselves as commissioners. We will have an additional focus on monitoring safer staffing levels throughout provider organisations and through contractual processes.

Quality Monitoring

We will work with our providers and use the contractual levers available to ensure that patients are treated in a safe environment, with an emphasis on zero tolerance of avoidable harm and ensuring that nursing care is of the highest standard;

We will ensure that systems are in place to monitor potential breaches of safety and improvements against the NHS Safety Thermometer, particularly in relation to pressure area care. We will ensure that provider organisations comply with national guidance in relation to the reporting of incidents to ensure that system wide learning can then be undertaken.

Hospital Acquired Infections

We will continue to reduce the number of Health Care Associated Infections (HCAIs) through the implementation of local action plans and we remain committed to a zero tolerance approach. We will employ expert resource in this field to bridge the gap between primary and secondary care and ensure that learning can be embedded throughout the health and social care sector.

Never Events

We will encourage a culture of transparency, openness and candour across the health system, to ensure that staff, patients and carers feel safe and secure when raising concerns and that we learn from patient safety incidents and 'never events' to prevent them from happening again.

Safeguarding

We will continue to work closely with our local authority partners to continually improve the safeguarding of children and vulnerable adults and to continue to be active members of the local safeguarding boards

We will continue to maximise opportunities for greater coordination and integration of adult and children's safeguarding arrangements

We will work with NHS England to ensure the recruitment of GP leads for safeguarding

We will work collaboratively to ensure the sharing and implementation of learning from serious case reviews and audits across the health community

We will continue to ensure that the continuing healthcare service is compliant with all national standards whilst retaining a focus on the quality of care being delivered.

Patient Experience

We will work with providers to put mechanisms in place to systematically gather real-time patient and carer feedback including ensuring the Friends and Family Test is in place across all providers.

We will continue to use real-time feedback from our patients and carers and build on this to assess the experience of people who receive care and treatment from a range of providers in a coordinated care package across health and social care.

Additional Quality Priorities

- The continued elimination of mixed sex accommodation and increased dignity for patients

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- full implementation of the NICE quality standards and the implementation of root cause analysis of any Venous Thromboembolism (VTE) occurrences
- reducing harm to patients, particularly pressure ulcers
- improve safety within maternity services

Performance

Contractual and Performance Management
Provider Development
CQUIN payments
Care Quality Commission
Friends and Family Test
Infection Control
Mixed Sex Accommodation
'Never Events'
Serious Untoward Incidents
NHS Constitution Standards
Waiting Times

Contractual and Performance Management

There has been an increased focus on provider performance management in 2013/14 and this will continue into 2014/16.

Our approach to management of the Hospital contract will focus around improving patient outcomes whilst achieving National Targets – for example 18 and 52 week referral to treatment times and ensuring compliance with all cancer waiting standards.

For community services we are one year through a two year contract and we will focus on establishing service lines within the scope of the vast community contract which can be independently monitored as part of the contracting process. For example, establishing a baseline for community nursing services and ensuring that for the money we spend we are getting enough of the right nursing services for our population.

The Mental Health contract will be moving from a Kent Wide commissioning arrangement to an East Kent contract to enable us to focus more closely on delivery of appropriate care for patients within this area. There will also be progress towards payment by results tariffs for Mental Health over the coming year moving us from historic block arrangements to a cost per case mechanism for payment.

Provider Development

There are 130 contracts which the CCG is a party too and we are undertaking a plan for systematically ensuring all of these are up to date and are properly monitored in relation to outcomes for patients but also to ensure appropriate amounts of activity are undertaken for the best possible value. The majority of the contracts are small but important services which contribute to the overall strategy outlined in this document of ensuring we can provide the most appropriate care setting.

The overarching approach to developing contracts for 2014-15 the CCG has taken account of:

- Improvement in Care of Patients especially the frail elderly,
- Avoidance of duplication and achievement of timeliness of care,
- The need to work within the funding available.

CQUIN payments

All NHS contracts must include a Commissioning for Quality and Innovation (CQUIN) payment which is a payment of 2.5% of contract value over the contract baseline which is payable as an incentive for innovative working.

For 2014-15 the CCG has identified areas to start making the change. It is likely that quality payments will be made to providers through the strategic use of the CQUIN arrangements covering the following areas:

- Chronic Obstructive Pulmonary Disorders (COPD)
- Diabetes
- Heart Failure
- Dementia

These quality payments will be linked to whole system outcome and process measures wherever possible. This will require providers to work together to drive change. Quality payments will not be made where one provider is successful but overall patient care does not improve. So we will attempt to put the same measurements into all contracts for the next year to ensure that the Hospital works with Community services or that Mental Health and Acute services are aligned and properly incentivised to deliver the best outcomes for the patients.

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Care Quality Commission

The CQC has launched their new Intelligent Monitoring report. This replaces the Quality Risk Profile (QRP). The new model monitors a range of key indicators about NHS acute and specialist hospitals. The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements but will be backed up by inspection. Each indicator has been analysed to identify two possible levels of risk ("risk" and "elevated risk").

East Kent Hospitals University NHS Foundation Trust (EKHUFT)were rated as a Band 3 organisation (the bands are 1-6 with 1 being the highest risk). There were four areas assessed at EKHUFT as showing an ‘elevated’ risk. These were:

- Mortality following hemi-arthroplasty repair of a fractured neck of femur - HMSR 125
- Patient experience and functional outcome following elective knee arthroplasty (PROMs)
- Response rate against the Friends and Family test
- Educational concerns reported to the CQC by the General Medical Council (GMC)

The CQC has subsequently written to EKHUFT with details of their forthcoming inspection. The CQC’s inspection will start on 3 March 2014. The core site visit is likely to last between two and five days. Inspections take around two weeks in total, but this includes the CQC’s team preparation day and any follow up work they will need to do. Within this ten day envelope, the CQC will spend around two to three days on site with a large team inspecting the eight key service areas. The CQC may add services to this depending on their assessment of risk and the number of acute sites. The CQC will be allocating leads to the inspection teams who will be the primary CQC contacts over the weeks running up to the inspection.

Friends and Family Test

The Friends and Family Test (FFT) aims to provide a simple, headline metric which, when combined with follow-up questions, can be used to drive cultural change and continuous improvements in the quality of the care received by NHS patients. Nationally, Trusts are measured using the Net Promoter Score (NPS) where a score of approximately 50 is deemed good.

EKHUFT’s NPS was 64 in October, thus demonstrating overall satisfaction with Trust services. The company, ‘iWantGreatCare’, which reports FFT data on behalf of EKHUFT have converted the NPS into a "star score" value (ranging from 0 to 5) thus making the interpretation of FFT results easier. The star score is calculated using an arithmetic mean, so a ward that scores 4 stars has an overall average rating of "likely" to be recommended. EKHUFT score for October was 4.6 stars out of 5 stars.

EKHUFT is achieving the overall response rate for F&F with inpatients but not A&E. The use of texting within A&E indicates improved response rates. Early indications for maternity, suggests low response rates. The recovery plan continues to be delivered, overseen by the Task and Finish Group.

Infection Control

There was one Trust assigned MRSA case in November which brings the YTD total to 7. There was one case of C.difficile (post 72 hours), during November 2013 bringing the YTD total to 36 against a year end trajectory of 29 cases. A comprehensive recovery plan is in place to ensure EKHUFT is providing adequate prevention, screening and appropriate treatment at all times, particularly around identifying patients requiring a stool specimen on admission. Public Health England has been invited to undertake an external review of the C. difficile control programme and this took place on 20 Nov-13.

Enhanced vigilance is being applied to infection prevention and control procedures given the current Trust performance against Department of Health targets. The Infection Prevention and Control Team (IPCT) use routine surveillance and the findings of Root Cause Analysis (RCA) and Post Infection Review meetings for MRSA bacteraemia and C.difficile cases to inform subsequent actions in providing support and challenge to wards and departments. Particular focus currently relates to antibiotic prescribing which is being audited. Clinical reviews of all inpatients with MRSA are being undertaken by the IPCT, which includes checking compliance with Trust policies in relation to the patient's management. The recently revised 'Diarrhoea Assessment Tool' has been introduced and is being applied in the management of all cases of diarrhoea. In addition enhanced surveillance of cleanliness standards in each of the sites is in progress. Site based briefings have taken place to emphasis adherence to policy.

Mandatory training performance for Infection Control is 85.2% Trust wide for October, against a 95% target. This remains a steady percentage, although the Divisions are working to action plans to improve the percentage. To date these action plans have not been received from EKHUFT.

Mixed Sex Accommodation

A performance notice has been issued to EKHUFT confirming that any previous agreement with the PCTs around the reporting of mixed sex accommodation breaches in CDU is no longer recognised, and that the national guidance clearly states that CDU is not exempt. In October 2013, there were 7 mixed sex breaches at WHH, 6 of which occurred in CDU, and 1 in the Richard Stevens Unit (RSU), affecting a total of 43 patients. None of these were reported by EKHUFT nationally to NHS England on the Unify2 system.

'Never Events'

One new Never Event has been reported in November 2013 for EKHUFT, this relates to a NG tube being misplaced which resulted in the patient death a few days later. Investigation is currently in progress.

EKHUFT have 4 on-going never events. These relate to 1 wrong site surgery, 1 incorrect chest aspiration, 1 retained swab post C-section, and 1 misplaced NG tube.

Serious Untoward Incidents

East Kent Hospitals University NHS Trust

EKHUFT has reported 3 Serious Incidents for the month of November, 2 at Kent and Canterbury, and 1 at William Harvey Hospital. All 3 have been categorised as Unexpected deaths. 1 was a mis-placed NG tube, and as such classified as a Never Event, one was a post-op Aortic Aneurysm patient, and 1 was a fall resulting in a head injury which led to the patient's death. This fall occurred in October, but was not reported until November, and is believed to relate to the severe harm fall reported in the October board paper by EKHUFT. There was also a lack of clarity as it was categorised as an unexpected death, rather than a Slip/Trip of fall, which was the cause of the head injury. EKHUFT is awaiting the decision on the primary cause of death from the Coroner, and further information will be provided when the Root cause and analysis are received.

2 Grade 2 serious incidents were reported in November 2013, the 72 hour reports were received in deadline maintaining 100% compliance.

Kent Community Health NHS Trust

During the month of November 2013, 4 new SIs were reported by KCHT. This consisted of 1 allegation against a HC non-professional, 2 confidential information leaks, and 1 drug incident.

One grade 2 serious incident has been reported in November 2013, a 72 hour report has been received in deadline maintaining 100% compliance as per the previous month.

Kent and Medway NHS Partnership Trust

During the month of November 2013 there were 6 SIs reported by KMPT , which is a slight decrease from the 7 reported in October, and a clear decrease from the 10 in September, 15 in August and 24 in July.

Overall, the majority of on-going KMPT serious incidents occur in patients' homes and public places. These two locations account for 57% of the on-going SIs for KMPT i.e. 25 of the 44 on-going serious incidents reported by the Trust.

Suicide by Outpatient (in receipt) is the highest category of on-going SIs for KMPT, with 34% of the total falling into this category. There is no apparent trend with regards to the area of Kent or team the clients were being treated by. Absconds are second highest with 23% of on-going KMPT SIs being attributed to this category. The highest number of these occurred at Medway Maritime Hospital, 4 in total, with 3 occurring on Sapphire Ward.

Despite absconds continuing to be one of the highest on-going categories in KMPT; there has been a decrease in their occurrence. Work is underway within KMPT to ensure that there is better management of Section 17 leave to try to avoid clients absconding when unescorted. Further agreement has also been reached between KMPT and West Kent CCG on which absconds are to be reported, as a number do not result in any harm to the patient who is returned within a matter of hours.

During November 2013, no Grade 2 SIs were reported.

South East Coast Ambulance NHS Trust

During November 2013 4 new SIs were reported; 2 (50%) were reported within the two working days deadline and 2 (50%) between 5-10 working days There were no Grade 2 SIs reported during November 2013.

NHS Constitution Standards

To be completed

Waiting Times

52-week

There has been a further reduction in the number of patients waiting more than 52 weeks for treatment, with 4 recorded as of end of October compared to 10 the previous month.

The Divisional Director for Surgical Services has confirmed that EKHUFT have an agreed action plan following the contract query notice which the CCGs have accepted. There is an agreed reduction trajectory in place which indicates that the backlog will be cleared by the end of December and details how this will be sustained going forward.

Despite the continuously improving position, it was confirmed in the month 5 contract performance letter that the appropriate breach penalties will continue to be applied until such times as the number of patients waiting beyond 52 weeks reaches zero. KMCS and the CCGs will monitor performance against the agreed reduction trajectory according to the contract query notice issued.

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4 Hour A&E Waits

EKHUFT has been struggling to achieve the 95% target for A&E 4 hour waits since April 2013 and have failed to meet the target for the second successive month, achieving only 92.71% in October. Despite this EKHUFT have managed to meet the 95% target for both Q1 and Q2, achieving 95.2% and 95.1% respectively and have therefore avoided any contractual penalties.

EKHUFT have identified a series of key challenges they believe have all contributed to the difficulties seen in achieving this target, and have detailed what actions are being undertaken in respect of each of them.

Cancer Waits

The current unvalidated position for October shows compliance across all standards with the exception of 31 day drug treatments, which is currently shown at 96.55% against the 98% target. EKHUFT reported that it had 1 patient breach against this target in October. The patient had to undergo a day surgery procedure to allow access for chemotherapy to be administered, which resulted in an extended pathway for the patient.

It has been identified that EKHUFT failed the 93% target for Q2 for the 2 week wait for symptomatic breast cancer standard, achieving only 88%. The consequence of this breach is '2% of revenue derived from the provision of the locally defined service line in the quarter of the under-achievement'. IPM has requested in the month 6 contract performance letter that EKHUFT detail what remedial actions have been put in place to address this issue and the trajectory by which EKHUFT hopes to maintain compliance. The CCGs have requested that EKHUFT present this update at the next contract performance meeting and would consider withholding the contractual penalty depending on how comprehensive an action plan has been developed.

Following non-compliance in both August and September, the 2 week wait for symptomatic breast cancer standard has returned to a compliant position for October, with unverified figures showing 93.75% against the target of 93%. EKHUFT report that this is as a result of rapid access referrals increasing significantly to cope with the additional demand.

For those tumour groups not meeting the relevant standard in October, each tumour site specialty has an action plan in place to address the issues and help deliver an improvement in performance. These action plans are being reviewed at Divisional Director and Divisional Medical Director level at monthly Cancer Compliance meetings.

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Sustainability

Provider Market
Capacity and Demand
Allocation Assumptions
2 Year Financial Plan
Expenditure Assumptions
Innovation Forum & Challenge Events
Clinical Leadership in Commissioning for GP Trainees

Provider Market

Ashford CCG commissions services from a wide range of providers with provision well distributed across the patch. Quality and performance are good but not consistent across all providers. There is an increasingly diverse provider market but the local geography and poor transport links can limit the willingness and ability of people to travel to receive care.

In addition to a number of GP practices, across the Ashford locality, who offer a wide range of services over and above their obligations under the GMS/PMS, detailed below are our main providers by area of care:

General Acute:

- East Kent Hospitals University Foundation Trust
- Medway NHS Foundation Trust
- Maidstone and Tunbridge Wells NHS Trust

Community:

- Kent Community NHS Trust
- ic24 (Out of Hours)

Mental Health:

- Kent and Medway NHS and Social Care Partnership NHS Trust
- South London and Maudsley NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust

Independent Sector:

- BMI Chaucer Hospital
- Spires Healthcare
- Benenden Hospital

The CCG are keen to work in partnership with major provider to ensure that we can protect essential services for our local population. However, we expect to see a shift towards more integration between provider and an increase in health and social care community providers. Within that context we will develop a local market where there in only a plurality of providers where appropriate and where that doesn't undermine the underlying system vision of integrated services for our patients.

In any provider market we wish to develop an environment conducive to high quality training, for *all* providers, which ensures that our patients will receive the highest quality of care both clinically and non-clinically.

Capacity and Demand

To be completed

Any Town CCG Analysis

Allocation Assumptions

The CCG is currently assuming a 20% move towards the new allocations formula. Although it is not known how much this will actually equate to, due to speed of implementation, it is felt that planning at this level is appropriately risk averse.

2 Year Financial Plan

Set out below is the expected allocation and expenditure for 2014/15 and 2015/16.

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	2014/2015	2015/2016
Final 13/14 Allocation	£130,093,000	£129,880,403
Less Non Recurrent Allocations	-£1,434,000	
2% Allocation Growth	£2,573,180	£2,467,728
CCG Funding for ITF	-£385,977	-£3,896,412
Assumption on Pace of Change for Allocations	-£965,800	-£965,800
Recurrent Baseline	£129,880,403	£127,485,919
Return of Surplus	£1,345,400	£1,342,358
£25 per head Running costs	£3,010,000	£2,709,000
Total Non-Recurrent Allocation	**£134,235,803**	**£131,537,277**
13/14 Forecast	£130,802,779	£128,037,703
Full Year Effect Issues (inc recurrent QIPP)	-£453,156	-£1,610,192
Non-Recurrent Spend	-£589,170	£0
Cost Pressures	£1,148,603	£1,174,633
1.5% Population Growth	£1,917,186	£1,920,566
1.6% Reduction in Tariff	-£2,044,999	-£2,048,603
QIPP	-£6,440,769	-£3,436,665
CQuin Impact	£844,718	£844,718
Expected 14/15 Programme Spend	£125,185,192	£124,882,158
£25 per head Running Costs	£3,010,000	£2,709,000
1.5% Non-Recurrent Transition Funding	£2,013,537	£1,315,373
1% Further Funding for ITF	£1,342,358	£0
1% Contingency	£1,342,358	£1,315,373
1% Surplus Requirement	£1,342,358	£1,315,373
Total Spend	**£134,235,803**	**£131,537,277**

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Expenditure Assumptions

The start point for the planning is the 13/14 forecast out-turn position. The CCG is on target to make its surplus but has had to use all of the 1% contingency and the 2% strategic change funding to support this position. This is due to a number of factors including those within and external to the CCGs control. 13/14 QIPP delivery has not been as expected, a major contributor to the current position. For some areas of expenditure, for example prescribing despite QIPP delivery the position has been adversely affected by changes in Category M pricing and other factors.

The Full Year effect adjustments include both QIPP investment and savings expected to continue from the 13/14 financial year.

The adjustment for non-recurrent funding reflects the fact that the CCG will no longer receive is reablement funding. As reablement funding has been used to deliver a number of joint projects across the health economy a resultant cost pressure has been included in the plan to reflect the need for a proportion of this funding going forward.

Cost pressures include growth allocated to those areas recognised in the planning guidelines as expecting price inflation. Additionally the CCG is undertaking significant developments across some of the larger East Kent contracts moving to payment based on real usage rather than fair share to allow better commissioning decision making. Finally a significant cost pressure determined nationally is the move Payment by Results for mental health although these values are yet to be finalised.

Population Growth is expected to be at 1.5% and tariff has been reduced as advised in the guidance.

The total QIPP amount included in the plan equates to £7.0m, comprised of £0.3m schemes to be continued and £6.7m of new commissioning plans. This equates to 5.3% of the total budget. In 13/14 the 3% planned level of QIPP was recognised as significantly challenging and one of the highest plans in the region. The CCG recognises that the level of QIPP in the 14/15 plan exceeds this by 2.3% and represents a significant challenge that can only be delivered through fundamental changes in delivery of healthcare across providers, that is facilitated by utilisation of all contracting options available to commissioners.

The creation of the ITF fund included in the 2014/15 plans is assumed as a cost to the CCG, with no financial benefit in year through reductions in activity in the acute setting, this will need to be discussed with our Social Care Partners.

The plan also assumes that there will be 1.5% strategic funding available and a further 1% for the ITF (described below). As required the plan also assumes 1% contingency and 1% surplus. No additional funding has been assumed at this time for savings in primary care and any quality premium.

Running costs will be at the expected level of £25 per head of population.

The challenge is further compounded in 2015/16 as the full impact of the ITF is included and the expected resource growth reduces. However, in year 2 of the two year plan a number of the more substantial integrated service models will be implemented or part implemented, thus generating the major change needed to sustainably move the CCG to an affordable baseline.

The challenge therefore for the CCG is to deliver the very challenging significant QIPP target in 2014/15 before the large integrated system changes impact in 2015/16.

Innovation Forum

The NHS is currently faced with quality, efficiency and demand challenges on a scale that has never been seen before. Organisations across the NHS have already made significant progress in reducing delays, improving quality, and giving patients access to new services and technologies. However, in order to respond effectively to the scale of the current challenge, all parts of the health and care system will need to collaborate to apply innovative approaches to the problems they face.

Innovation, Health and Wealth (DH, 2011) defines innovation as:

> *"An idea, service or product, new to the NHS or applied in a way that is new to the NHS, which significantly improves the quality of health and care wherever it is applied"*

This gives clinical commissioners the dual role of championing the adoption of innovation and best practice seen elsewhere, alongside seeking to generate new ideas and ways to apply new opportunities creatively.

In recognition of this, NHS organisations now have a "duty to innovate". The commitment to champion innovation was included as part of the CCG authorisation process.

Together with Ashford CCG we have established an Innovation Forum, through which we can:

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- Generate new ideas
- Learn about best practice opportunities
- Agree new ways to address complex priority areas

The objectives of doing this are to:

- Accelerate the identification, adoption and diffusion of innovations that will improve patient outcomes and service quality in areas that the CCG defines as priorities
- Embed innovation into the CCGs' commissioning cycles
- Build an innovation climate within the CCGs and partner organisations
- Link with other organisations involved in health and care (commissioners and providers) so that they can also embed innovation and innovation projects in their business planning processes

The Innovation Forum brings together senior CCG decision makers along with agreed relevant external input from the academic community, technology industry and health and social care stakeholders. Participants are asked in advance to consider specific questions or focus areas, and to identify relevant information, research or case studies based on their own experience or areas of work. This also involves considering how existing practice or tools could be applied differently or in other areas. The aim of the Innovation Forum is not to carry out an in-depth review of opportunities, but to consider how they might impact on the health challenges that the group prioritises.

Innovation Challenge Events

Twice yearly an Innovation Challenge event will be run, bringing together a wider group of people to learn about opportunities in a particular area and consider how they will be applied for local people. Each Innovation Challenge event will have its own objectives, which will vary according on the questions being posed, however events will have a number of objectives in common:

Learn and challenge	Generate ideas
• Increase understanding of the presenting issue from different perspectives • Hear about alternative solutions (or components of solutions) from providers and users • Learn about what has worked – and what hasn't – in other areas • Consider why the approach in place locally does not fully meet the needs of service users	• Consider how new approaches or tools would impact the presenting issue • Discuss how existing tools (new or already in use in the area) could be improved • Review what could be done differently to address gaps in services • Learn from how other organisations or industries are addressing similar challenges • Probe the ideas considered: do they fully address the presenting issue or is there a way to enhance them further?
Agree actions	**Synthesise solutions**
• Agree what should be taken forward and how • Define specific actions and owners • Understand what inputs are required to make each action happen • Ensure clarity over who's leading on different solution areas • Confirm expectations of stakeholders	• Identify groups of linked opportunities • Prioritise the ideas raised • Gauge interest and consensus from different stakeholders • Gain stakeholder commitment to being involved in developing the opportunity from idea/pilot to broader diffusion

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The first Innovation Challenge Day was held in April, focussing on Dementia. Working with the Young Foundation, the event was attended by commissioners and provider organisations, local authority, third sector organisations, universities, and technology firms.

Our aim was to think differently and hear different things about ways to support people with dementia. Speakers presented on their innovative tools or services supporting different aspects of dementia care. Small group discussion to help review, understand or prioritise the innovative ideas presented. Participants were asked to identify ways in which they would take back the ideas generated and use them to influence change in their own organisations.

It is important to differentiate between an Innovation Challenge event and a patient co-design or consultation event. People who use services should be involved to raise their alternative perspectives of services and their ideas about what could make them better, as well as ensuring that the group understands the potential impact of opportunities. However, Innovation Challenge events should be focused on opportunities to deliver transformational change benefiting a large number of people, rather than redesigning elements of specific services in detail. A project initiated at an Innovation Challenge event could lead to a number of other engagement events during the development and delivery period.

Clinical Leadership in Commissioning for GP Trainees

The GP Clinical Leadership in Commissioning (CLIC) rotation is an innovative or integrative GP training post (ITP). ITPs and have been used for a number of years, and have been a feature of many areas in Kent, Surrey and Sussex. Educationally, they are an extension of the educational placement for trainees that are a regular part of the GP placement (such as attending an outpatient clinic, community clinic, or public health department). Previously, they have consisted of a combination of GP Trainer employed and hosted posts, or part placement (and employment) in a GP Training Practice and part placement in a hospital or community clinic post.

The commissioning rotation comprises 5 clinical sessions within a GP practice and 2 days within the commissioning setting. Most trainees will work on a Wednesday and Thursday within the commissioning component of the rotation, with the other five clinical sessions in GP. Mandatory sessions are structured with experts in areas of commissioning or workshops which relate to key aspects of leadership development. Each trainee is allocated a commissioning project which they work on alongside the CCG commissioning team.

Trainees are expected to demonstrate evidence of learning, teaching and team working as part of RCGP curriculum requirements and personal professional development. In this placement the trainees are invited to present to their supervisors and peers at the end of the 4m placement.

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Governance

Patient and Public Involvement
Delivery Architecture
Decommissioning and Disinvestment
Conflict of Interest
Complaints and Compliments
Freedom of Information
Equality and Diversity

Patient and Public Involvement

A communication and engagement strategy document has been developed to set out how Ashford CCG will inform and involve residents, partners, health and social care professionals, voluntary and community sector groups to ensure that specific health care needs that have been identified in the Joint Strategic Needs Assessment are addressed. This document is to be found on the website:

www.ashfordccg.nhs.uk/

In summary though, our main means of engaging patients and public include:

Means of Engaging Patients and Public	Detail
Patient participation groups (PPGs)	Ashford's CCGs practices have a patient participation group. Representatives from the CCG attend these group meetings to listen and act on patient views. Ashford Patient Participation Group also attends (in a non-voting capacity) the CCG Governing Body
Public reference group (PRG)	Consists of a representative from the PPGs as well as representatives from key groups and organisations.
Ashford Health Network	Ashford CCG is looking to set up a virtual group of patients, members of the public and voluntary organisations who help make decisions about local health services.
Ashford Health magazine	Free quarterly health promotion magazine available online. To receive a hard copy of the magazine patients/public are able complete a form and send back using a freepost address. These are available in surgeries and other community venues.
Governing Body meetings	These are now held in public where people can contribute to the meeting agenda.
Healthwatch Kent	Healthwatch Kent will be run by a consortium of 'Kent and Medway Citizens Advice' (KAMCA), 'Voluntary Action within Kent' and 'Activmob'. The consortium aims to excel at providing advice and information to the public, supporting the voluntary sector, and engaging with the public in new and innovative ways. C&C CCG is looking forward to working with Healthwatch Kent as it continues to emerge in 2013.
@AshfordHealth	Twitter account for Ashford CCG with latest news, tips and advice for Ashford's local community

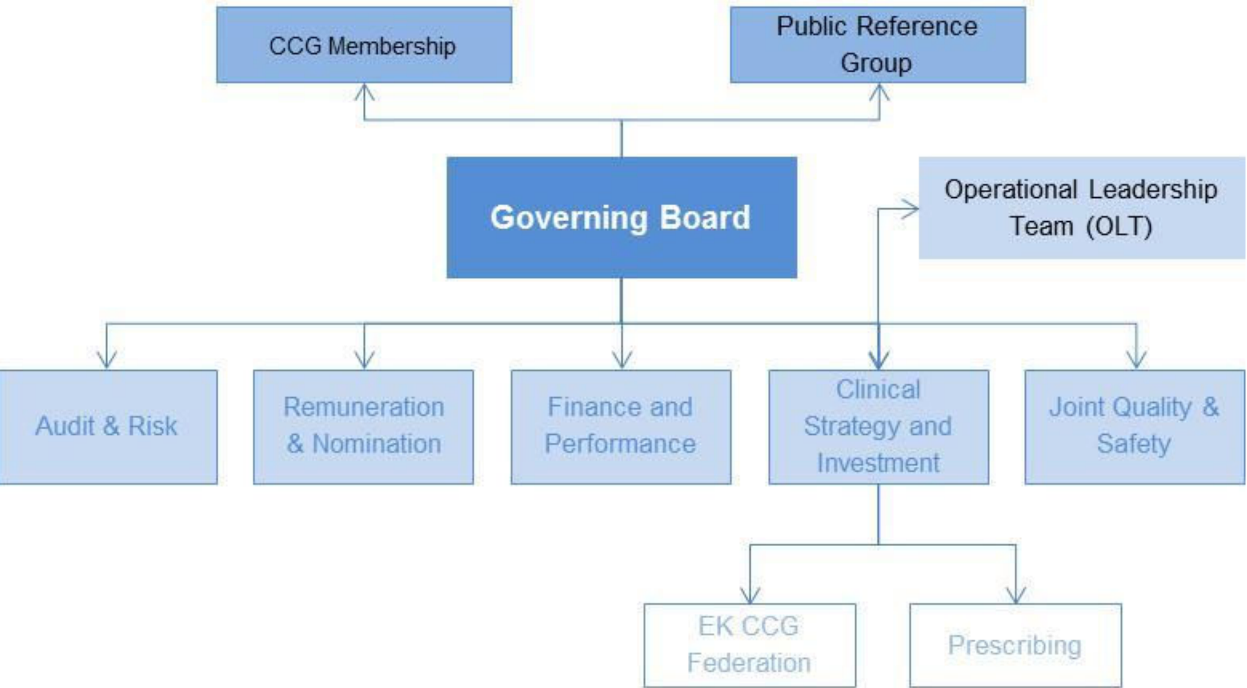
Delivery Architecture

To ensure that Ashford CCG remains focused on delivery of its plans throughout 2014/16 and beyond it will implement the following tracking mechanisms.

- Monthly review of project progress at operational team meetings, run by the Head of Commissioning Delivery
- Monthly meetings between the Clinical Programme Lead and Commissioners
- Monthly review of programme or project progress at CCG clinical strategy committee meetings
- Monthly review of how the CCG is doing against its Quality Premium indicators

Where possible, the benefits of each project should be tracked to monitor its effectiveness in achieving its objectives. The aforementioned fora will be used to check whether benefits have been realised. If they have not been realised, a decision will be taken about whether the project continues or is adapted.

To support the on-going development and delivery of the Strategic Commissioning Plan, the CCG has developed the following governance structure.



Decommissioning and Disinvestment

To ensure that limited resources are consistently directed to the highest priority areas the CCG have identified the need to develop a Decommissioning and Disinvestment Plan that sets out the agreed principles for decommissioning services to allow funds to be redirected where appropriate. There is a need to ensure that when approval has been given to decommission, or disinvest from, a service a clearly defined process is followed, with clear lines of accountability and responsibility.

> ***Decommissioning:*** *This relates to the withdrawal of funding from a provider organisation where the service is subsequently re-commissioned in a different format.*
>
> ***Disinvestment:*** *This relates to the withdrawal of funding from a provider organisation and the subsequent stopping of the service.*

In some circumstances there will be the need to re-commission part of the service or a modified service to ensure that there are no gaps in healthcare delivery.

The following points will be considered when making the decision to decommission a service.

- The patient experience and health need must be paramount and gaps in service provision minimised once the service ceases.
- The potential destabilising effect on other organisations e.g. third sector, of a decision to decommission/disinvest should be considered.

Conflict of Interest

The CCG takes conflicts of interest very seriously. Ashford's constitution details how conflicts of interest will be managed but in summary:

Declarations of interest are published on the Ashford CCG website: www.ashfordccgnhs.uk

Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the Group's exercise of its commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the Head of Corporate Services.

The chair of the meeting will then determine how this should be managed and inform the member of their decision. Where no arrangements have been confirmed, the chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

Complaints and Compliments

Most medical care and treatment goes well, but things occasionally go wrong, and people may want to complain. They may want to make positive comments on the care and services that they or their family have received. These comments are just as important because they tell NHS organisations which factors are contributing to a good experience for patients.

We welcome complaints as a valuable means of receiving feedback on the services we commission for the people of Ashford and also on the way we go about our business. The CCG aims to use information gathered from complaints as a means of improving services and the effectiveness of the organisations. We seek to identify learning points that can be translated into positive action, and where necessary provide redress to set right any injustice that may have occurred.

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Personal information may be anonymised for the purposes of monitoring the complaints process or improving service quality. The purposes for which identifiable information will be used is strictly for the processing of the complaint. This may include passing relevant information to a service provider in order that they can provide appropriate responses and comments on the circumstances set out in the complaint.

Patients and service users are encouraged to express complaints, concerns and views both positive and negative about the treatment and services they receive, in the knowledge that:

- they will be taken seriously
- they will receive a speedy and effective response by a member of staff appropriately qualified and trained to respond
- appropriate action will be taken
- lessons will be learnt and disseminated to staff accordingly
- there will be no adverse effects on their care or that of their families

We are committed to dealing with all complaints fairly and impartially and to providing a high quality service to complainants.

Complaints received by NHS Ashford CCG are investigated by Kent and Medway Commissioning Support (KMCS). KMCS is hosted by NHS England, and provides a number of administrative functions including managing the complaints process. This may involve accessing your case records and disclosing relevant information to the CCG in order that we can discharge our duties to you under the NHS Complaints Regulations.

Freedom of Information (FoI)

The Freedom of Information Act 2000 (FOIA) came into force on 1 January 2005, and gives the public and other organisations the right of access to information held by NHS Ashford CCG. We are committed to openness and transparency in the conduct of all our business.

The Freedom of Information Act 2000 recognises that, gives the public and other organisations have the right to know how public services such as the NHS make their operational decisions and how public money is used. The Act gives anyone a general right to request access to see official information held by public authorities. The Act reflects a national policy to shift from a culture of confidentiality to one of openness, where information is routinely available, subject to certain exemptions, to anyone who wishes to see it.

Freedom of Information (FOI) requests are processed by Kent and Medway Commissioning Support (KMCS) on our behalf and we maintain a disclosure log on information that has already been published which is available through our website to download. However, if someone is unable to find what they are looking for on the publication scheme, then a written request should be sent to:

Freedom of Information Team
Kent House - 4th Floor
81 Station Road
Ashford
Kent
TN23 1PP
Email: foi@nhs.net

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Equality and Diversity

We fully recognise the importance of the Public Sector Equality Duty (PSED) and have already developed our Equality and Diversity Strategy which includes our equality objectives, set in line with the four Equality Delivery System (DH Toolkit) goals. These are detailed below:

Goal	Narrative	Outcome
1. Better health outcomes for all	The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results	1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities 1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways 1.3 Changes across services for individual patients are discussed with them, and transitions are made smoothly 1.4 The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all 1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups
2. Improved patient access and experience	The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience	2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds 2.2 Patients are informed and supported to be as involved as they wish to be in their diagnoses and decisions about their care, and to exercise choice about treatments and places of treatment 2.3 Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised 2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently
3. Empowered, engaged and well-supported staff	The NHS should Increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better respond to patients' and communities' needs	3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades 3.2 Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work and work rated as of equal value being entitled to equal pay 3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately 3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all 3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives. (Flexible working may be a reasonable adjustment for disabled members of staff or carers.) 3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population
4. Inclusive leadership at all levels	NHS organisations should ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions	4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond 4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination 4.3 The organisation uses the "Competency Framework for Equality and Diversity Leadership" to recruit, develop and support strategic leaders to advance equality outcomes

We will review these annually and ensure our staff are supported to commission services which ensure equality of access to services and that meet the needs of our diverse population.

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Operational Plan

April 2014- March 2016

v0.2

Integrated Urgent Care Centre	**Urgent Care**

Description

Evidence Base

- East Kent Integrated Care Pilot 2009
- ECIST review of the Urgent Care System 2010
- Clinical Systems Model for Integrated Urgent Care and Long Term Conditions 2012
- Kings Fund review of Urgent and Emergency Care NHS South of England 2013.

Key Changes

- enhanced GP out of hours service to replicate what is provided in hours;
- enhanced input to review and treat patients within care homes, reducing the need to access acute hospital services;
- consistently responsive and reliable service 24/7;
- integration of the out of hours service with other care providers;
- clear discharge processes from urgent care to planned or primary care, to maintain capacity within the system; and
- proactive case management.

High Level Benefit Assessment

- Provide a rapid multi-disciplinary assessment of patients quickly
- Provide rapid access to a range of services that will ensure that patients are managed seamlessly and are better supported to cope within their local community.

Key Risks

- Quality / complaints
- Human resources / organisational development / staffing / competence
- Adverse publicity / reputation

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Securing additional years of life for people with treatable mental and physical health conditions.	Improving the health related quality of people with one or more long-term condition, including mental health conditions.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	Increasing the proportion of older people living independently at home following discharge from hospital.	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

<table>
<tr><th colspan="4">Project Accountability</th></tr>
<tr><td>Clinical Lead</td><td>Dr M Jones</td><td>Managerial Lead</td><td>Alastair Martin</td></tr>
<tr><td>Key Partners</td><td colspan="3">East Kent Hospitals University NHS Foundation Trust
Kent Community Health NHS Trust
Kent County Council
Local CCGs</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="2">Key Measures</td><td></td><td colspan="2"></td></tr>
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Transformation of Outpatient Services	**Planned Care**
Description	Key Changes • Pre-Referral Advice and Guidance Service • One-Stop Clinics • Improved Triage High Level Benefit Assessment For patients • Appropriate referral to the right clinician • Management of their condition by local clinicians • Reduced attendances in acute settings For GPs • Education resource • Reduces redirection/rejected referrals • Reduction in overall referrals For provider • Only those patients that need to be in clinic are seen • More diagnostic tests, where appropriate, can be completed prior to referral • Improves RTT timelines where redirection of referrals has added delays in the past For CCG's • Confidence that referrals to secondary care are appropriate • Potential for savings where patients are not referred and managed in primary/community care Key Risks • Potential for provider to miscode response and therefore output data maybe of questionable quality • Percentage of referrals avoided provides minimal savings • Engagement with GPs

NHS Outcomes Framework

1		2	3		4	5
Preventing people from dying prematurely		**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**		**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**
Securing additional years of life for people with treatable mental and physical health conditions.	Improving the health related quality of people with one or more long-term condition, including mental health conditions.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	Increasing the proportion of older people living independently at home following discharge from hospital.	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Project Accountability			
Clinical Lead	Dr G Gupta	**Managerial Leads**	Paula Smith Sue Luff Felix Robinson
Key Partners	East Kent Hospitals University NHS Foundation Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			

Macula Oedema	Planned Care

Description

Evidence Base

- NICE Technology Appraisal Guidance
- Diabetic Macular Oedema (DMO; TA274)
- Wet Age-Related Macular Degeneration (WAMD; TA155)

Key Changes

- A hub and spoke type service model to provide patients with community monitoring facilities and a central acute site(s) for the treatment/drug administration

High Level Benefit Assessment

- Patients would not need to attend acute hospital sites for every appointment.
- Patients seen in a timely fashion and impact on their vision is minimised
- Improved delivery of high quality and value for money monitoring service that will also provide the maintenance a patient requires between injections
- Improved access and choice
- Delivers greater consistency of treatments
- Equity of services across the localities which enhances patient experience and reduces wait times

Key Risks

- Fragmentation of service
- Patients confused where their next treatment will be provided
- Community provider monitoring patients fails to identify developing problems
- Agreed tariff too low to be viable & attract providers

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

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Project Accountability			
Clinical Lead	Dr G Gupta	**Managerial Lead**	Paula Smith
Key Partners	East Kent Hospitals University NHS Foundation Trust Local Optometrist Committee Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			

Dermatology	**Planned Care**

Description

Key Changes

- Prime contractor will be responsible for developing and implementing an integrated and coordinated programme of Dermatology care
- Services will be commissioned on the basis of "outcome" rather than separate services for each condition.

High Level Benefit Assessment

- Reducing fragmentation in the patient pathway.
- Reducing confusion for GPs with regard to where to refer.
- The patient being seen by the right clinician in the right place first time.
- Ensuring the right investigations is undertaken.
- Creating efficiencies and financial savings.
- Better clinical effectiveness and increase quality of service.
- Monitoring based on outcomes.
- Supports education in primary care.

Key Risks

- Conflicts of interest from current providers engaged within the Task and Finish Group
- Destabilisation of the Trusts Cancer services
- Inability to procure a new service by October.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	Enhancing quality of life for people with long-term conditions	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

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<tr><td>Clinical Lead</td><td>Dr G Gupta</td><td>Managerial Lead</td><td>Laura Counter</td></tr>
<tr><td>Key Partners</td><td colspan="3">East Kent Hospitals University NHS Foundation Trust
Kent Community Health NHS Trust
Local CCGs</td></tr>
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<tr><td></td><td colspan="2"></td></tr>
<tr><td rowspan="7">Key Milestones</td><td>February 2014</td><td colspan="2">Service Review</td></tr>
<tr><td>March 2014</td><td colspan="2">Redesign</td></tr>
<tr><td>October 2014</td><td colspan="2">Implement changes</td></tr>
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Transformation of ADHD Service	**Mental Health**

Description	Evidence Base • NICE Guideline CG72 Attention Deficit Hyperactivity Disorder (ADHD) 2008 Key Changes • Integrated all-age pathway, reducing need to transition across paediatric and adult services • Increased community based service provision • Shared care between GPs and specialist services High Level Benefit Assessment • Improve the recognition, accurate diagnosis and treatment of ADHD in children, young people and adults • Limit the impact of late initiation of treatment • Improve the quality of care and may reduce the number of mental health contacts, with the associated costs Key Risks • Lack of engagement and buy in to the transformation of services from stakeholders particularly at the early stages of the children's pathway • GPs unwilling to sign up to an ADHD shared care and prescribing protocol

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	Helping people to recover from episodes of ill health or following injury	**Ensuring that people have a positive experience of care**	Treating and caring for people in a safe environment and protecting them from avoidable harm

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Project Accountability			
Clinical Lead		**Managerial Lead**	Jacqui Davis
Key Partners	Kent and Medway Partnership Trust Sussex Partnership NHS Trust East Kent Hospitals University NHS Foundation Trust Medway NHS Foundation Trust Kent Community Health NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones	March 2014	Determine the level of service required	
	June 2014	Service design (including prescribing arrangements)	
	September 2014	Development of shared care and prescribing protocol	
	March 2015	Procurement process and implementation of new service	

Eating Disorders Service	**Mental Health**

Description

Strategic Fit
- Kent Health and Wellbeing Strategy

Evidence Base
- NICE guidelines for Borderline Personality Disorder

Key Changes
- TBA

High Level Benefit Assessment
- To improve the condition of patients with eating difficulties or disorders, whereby they are able to maintain their physical and psychological health either with no or less specialist assistance
- To improve the nutritional health of patients with eating difficulties or disorders
- A reduction in subjective distress of patients
- To liaise with secondary and tertiary care providers to provide appropriate and timely care for patients identified as needing more intensive treatment or admission

Key Risks
- Derogation of funds from NHSE to CCGs – no agreement in place between CCGs regarding fair share of funding and resources

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	Enhancing quality of life for people with long-term conditions	Helping people to recover from episodes of ill health or following injury	Ensuring that people have a positive experience of care	Treating and caring for people in a safe environment and protecting them from avoidable harm

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Autistic Spectrum Conditions Diagnostic Assessment Service	**Learning Disabilities**

Description

Strategic Fit

- It was identified in 2010 that there was no clear diagnostic or care pathway for adults with high functioning autism and Aspergers syndrome in Kent
- The current capacity of the service is 60 diagnostic assessments a year, and the waiting list as of July was 280 patients

Evidence Base

- NICE quality standards

Key Changes

- Increase capacity for assessment service

High Level Benefit Assessment

- The backlog of people waiting for diagnostic assessment will be addressed
- There will be improved multi disciplinary working including the provision of joint health and social care assessment meetings and specialist interventions
- Formal diagnosis ensures individuals are not referred to inappropriate health, social care and community and voluntary services.
- Carers and families will have a greater understanding of autism as a result of the development of this service.
- The service would meet key requirements of national policy and guidance.

Key Risks

- Risk that current level of referrals may not be a true representation of future demand for service – the prevalence data suggests referrals could continue to increase
- Risk that current provider cannot sustain current service which may pre-empt closure of the current service.

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	Helping people to recover from episodes of ill health or following injury	**Ensuring that people have a positive experience of care**	Treating and caring for people in a safe environment and protecting them from avoidable harm

Securing additional years of life for people with treatable mental and physical health conditions.	Improving the health related quality of people with one or more long-term condition, including mental health conditions.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	Increasing the proportion of older people living independently at home following discharge from hospital.	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

<table>
<tr><th colspan="4">Project Accountability</th></tr>
<tr><td>Clinical Lead</td><td></td><td>Managerial Lead</td><td>Sue Gratton</td></tr>
<tr><td>Key Partners</td><td colspan="3">Kent County Council
Local CCGs</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="3">Key Measures</td><td colspan="3">Service meeting NICE guidelines</td></tr>
<tr><td colspan="3">Reduced waits for diagnosis</td></tr>
<tr><td colspan="3">Increased referrals</td></tr>
<tr><td rowspan="3">Key Milestones</td><td>October 2014</td><td colspan="2">Additional staff recruited</td></tr>
<tr><td>January 2015</td><td colspan="2">New capacity available</td></tr>
<tr><td></td><td colspan="2"></td></tr>
</table>

Winterbourne Joint Plan	**Learning Disabilities**
Description	Evidence Base • The *Winterbourne Concordat: Programme of Action* (DH 2012) Key Changes • Agree a personal plan for each individual that is inappropriately placed in CCG or NHS England commissioned learning disability or autism in-patient services and put the plans into action so that all individuals receive personalised care and support in the community no later than 1 June 2014 • Put in place a locally agreed joint plan for high quality care and support services by April 2014, which accords with the model of good care to ensure that a new generation of inpatients do not take the place of people currently in hospital. High Level Benefit Assessment • People with learning disability and autism who have complex mental health or behaviour problems will experience more integrated care and support in the community • There will be improved multi-disciplinary working including the provision of joint health and social care assessment meetings and specialist interventions • There will be reduced reliance on the use of high cost in-patient services • Clinical consultancy and support would be available for other professionals in mainstream services to enable them to make reasonable adjustments. • The service would meet key requirements of national policy and guidance. Key Risks • Lack of funding from NHSE Specialised Commissioning renders commissioning recommendations unaffordable for CCGs and Local Authority • June 2014 deadline for discharges of current in-patients not met due to requirement to undertake procurement process for new services

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

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Project Accountability			
Clinical Lead	Bethan Haskins	**Managerial Lead**	Sue Gratton
Key Partners	Local CCGs		
Delivery in 2014-16			
Key Measures	Reduced number of hospital admissions		
	Reduced length of stay for hospital admissions		
Key Milestones	Completed	Identify current in-patients for discharge	
	February 2014	Details of each patients support and accommodation needs	
	March 2014	Consult on new care pathway and models of care	
	April 2014	Final Joint Plan	
	June 2014	All current in-patients discharged or agreed discharge plan / procurement being implemented.	

Multi-agency whole system approach for supporting disabled children and young people with challenging behaviour	**Child Health and Maternity**

Description	Strategic Fit • Kent Health and Wellbeing Strategy Evidence Base • Department of Health's Report into Winterbourne View • Children and Families Bill • Kent Sufficiency Strategy (2013) Key Changes • A new multi-agency integrated pathway involving professionals working at universal, targeted, specialist and highly specialist levels Integrated assessments and care planning process aligned to the new Education Health and Care plans High Level Benefit Assessment • Children and young people are able to remain living at home with their families. • Children and young people are educated in a Kent school. • Children and young people are able to maintain or develop friendships and access local community services. • Families feel confident in managing their son or daughter's challenging behaviour and are able to participate in everyday activities. Key Risks • Delay in recruiting the right staff with the right level of training and experience. • Unable to agree contract variation to support the implementation of the transformation programme. • Decision by any partner not to invest in this transformation programme.

NHS Outcomes Framework

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Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

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Project Accountability			
Clinical Lead	Dr D Grice	**Managerial Lead**	Martin Cunnington
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent County Council Sussex Partnership NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures	Reduce the number of out of county placements for children with severe autism and challenging behaviour.		
Key Milestones	June 2014	Baseline data and scope of the evaluation agreed.	
	September 2014	New outcome measures and KPIs included in a range of contracts and a central data collection system agreed.	
	December 2014	Remodelling and training within CAMHS, social care and education to implement new integrated pathway across universal, targeted and specialist services	

Early Pregnancy Assessment Unit	Child Health and Maternity

Description

Strategic Fit

- Kent Health and Wellbeing Strategy
- Kent's Children and Young People's plan 'Every Day Matters'
- Kent Health Inequalities Action Plan "Mind the Gap"

Evidence Base

- NICE Guidelines for Ectopic pregnancy and miscarriage

Key Changes

- Ensure pathways are transparent, equitable and clearly communicated
- Single Point of Access (SPA) led by a clinician who will feed into primary care and OOH services that link to the A&E pathways.
- Improved access to scanning appointments, or explore having a scanner available in primary care

High Level Benefit Assessment

- Ensure the right care is given at the right time, at the right place and by the right professional
- Deliver the best, proactive care to prevent avoidable complications and interventions. Supporting the reduction of adverse outcomes of pregnancy
- Enable and empower women and GPs to use appropriate access routes to the services
- Improve transparency and accuracy of coding to result in more efficient use of resources
- Continued reduction of A&E attendances – improve pathways and reduce activity though this route

Key Risks

- Destabilisation of services
- Lack of engagement
- Projected benefits are not fully realised.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

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<tr><td>Clinical Lead</td><td>Dr A Weatherley</td><td>Managerial Lead</td><td>Adam Warmington</td></tr>
<tr><td>Key Partners</td><td colspan="3">East Kent Hospitals University NHS Foundation Trust
Local CCGs</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="4">Key Measures</td><td colspan="3">Reduced attendance at A&E for pregnancy complications</td></tr>
<tr><td colspan="3">Waiting times following GP referral</td></tr>
<tr><td colspan="3">Proportion of scans undertaken on same day</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td rowspan="3">Key Milestones</td><td>June 2014</td><td colspan="2">Research and understand best practice</td></tr>
<tr><td>July 2014</td><td colspan="2">Implement new EPAU pathway</td></tr>
<tr><td></td><td colspan="2"></td></tr>
</table>

Transformational of Urgent Care for Children and Young People	**Child Health and Maternity**

Description

Evidence Base

- DH and DfE, Improving Children and Young People's Health Outcomes – a system wide response (2013)
- DH, Report of Children and Young People's Health Outcomes Forum (2012)
- RCGP in partnership with RCPCH and RCN, Commissioning a good child health service (2013)
- Standards for children and young people in emergency care settings (2012)
- NHS Institute for Innovation and Improvement, Focus on: Children and Young People Emergency and Urgent Care (2010)

Key Changes

- New urgent and emergency care clinical network for children and young people
- Use of assistive technology
- Working with Public Health and the School Nursing Service to deliver key messages in schools.
- Develop lesson plans for use in schools around PSHE.

High Level Benefit Assessment

- Parents have an increased level of awareness and confidence in being able to support their children with common illnesses which may require urgent or emergency care.
- Children and young people, where it is clinically safe are treated and supported outside of hospital in their local community.
- Increase in confidence to manage their condition.

Key Risks

- Destabilisation of services
- Lack of engagement
- Services not streamlined
- Efficiencies and quality not meeting expectations

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

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<tr><td>Key Partners</td><td colspan="3">East Kent Hospitals University NHS Foundation Trust
Kent Community Health NHS Trust
Kent County Council
Sussex Partnership NHS Trust
Local CCGs</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="3">Key Measures</td><td colspan="3">Reduction in A&E attendances</td></tr>
<tr><td colspan="3">Reduce short stay admissions</td></tr>
<tr><td colspan="3">Increased community based support</td></tr>
<tr><td rowspan="3">Key Milestones</td><td>December 2014</td><td colspan="2">Reviews of existing services complete</td></tr>
<tr><td>June 2015</td><td colspan="2">New system design complete</td></tr>
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Admiral Nursing	Long Term Conditions
Description	Strategic Fit • Dementia has been identified as a priority for the Kent HWB as well as the CCG. • The provision of good community support for people with dementia is identified as an objective in the National Dementia Strategy 2009 and the Prime Ministers Dementia Challenge 2012. Evidence Base • NICE QS30 Supporting people to live well with Dementia. Quality Standard 30 (NICE 2012) • NICE CG42 Dementia Support people with dementia and their carers in health & social care (NICE 2005) Key Changes • The existing Admiral Nurse be integrated into the Neighbourhood Care Teams • The service will need to develop stronger working links with Age UK (who currently hold the contract for Dementia Café in Canterbury). • A combination of clinic and home visit approach is explored and adopted to create capacity, utilising existing voluntary sector accommodation where appropriate (Age UK etc.) • Improve links with carers rapid response and other jointly commissioned services i.e. Crossroads crisis service. High Level Benefit Assessment • Reduced carer admissions • Improved access for carers/families to support them in caring role. • Integrated working between Neighbourhood Care Teams/admiral nursing/voluntary sector • Capacity for service to educate other professionals. Key Risks • Capacity of the team across other parts of East Kent means that the administrative post is diluted

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	Enhancing quality of life for people with long-term conditions	Helping people to recover from episodes of ill health or following injury	Ensuring that people have a positive experience of care	Treating and caring for people in a safe environment and protecting them from avoidable harm

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<table>
<tr><th colspan="4">Project Accountability</th></tr>
<tr><td>Clinical Lead</td><td>Dr G Jones</td><td>Managerial Lead</td><td>Lisa Barclay</td></tr>
<tr><td>Key Partners</td><td colspan="3">Kent Community Health NHS Trust
Kent County Council
Local CCGs</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="2">Key Measures</td><td colspan="3">Reduced admissions due to carer breakdown</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td rowspan="7">Key Milestones</td><td></td><td colspan="2"></td></tr>
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Cardiology	**Long Term Conditions**

Description

Key Changes

- Review all of the existing services
- Develop an integrated service model
- Services commissioned on the basis of "outcome" rather than separate services for each condition
- Care delivered in a community setting
- Clear and responsive referral routes into secondary care services.

High Level Benefit Assessment

- Reducing fragmentation in the patient pathway.
- Ensuring the patients are seen by the right clinician in the right place first time.
- Creating efficiencies and financial savings, providing value for money against existing services
- Better clinical effectiveness and increase quality of service.
- To improve health outcomes through earlier diagnosis and treatment of common cardiology conditions
- To reduce the number of referrals, so far as clinically appropriate, to secondary care
- To establish a robust communication mechanism between all parties providing and receiving the service.

Key Risks

- KCHT may not wish to support the continuation of the GPwSI service on an interim basis
- Lack of data on the GPwSI service to review effectiveness
- Clinicians ability to dedicate time to the Task and Finish Groups

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Securing additional years of life for people with treatable mental and physical health conditions.	Improving the health related quality of people with one or more long-term condition, including mental health conditions.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	Increasing the proportion of older people living independently at home following discharge from hospital.	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

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<tr><th colspan="4">Project Accountability</th></tr>
<tr><td>Clinical Lead</td><td>Dr J Ribchester</td><td>Managerial Lead</td><td>Laura Counter</td></tr>
<tr><td>Key Partners</td><td colspan="3">East Kent Hospitals University NHS Foundation Trust
Kent Community Health NHS Trust
Local CCGs</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="3">Key Measures</td><td colspan="3">Reduction in GP referrals</td></tr>
<tr><td colspan="3">Reduced admissions</td></tr>
<tr><td colspan="3">Improved life expectancy</td></tr>
<tr><td rowspan="7">Key Milestones</td><td>February 2014</td><td colspan="2">Service review completed</td></tr>
<tr><td>April 2014</td><td colspan="2">Full Business Case</td></tr>
<tr><td>October 2014</td><td colspan="2">Implementation</td></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><td></td><td colspan="2"></td></tr>
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Memory Assessment	**Long Term Conditions**

Description

Strategic Fit

- The provision of early diagnosis for people with dementia is identified as an objective in the National Dementia Strategy 2009
- Prime Minister's Dementia Challenge, 2012 which sets a target diagnosis rate of 66% by 2015 (against expected prevalence).

Key Changes

- The pathway envisages in future that the majority of people with dementia will be reviewed and monitored in primary care.
- Dementia screening should be undertaken in primary care to exclude other reasons for the cognitive impairment
- Magnetic resonance imaging (MRI) is suggested as the preferred modality to assist with early diagnosis and detect subcortical vascular changes, the suggestion would be that the scan should be ordered in primary care.

High Level Benefit Assessment

- Care closer to home by increasing the assessment and treatment available in primary care.
- A more multi disciplinary approach to patients will also help to support the integration of services
- Free up capacity in the memory assessment service for those people who need more specialist input

Key Risks

- Redesign of pathway does not increase capacity in memory assessment services leading to delays in assessment.
- Future modelling of local tariffs and activity indicate current budget is insufficient.
- Prescribing will continue to be a cost pressure unless appropriate agreements are reached.

NHS Outcomes Framework

1	2	3	4	5
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Project Accountability			
Clinical Lead	Dr L Kanagasooriam	**Managerial Lead**	Linda Caldwell
Key Partners	Kent and Medway Partnership NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures	Reduction in admission to acute hospital beds		
	Time of referral to the service.		
Key Milestones	January 2014	Review additional data, eg scanning data, number of referrals converted to diagnosis.	
	February 2014	Second workshop for dementia leads	
	Mid February 2014	Agree specification for cluster 18	
	April 2014	Initial evaluation of Cantabmobile pilot	

Dementia Out Of Hours Crisis Support	**Long Term Conditions**
Description	Strategic Fit • Dementia has been identified as a priority for the Kent HWB as well as the CCG. The business supports the desire to deliver care as close to home as possible. • The provision of good community support for people with dementia is identified as an objective in the National Dementia Strategy,2009 and the Prime Ministers Dementia Challenge, 2012. Key Changes • The proposal is to develop existing community services • This enhanced service would provide an out of hours response for both older people with functional problems as well as people with dementia • The service would be available to both patients known to the secondary mental health services and new referrals and would deliver a service to individuals in their own homes, including care homes • The service will be targeted at those patients requiring an urgent response from mental health services and those patients who needs may require a joint response between community nursing and mental health services because a physical problem has enhanced their level of confusion. High Level Benefit Assessment • Enable older people to remain in their own home (which could be a care home) at times of crisis. • Avoid unnecessary hospital attendances and admissions. • Facilitate hospital discharge Key Risks • Inability recruit to additional posts will impact on service delivery • Service does not ultimately deliver savings.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	Helping people to recover from episodes of ill health or following injury	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

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<tr><td>Clinical Lead</td><td>Dr L Kanagasooriam</td><td>Managerial Lead</td><td>Linda Caldwell</td></tr>
<tr><td>Key Partners</td><td colspan="3">Kent and Medway Partnership Trust
Local CCGs</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="2">Key Measures</td><td colspan="3">Reduction in admission to acute hospital beds</td></tr>
<tr><td colspan="3">Time of referral to the service.</td></tr>
<tr><td rowspan="7">Key Milestones</td><td>January 2014</td><td colspan="2">Undertake modelling to identify hours service needed.</td></tr>
<tr><td>February 2014</td><td colspan="2">Agree activity and KPIs for inclusion in KMPT contract</td></tr>
<tr><td>Mid February 2014</td><td colspan="2">Advertise for posts</td></tr>
<tr><td>May 2014</td><td colspan="2">Service fully implemented</td></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><td></td><td colspan="2"></td></tr>
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Falls Strategy	Long Term Conditions
Description	Strategic Fit • Kent has an aging population, the over 65 population is expected to rise by at least 15% over the next 5 years (more than 20% for over 85 years). Evidence Base • One in three people aged 65+ will fall each year and one in two people aged 80+ will fall each year (NHS Confederation, April 2012) • Falls account for approx. 10 to 25% of ambulance callout (NHS Confederation). • NICE and National Service Framework (NSF) for older people recommend the prompt delivery of multifactorial assessment and interventions Key Changes • Screening of adults who are at a higher risk of falls • Integrated multi-disciplinary assessment for the secondary prevention of • falls and fractures • Use of standardised Multifactorial Falls Assessment and Evaluation tool • across Kent • Availability of community based postural stability exercise classes • Follow on community support for on-going maintenance closer to home High Level Benefit Assessment • Improve access to services • Reduce hospital admissions related to falls by preventing the patient from having a second fall • To reduce the number of health and social care activity related to falls and fracture in older people • Improve patient experience of services • Improve outcomes for patients Key Risks • Public Health timescales for the training and delivery of Postural Stability Instructors may not align with the delivery of the integrated pathway.

NHS Outcomes Framework

1	2	3	4	5
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Securing additional years of life for people with treatable mental and physical health conditions.	Improving the health related quality of people with one or more long-term condition, including mental health conditions.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	Increasing the proportion of older people living independently at home following discharge from hospital.	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

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<tr><td>Key Partners</td><td colspan="3">Kent Community Health NHS Trust
Kent County Council
Local CCGs
Kent Fire and Rescue Service</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="2">Key Measures</td><td colspan="3">Reduced falls related admissions</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td rowspan="7">Key Milestones</td><td>March 2014</td><td colspan="2">Scoping exercise complete</td></tr>
<tr><td>April 2014</td><td colspan="2">Full Business Case</td></tr>
<tr><td></td><td colspan="2"></td></tr>
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Community Equipment Loan Store	**Long Term Conditions**

Description	Key Changes • Procure joint social and health care loan store service • Implement seven day working • Faster, more responsive, service appropriate to patient need High Level Benefit Assessment • Creating efficiencies and financial savings, providing value for money against existing services • Reduction in admissions by ensuring patients have access to necessary equipment allowing them to remain living in their own homes Key Risks • Significant investment required • Unable to identify provider through procurement process • Implementation of new service does not meet objectives • Unable to gain support across health and social care for new service specification

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Securing additional years of life for people with treatable mental and physical health conditions.	Improving the health related quality of people with one or more long-term condition, including mental health conditions.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	Increasing the proportion of older people living independently at home following discharge from hospital.	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Project Accountability			
Clinical Lead	Dr J Ribchester	**Managerial Lead**	Laura Counter
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent Community Health NHS Trust Local CCGs		

Delivery in 2014-16		
Key Measures	Reduced admissions	
	Reduction in length of stay and delayed discharges	
Key Milestones	October 2014	Commence tender exercise
	April 2015	Implement new service

Expansion of Neighbourhood Care Team	**Long Term Conditions**

Description

Evidence Base

- Neighbourhood Care Team was implemented in February 2013, A&E attendance and admission avoidance achieved in line with plans

Key Changes

- Make the current H&SCC roles substantive within NCT, recognising the role functions as a central point of access and service navigation for practices.
- Review measurement of savings and test cost assumptions on patient cohort where admission avoidance achieved.
- Increase the H&SCC roles to cover Sunday between 10-2pm
- Extend current NCT team cover for long term conditions, to allow service cover until 8pm at night (currently 5pm), with an on call service being available for care homes 8-8, Mon-Sun
- Improve working relationships between Discharge Referral Service and community care to reduce LoS
- Encourage use of integrated team through H&SCC, by Out of Hours GP Provider.
- Embed use of Share My Care across EKHUFT/KCHT/IC24 and Secamb to reduce A&E attendances and admissions.

High Level Benefit Assessment

- Continue to reduce A&E attendances in 65+ age group – absorb growth in population attendances
- Improve provider integration

Key Risks

- Unable to recruit additional staff
- Service does not meet expected outcomes

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Securing additional years of life for people with treatable mental and physical health conditions.	Improving the health related quality of people with one or more long-term condition, including mental health conditions.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	Increasing the proportion of older people living independently at home following discharge from hospital.	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Project Accountability			
Clinical Lead	Dr G Jones	**Managerial Lead**	Lisa Barclay
Key Partners	Kent Community Health NHS Trust Kent County Council Local CCGs		
Delivery in 2014-16			
Key Measures	Reduced admissions		
	Reduction in length of stay and delays in discharges		
Key Milestones	March 2014	Trial extended hours	
	June 2014	Review outcome of trial peroid	

Personal Health Budgets	**Long Term Conditions**
Description	Strategic Fit • From 1st April 2014 everyone eligible for NHS Continuing Healthcare funding will have a right to ask for a personal health budget Evidence Base The final national evaluation of the personal health budget pilot programme was released in May 2013. The key findings of the evaluation were: • 72.6% of budget holders reported their budget having a positive impact on their independence • 67.9% reported a positive impact on being supported with dignity and respect • 67.7% reported a positive impact on being in control of their support • 63.9% reported a positive impact on their mental wellbeing Key Changes • Implement a robust governance system for assessment and planning linked to the SE7 SEN and Disabled Children Pathfinder and the establishment of the new Education, Health and Care Plans. • Implement a multi-agency joint commissioning approach to the provision and monitoring of a personal budget. High Level Benefit Assessment *Benefits to budget holders and carers* • Greater choice and control • Improved alignment with patients personal life and circumstances *Wider system benefits* • Greater transparency in the allocation of NHS funds • Greater integration • Greater innovation and service development Key Risks • Section 75 agreement not completed by April 2014 • Inability to recruit broker resources • Unable to agree clinical quality monitoring and support with existing providers

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	Helping people to recover from episodes of ill health or following injury	**Ensuring that people have a positive experience of care**	Treating and caring for people in a safe environment and protecting them from avoidable harm

Securing additional years of life for people with treatable mental and physical health conditions.	Improving the health related quality of people with one or more long-term condition, including mental health conditions.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	Increasing the proportion of older people living independently at home following discharge from hospital.	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

<table>
<tr><th colspan="4">Project Accountability</th></tr>
<tr><td>Clinical Lead</td><td>Dr J Ribchester</td><td>Managerial Lead</td><td>Marie Reynolds</td></tr>
<tr><td>Key Partners</td><td colspan="3">Kent County Council
Local CCGs</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
<tr><td rowspan="5">Key Measures</td><td colspan="3">Satisfactory levels of positive patient feedback.</td></tr>
<tr><td colspan="3">All PHB referrals are processed following agreed procedures within agreed timeframes.</td></tr>
<tr><td colspan="3">Tracking and comparison of PHB costs against traditional care package cost baseline provided through Decision Support Tool (for CHC).</td></tr>
<tr><td colspan="3">Reduced acute admissions and re-admissions and reduced A&E attendances, ICT referrals.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td rowspan="7">Key Milestones</td><td>Mar 2014</td><td colspan="2">Completion of Section 75 agreement</td></tr>
<tr><td>Jul 2014</td><td colspan="2">Broker recruitment and training completed</td></tr>
<tr><td>Aug 2014</td><td colspan="2">Development and approval of joint assessment processes for children with SEN and Disabilities</td></tr>
<tr><td></td><td colspan="2"></td></tr>
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Pulmonary Rehabilitation Service	**Long Term Conditions**
Description	Strategic Fit • Respiratory disease is the third most common cause of chronic ill health in the UK, (Thorax Journal) • 21% of adults recorded as "smokers" Key Changes • Increase capacity in the Pulmonary Rehabilitation Service • Encourage and facilitate patient self-management exercise groups • Ensure consistency in acute sites operate across East Kent High Level Benefit Assessment • Reduced duplication and meet existing gaps in provision – clear patient pathway • Reduced unnecessary appointments by improving patient self-management • Equitable service across East Kent • Closer working relationships between the acute trust and community clinicians • Accurate Asthma and COPD registers, and achievement of respiratory QoF points Key Risks • Workforce development • No increase in referrals

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

Securing additional years of life for people with treatable mental and physical health conditions.	Improving the health related quality of people with one or more long-term condition, including mental health conditions.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	Increasing the proportion of older people living independently at home following discharge from hospital.	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Project Accountability			
Clinical Lead	Dr J Ribchester	**Managerial Lead**	Kim Eaglestone
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent Community Health NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures	Reduction of A&E attendances and re-admissions for those patients that have experienced the Pulmonary Rehabilitation service;		
Key Milestones	March 2014	Task and Finish Group Commences	
	July 2014	Service Specification Complete	

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Strategic Commissioning Plan

April 2014- March 2019

(Incl. Operational Plan April 2014-March 2016)

v0.7

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Introduction

The NHS has changed, with responsibility for planning and paying for local health services being transferred from Primary Care Trusts (PCT) to Clinical Commissioning Groups (CCGs). We have thought long and hard about how we can use these reforms to improve the health of the community we serve, by capitalising on our knowledge and understanding of the local population.

The CCG has a membership of 22 practices, covering the Canterbury, Sandwich, Faversham, Herne Bay, Whitstable and the surrounding rural areas, and is led by local GPs and senior healthcare managers. We inherited a local NHS which offers good services, in good facilities and delivers good outcomes for most people, but is often uncoordinated and this means that the right things for patients are not always the easiest things to do. We will continue to work with residents and organisations, including Kent County Council, local District Councils, providers of health and social care, and the voluntary and community sector. Throughout this document you will find examples of this joint approach to meeting the needs of our population.

The aim of our Strategic Commissioning Plan is to tell the end-to-end story about how we will move from assessing the needs of our population to delivering services that will drive improvements in health outcomes. This document also sets out how Canterbury and Coastal CCG will inform and involve residents, partners, health and social care professionals, and voluntary and community sector groups to ensure we champion their needs, and ensure their thoughts shape our decisions.

Some of the decisions we will have to make this year and next will be tough, but we know that together with local doctors, nurses, NHS staff and you, our patients and our public, we can make a real difference to the quality of services you receive and the NHS is able to offer. In all we do, we want to ensure patients are involved and can have their say. In establishing our channels for engaging the public we are taking the best of the past and incorporating it into exciting new engagement models, including using new technologies to help us create a social movement for improved healthcare.

We promise that your health services are in safe hands and we will be open and honest about any decision we make to improve your care now and in the future.

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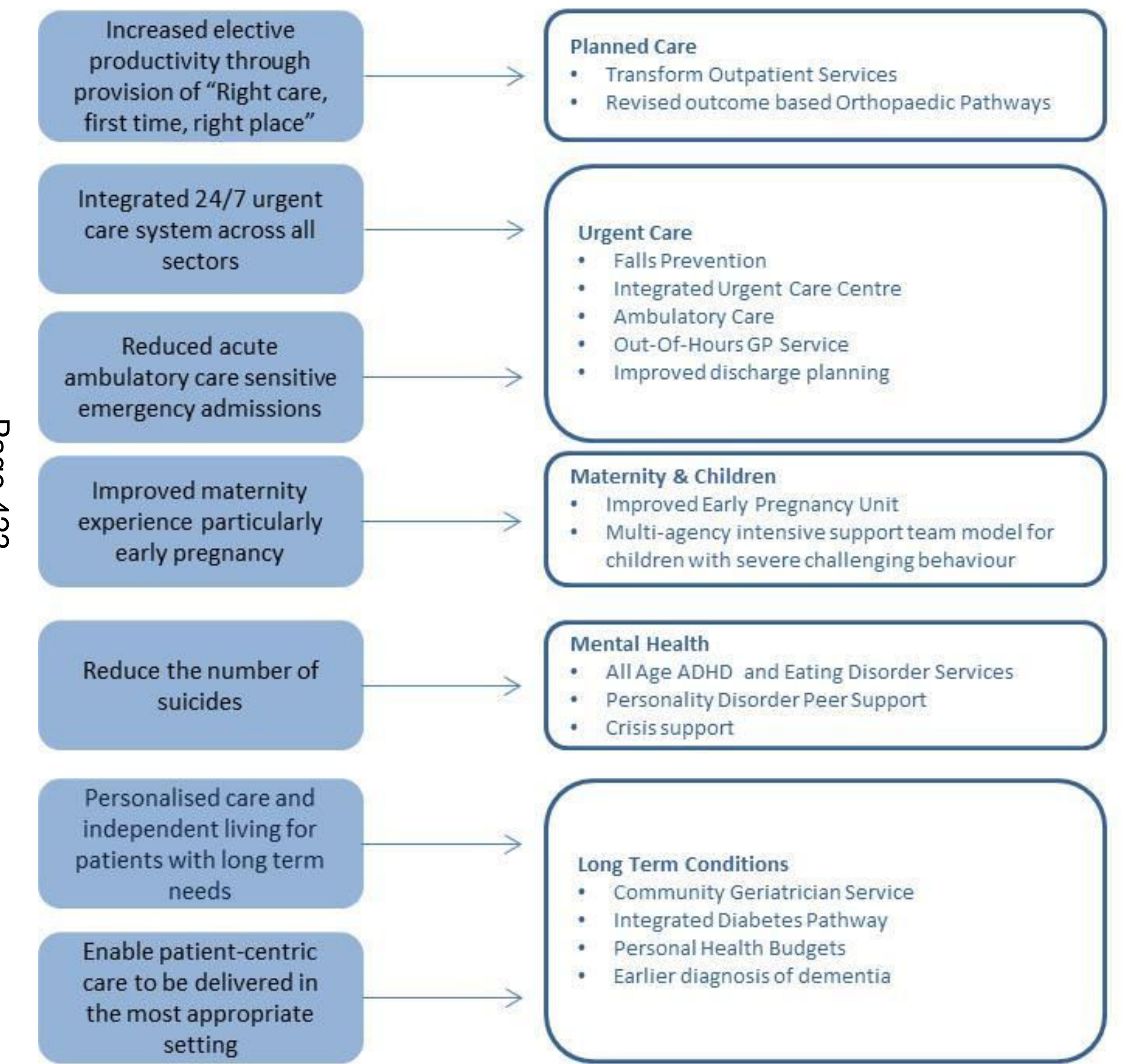
We want a health economy that is sustainable for the future with primary and community care services working closer together, along with voluntary organisations and other independent sector organisations able to forge common goals for improving the health and well-being of local people and communities



Governance

- Kent Health and Wellbeing Board
- Programme Boards for Urgent and Planned Care
- Corporate Governance Structure
- Monthly review of programme or project progress at CCG Clinical Strategy and Investment Committee meetings
- Identified Leads CCG for specific projects

Success Criteria

- Primary and community care services will work closer together, along with voluntary organisations and other independent sector organisations reducing the time people currently spend waiting for a service.
- We will see less acute admissions and reduced length of stay.
- We will see more people remaining in their own homes and a reduction in the proportion of the population living in care homes.
- More people will be living independently following reablement/intermediate care

Values and Principles

- People are supported to live in their own homes or communities.
- We have a workforce with skills to deliver integrated care.
- Our integrated teams respond rapidly to people at risk of admission
- Carers are be supported and have access to services as appropriate.
- We will have systematised self-care so that people can to manage their own health and social care needs

About the CCG

Background and Context
Health Profile
Working Together
Health and Wellbeing Board

Background and Context

The Health and Social Care Act (2012) gave more power and responsibility to front-line professionals to commission safe, high-quality and compassionate care and to make decisions about the use of resources through Clinical Commissioning Groups. This comes at a time when, across England, the NHS must continue its QIPP programme to deliver £30bn of savings by 2020. We have started to build a track record of delivering change and have established a strong partnership approach in our local health and social care economy

This means that the next five years (2014-19) will be another challenging period for the NHS and your local CCG who will be supporting the delivery of the improvements and standards set out in the NHS Constitution, the NHS Mandate and the NHS Outcomes Framework.

In support of the 2014/19 planning and delivery process the CCG has produced this document to:

- Provide the context in which the CCG operates
- Communicate our plan to our patients and local population
- Mobilise commissioners, providers, partners, voluntary organisations and members around a common set of objectives and plans
- Provide assurance on how we will deliver what the CCG aims to achieve

The document and content within it is generated from, amongst other inputs, demographic information, performance data, national guidance and recent health inquiries. However, one of our most important sources of information is that which our patients and public provide us directly. We have used a number of stakeholder events, feedback given to our practices and our formalised patient participation groups to inform this plan and we will continue to refine and update our plans based on what our patients and public are telling us.

We believe that these steps will deliver ambitious improvements to the local NHS in line with the needs of local people as set out in our Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy as well as against the 5 Domains of the NHS Outcomes Framework:

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring that people have a positive experience of care
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm

This plan is owned and sponsored by our governing body and member practices and represents our commissioning and delivery intentions.

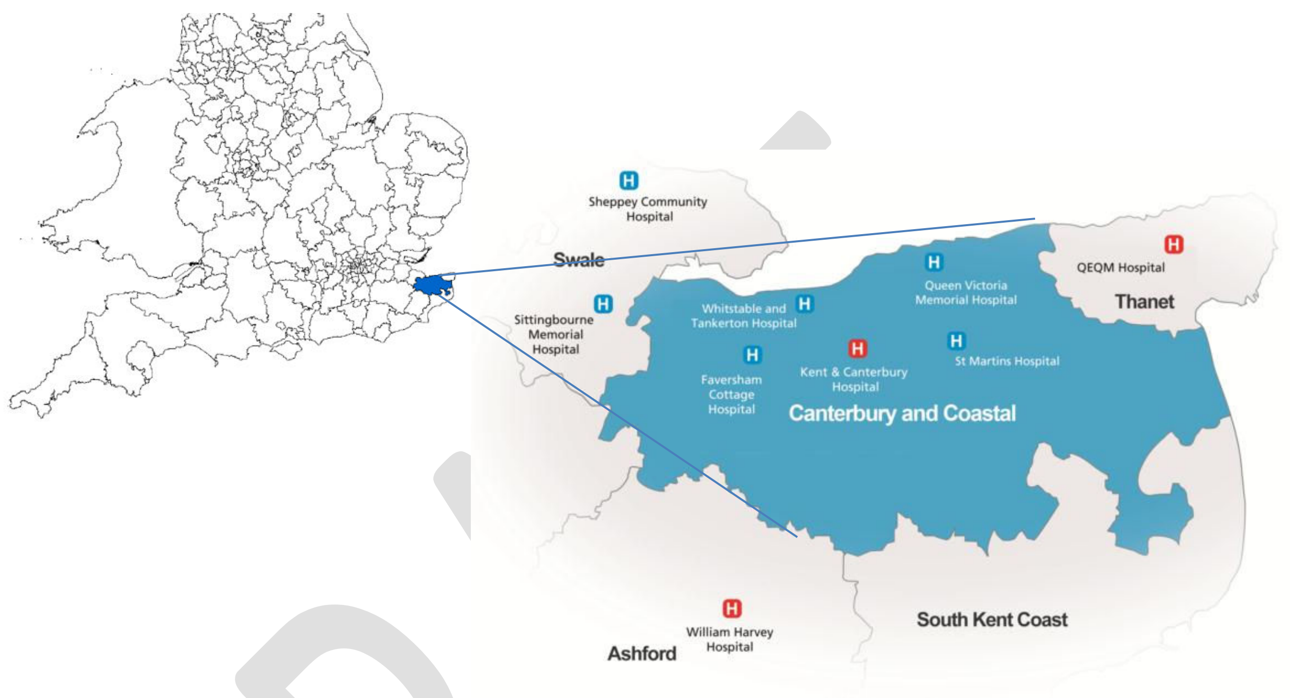
Joint Strategic Needs Assessment

SUMMARY – OUR POPULATION HEALTH CHALLENGES	
Inequalities	Life expectancy from birth in the Canterbury and Coastal area is estimated to be 81.2 years, nearly a year less than Ashford but greater than the other east Kent CCGs and marginally better than the Kent and Medway average. However, the range between ward with highest life expectancy - St Stephens (84.1) - and the lowest - Northgate (76.2) - is nearly 8 years
Population	Compared to the population pattern of Kent and Medway, the CCG is under represented in the early years, in childhood and youth, in the middle age cohorts. From age 65 onwards, there are increasing numbers of females relative to males. Canterbury is a university city; hence the population aged 15-29 is considerably greater than the pattern seen elsewhere in Kent and Medway. Using resident populations for the district of Canterbury, the population aged 65+ is likely to increase by 56.1% between 2011 and 2031 (from 28,700 to 44,800). This increase is predicted to be greater in the 85+ age group (97.7%) over the same period (4,400 to 8,700).
Cause of Death	Circulatory Disease is now the main cause of death, followed by Cancer and respiratory disease.
Lifestyles	The rate of smoking for the Canterbury City Council area is 20.7% of adults but masks a concentration of residents who smoke in the Canterbury City area and central Herne Bay. Smoking rates are higher amongst younger people. 23.4% of adults are estimated to be obese in the Canterbury City Council area. This position is slightly better than the England average (24.2%). The trend in alcohol specific admissions shows an increase from 2008/09 although the rate of alcohol admissions for under 18s continues to decline from a high in 2008/09. However the rate for the CCG area is greater than that for Kent as a whole.
Long-Term Conditions	There will be increasing numbers of people who have long-term conditions and this will further increase with the ageing population, particularly the likelihood of having more than two conditions.
Dementia	Dementia - with the increasing age of the population the number of dementia cases will rise; prevalence increases particularly in the population older than 65.

The information in this section provides the geographical, socio-economical, regulatory and financial context in which NHS Canterbury & Coastal CCG will commission services in 2014/16. It directly informs what we will prioritise within the context of limited resources.

Location

NHS Canterbury and Coastal CCG covers the City of Canterbury, the towns of Faversham, Whitstable, Herne Bay, Sandwich & Ash as well as surrounding rural areas.



Key High-Level Data

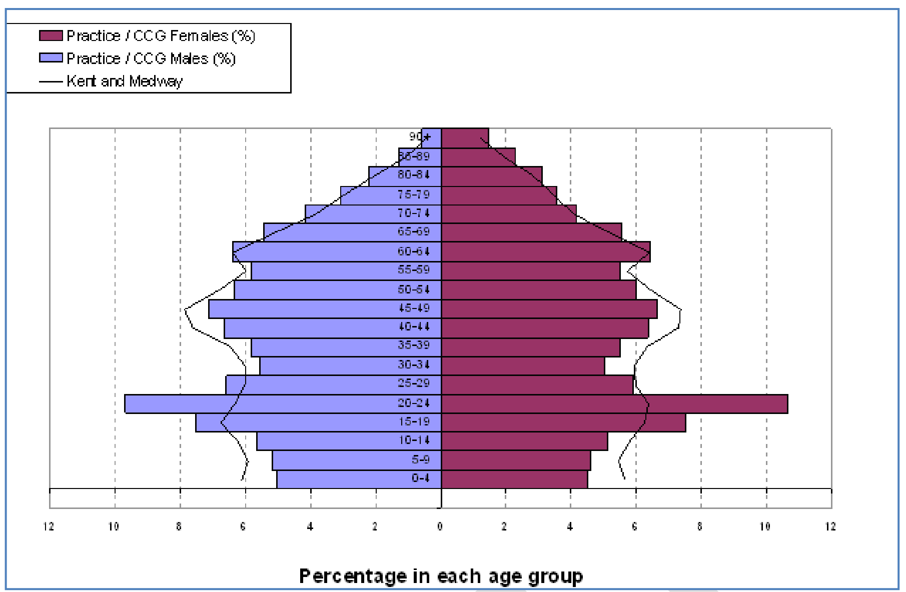
Below are some high-level data points which are relevant to this CCG and its commissioning activity:

Data Point	Data
Registered patient population:	211,651
Number of GP practices:	22
Neighbouring CCGs	5
Community Hospitals	4[1]
Acute Hospital (within CCG boundaries)	1[2]
Community Mental Health Hospital	1
Commissioning budget:	£238M

High-level demographic information

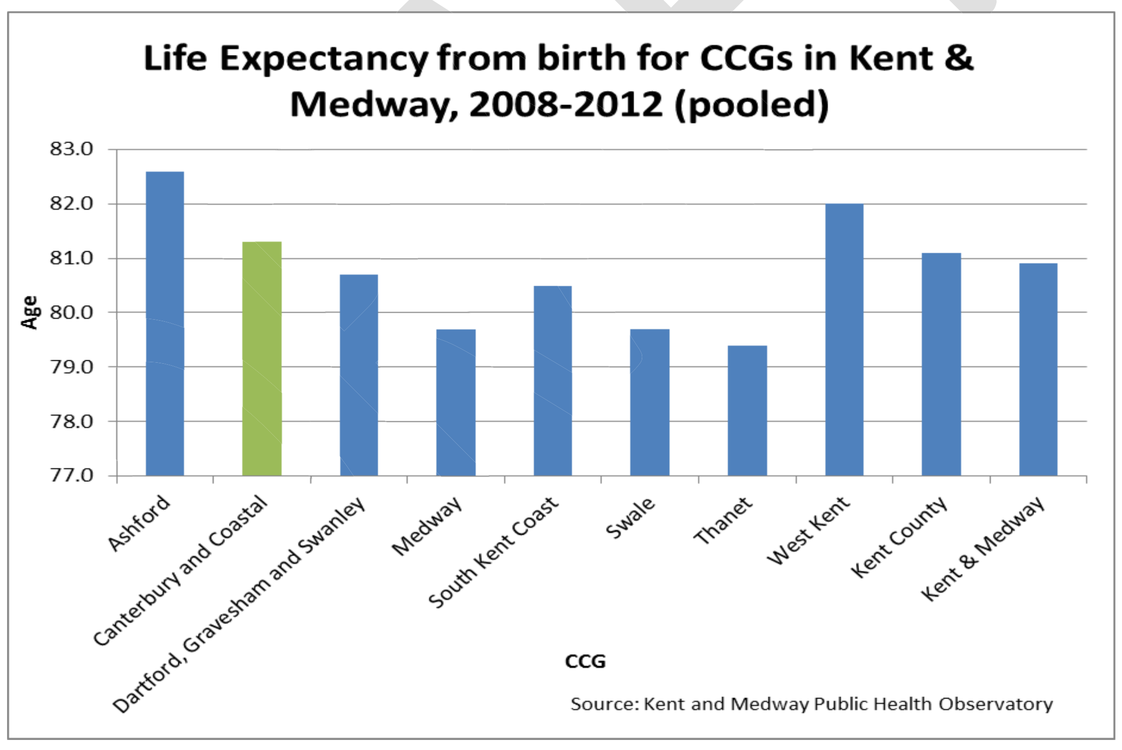
Compared to the rest of Kent and Medway, Canterbury and Coastal has a higher than average student and elderly population. For the elderly population this means that there may be a higher than average demand for services pertaining to long term conditions (including dementia) whilst for the student population services related to health promotion, lifestyle and sexual health will be key.

[1] Includes Deal Community Hospital which our patients in Sandwich and Ash are referred to
[2] The CCG also refers patients to Queen Elizabeth the Queen Mother Hospital in Thanet and to William Harvey Hospital in Ashford



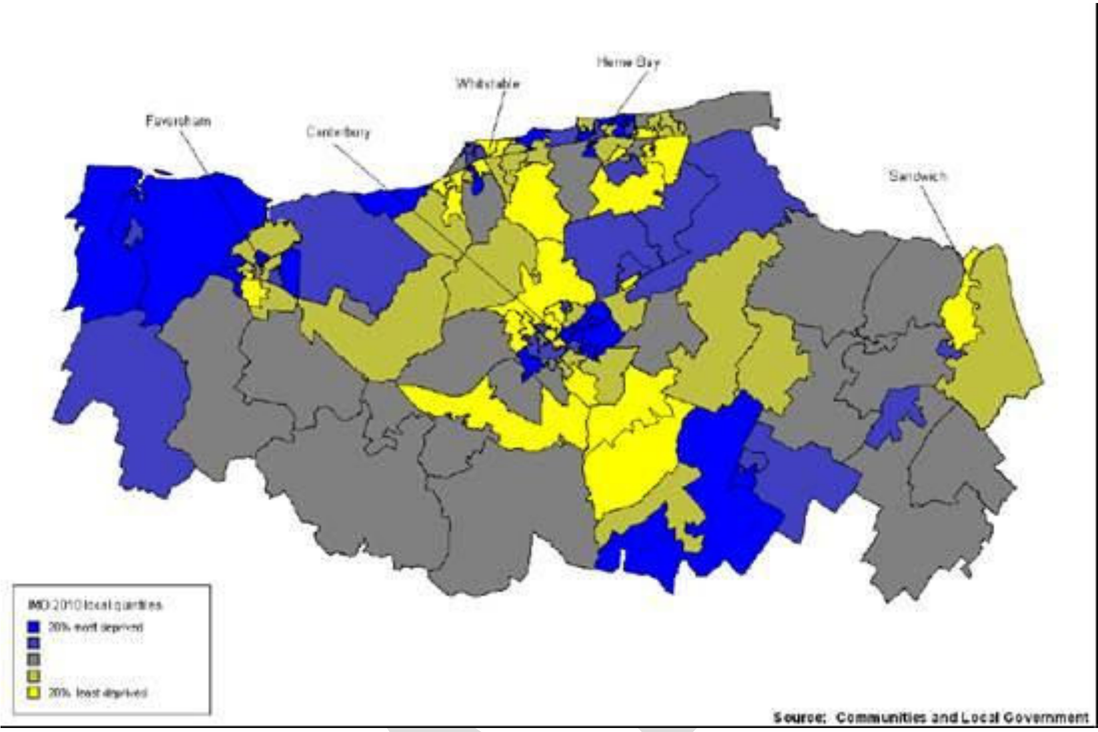
Life Expectancy

Compared to the Kent and Medway average, life expectancy is higher than the average but not as high as our neighbouring CCG, Ashford.



Deprivation

Whilst the C&C CCG benefits from relatively good health outcomes and life expectancy it does include some wards which count amongst the most deprived in the country denoted by the blue areas in the diagram below.



The greatest concentrations of people living in relative deprivation are to be found in the rural outlying areas of Faversham and its hinterland, in particular areas of the coastal towns Whitstable (Seasalter, Harbour, Gorrel and Swalecliffe) Herne Bay (Heron and Greenhill) Canterbury (Northgate, Spring Lane, Wincheap and Hales Place) the rural area of Marshside, Hersden and north Sturry; Sandwich, Eastry and downland farming area to the south west of Littlebourne.

Inequalities in health are primarily a socio-economic relationship. The poorer people are, the greater the likelihood of early onset disability and chronic disease and shorter life span. In contrast, those who are of high status have expectations of a much greater disability free life span and of a good old age.

People with low socio-economic status are at greater risk of behaviours causing ill health. They will have higher smoking rates, have a poorer diet, have less opportunity to take part in social activities, have poor mental health. Whilst it is undeniable that individual behaviour is a significant driver of ill health, it is wrong to attribute all causes of premature poor health and early death to personal behaviour. If such behaviour was eliminated, people with the lowest socio-economic status would certainly live longer, but would continue to die prematurely relative to the mainstream society.

Addressing health inequalities as a strategic response requires CCGs to commit to partnership working with other statutory agencies whose capacity to address the wider determinants of health is core to their purpose. Accordingly C&C CCG must support the actions of Public Health working with local authorities to address the root causes of disadvantage, whether through the Kent Health Inequalities Strategy, through Canterbury City Council's Corporate Plan (which has a dedicated section to tackling disadvantage), with neighbouring councils or through the work of Local Children's Trusts.

Working across CCGs

In some instances, CCGs need to work together to create a bigger footprint as a "unit of planning" in order to effectively commission some of the services for which they are responsible, but also to share risk safely, transfer skills and secure commissioning support. The CCGs in east Kent have agreed to collaborate in a range of areas where working together will;

- **Support Clinical Improvement –** through consistent, evidence based pathway development and effective and consistent performance management
- **Drive greater efficiency –** by ensuring leverage with providers; keeping transaction costs low; and sharing (potentially scarce) expertise and capacity
- **Provide greater resilience –** by managing financial risks together; improving risk management and sustaining more effective business continuity arrangements

A range of initiatives have been agreed which will ensure that CCGs are able to work together across east Kent to both deliver transformation in areas where a greater critical mass must be achieved to make change sustainable and where wider approaches are key levers to improvements in individual CCGs.

As illustrated in the diagram below the projects will be planned and delivered at either an East Kent-level, as joint projects with Ashford CCG or as a local project only to serve Canterbury and Coastal CCG's needs:

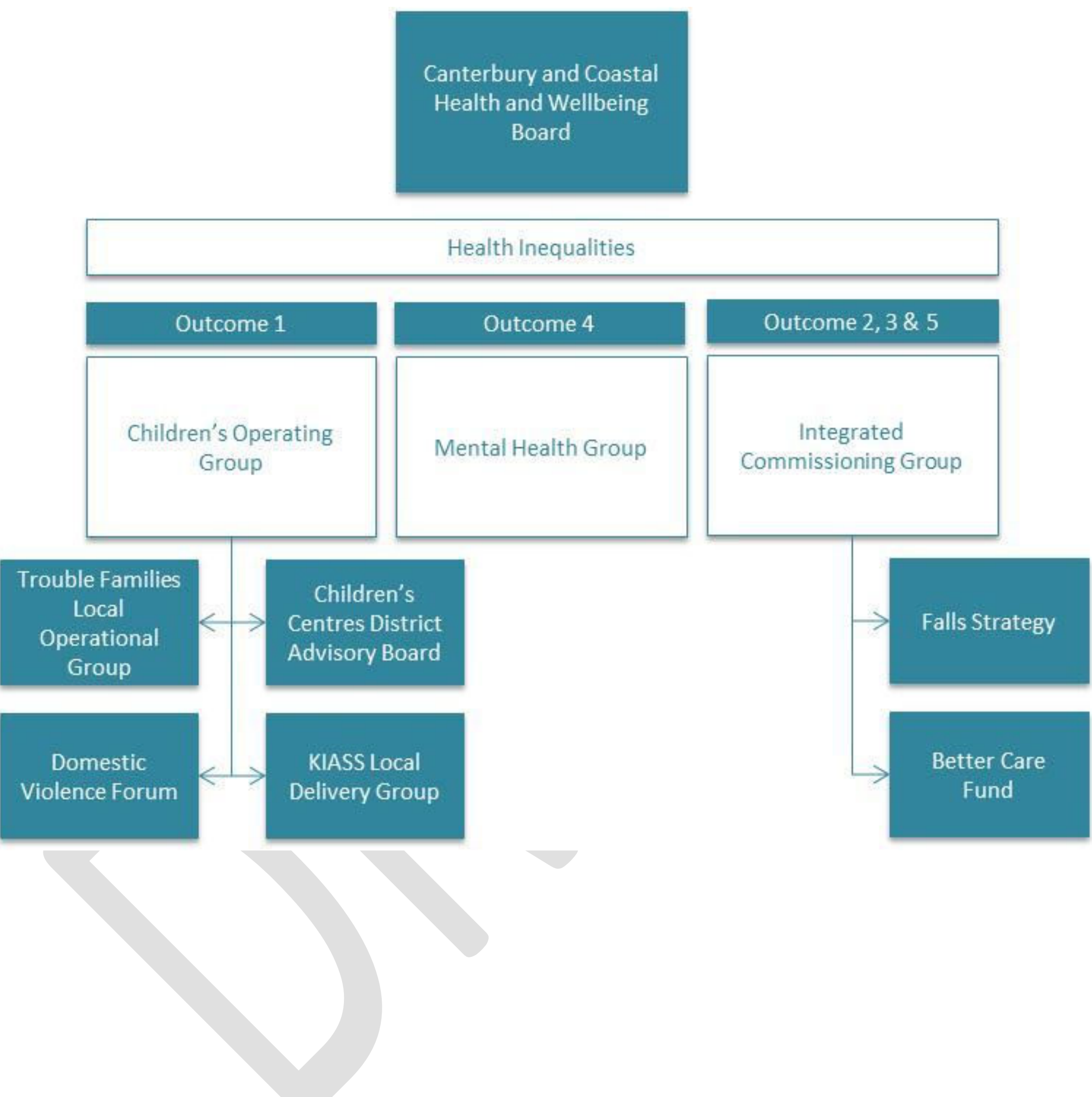
South Kent CCG	Thanet CCG	Ashford CCG	Canterbury and Coastal CCG
4 x East Kent Wide Transformational Programmes (Planned Care, Urgent Care, Mental Health, Children and Young People)			
Joint Projects		Joint Projects	
Local Projects	Local Projects	Local Projects	Local Projects

Canterbury and Coastal Health and Wellbeing Board

The Canterbury and Coastal Health and Wellbeing Board brings together the statutory and voluntary organisations which are involved in healthcare, social care and public health to champion the delivery of better, more efficient and integrated services in the area. It is a forum where partners can share their respective objectives, performance requirements and proposed plans with a view to identifying areas of mutual interest and support. Although formally a sub-committee of the Kent board, the local board is closer to local citizens/patients and has a more detailed insight into their needs and preferences which therefore complements the county-wide overview and is able to inform and influence County priorities and actions

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

In order to discharge its responsibilities, the board has identified three working groups to deliver against the domains of the Kent Health and Wellbeing Strategy. These groups are detailed below;



System Vision

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Community Based Care
Primary Care
Urgent Care
Long Term Conditions
Children and Young People
Planned Care
Mental Health
Working with Social Care – The Better Care Fund
Centres of Excellence
Cancer Services
Cardiovascular

Our Vision

Our vision and goals within our plan have not been developed in isolation and reflect the broader strategic context in which we operate as a statutory body. There are a number of external factors and influences, plus national requirements on which we are mandated to deliver. These can be broadly encapsulated in the following analysis.

Political	Economic
• National policy implementation • Changing NHS landscape • Secretary of States mandate • Public Health Transition • Legislative changes • Regulatory bodies • Market development • NHS England • Healthwatch • Health & Wellbeing Board • Professional preferences and resistance	• Financial sustainability • Financial Accountability • QIPP Challenge • Financial climate • Patient choice • NHS Cooperation and Competition • Foundation Trust pipeline
Social	**Technological**
• Health inequalities • Deprivation factors • Equity of Access • Lifestyle choices • Ethical decisions • Protected characteristics	• NICE guidance • Evidence based decisions • IMT providers and suppliers • Emerging technology • Introduction of new drugs • Use of social media and internet

Canterbury and Coastal CCG worked on our, vision and strategic priorities as we progressed through the authorisation process to become a statutory commissioning body and have continued to develop these further since April 2013.

The outcome is the result of consultation with our patients, members, partners and Governing Body. They are also aligned to and informed by both the Kent Health and Wellbeing Strategy and national strategic directions, as set out through "Everybody Counts"

By 2018/19 we want to achieve a health economy that is sustainable for the future. We want care that crosses the boundaries between primary, community, hospital and social care. Our vision is of primary and community care services working closer together, along with voluntary organisations and other independent sector organisations able to forge common goals for improving the health and well-being of local people and communities.

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Community Based Care

There is no lack of ambition to deliver the right outcomes for our patients and the wider population but we recognise the unprecedented scale of the challenge that faces the NHS nationally and locally. However, we believe that our developing plans give us the building blocks for a sustainable health economy in east Kent.

We have sufficient evidence for us to adopt radical change across the local health economy, drive improvements in medicines use and by working in partnership with our members, improve Primary Care infrastructure, workforce and services for patients.

We are confident that we are doing the right things for both patient care and for the delivery of a sustainable, viable and vibrant health economy, where we will actively seek and support opportunities for integrated care and integration between health and social care.

We are convinced that maintaining and driving the types of improvement to the quality of services set out in this plan will drive the productivity which delivers long term sustainability.

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

Our patients and carers should expect a high quality, compassionate, safe and personal service based around their needs, present and future. They should be enabled to take ownership of their health and social care and with that accept responsibility for their health behaviour and use of health and social care services.

The focus on quality must be our first consideration. Patients should not come to harm as a result of accessing and receiving care and we will commission services which deliver the best possible clinical outcomes within the available resources.

As part of this, we will move towards affordable 24/7 services, which are integrated across health service providers with voluntary and social services incorporated into community-based contracts. To enable this we will use new contract mechanisms (e.g.: alliance, lead provider), for defined geographical locations and which have clear, explicit, measurable outcomes for defined cohorts of patients

Primary Care

Whilst NHS England have responsibility for commissioning GP services through the national GMS and PMS contracts, general practice delivers significantly more services than ten years ago and this trend will continue with a proportion of this additional work transferred from traditional community or hospital bases. Excellent General Practice is core to the delivery of Ashford CCGs strategic vision.

In order for this is be possible a number of changes in the way which general practice operates will need to occur. NHS England has set out a call to action to staff, public and politicians to help the NHS meet future demands, including those faced by GPs. As a CCG we are supporting our practices as they endeavour to reconfigure their approach in response to this call.

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

Urgent Care

People using services and their carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need. Many patients, through better preventative care, should not need to access urgent care services. In addition patients often experience issues in identifying the best urgent care option to suit their needs. Furthermore, once they access urgent care services they may find it difficult to be discharged quickly and effectively due to sub-optimal integration of care services.

Traditional models of Urgent Care services have often been described as being highly fragmented and generate confusion among patients about how and when to access care. The Kings Fund report "Transforming our health care system" identifies a number of common issues across Urgent Care:

- Patients are frequently admitted to Hospital when it is not clinically justified because of a lack of alternative available options
- Poor sharing of information as patients move between different providers is a cause of significant failures of care (Ghandi, 2005)
- The growth of new forms of Urgent Care, such as walk in centres has failed to reduce A&E attendances (Cooke et al, 2004)
- New forms of urgent care have also failed to reduce Emergency Admissions, which continue to grow, rising by 5% between 2008/9 and 2011/12 (Department of Health 2011d; 2012).

An activity analysis of the patients who attend A&E has suggested locally that 38% of patients attend A&E present with Primary Care conditions. Provider organisations across East Kent recognise that patients attend A&E for a variety of reasons including:

- Health care Services are fragmented and difficult to understand
- Services in and out of hours offer different levels of cover
- A&E is recognised as a one stop shop service

It has long been recognised within east Kent that integrating services will reduce the amount of duplication and improve speed and ease of access for patients. Following the integration and roll out of several significant initiatives within the area, the east Kent health economy is proposing a fully integrated Urgent Care service. This has been designed by all providers in East Kent as one project.

The proposed model will bring services together to ensure that care will achieve a number of goals including a rapid multi-disciplinary assessment with rapid access to a range of services that will ensure that patients are managed seamlessly and are better supported to cope within their local community. This service will prevent a significant cohort of patients from having to attend hospital, improve recovery following an event and ensure that patients retain independence.

It will achieve this by providing rapid access to key health economy services which include:

- General Practitioners
- Community Support Services
- Social Services
- Psychiatric Services
- Secondary Care Consultants (including Geriatricians)

A variety of apparently isolated service developments are in fact drawn together leading to the colocation of a number of key services within hubs across East Kent under a single command and control structure to create a multi-disciplinary team working as an Integrated Urgent Care Centre (IUCC).

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These centres are about the colocation of services around specific buildings to provide an immediate multi-disciplinary response to self-presenting patients and also the coordination of a number of services which together form east Kent response to increasing demands. Our collective vision provides rapid access to care for a greater cohort of patients complimented with enhanced local support services for patients on a 24/7 basis. This will significantly reduce conveyances to hospital and provide enhanced care and support for patients to help them recover in their own home or place of residence.

Long Term Conditions

Our approach to the management of patients with long term health and social needs, also links with our vision for urgent care and our community based approach. The number of patients with long term needs is expected to rise due to an ageing population and certain lifestyle choices that people make.

We will continue our current approach of identifying patients requiring additional support through risk profiling. Risk stratification tools are utilised to support the identification of patients at risk and GPs are working locally with community nurses and members of the integrated health and social care teams (locally referred to as Neighbourhood Care Teams) to ensure Management Care Plans are developed to support and educate patients to manage their own conditions.

Previously, a patient may have received visits from a number of community teams and GPs would have to refer patients to a variety of organisations depending on the patients' needs. The approach means patients only have to tell their health story once, and GPs only need to refer a patient to one team through a health and social care coordinator. As previously stated a key component of this is to ensure that the neighbourhood care teams are based in and around towns in the area, and aim to provide a more integrated health and social care service and work closely with the patient's GP to ensure patients receive the right services and support quickly to avoid an unnecessary admission to hospital.

Children and Young People

As our health profile demonstrates, Canterbury and Coastal CCG will see significant growth in the child population during the next 7 years, however some of the largest increases will fall within the 0-4 age range, creating significant demands on paediatric services.

National research states that the use of A&E departments by children is often not for emergency care but the default position for concerned parents, or just sometimes the nearest centre of care. In essence this demonstrates a need for us to improve access to paediatric services that can be provided in primary care, children's centres and other community settings to reduce unnecessary and avoidable admissions to Secondary Care and to ensure that parents are supported within their own communities.

We will ensure that vertical and horizontal integration of all paediatric services, including health, social and voluntary sectors, to reduce inequalities in care, narrow the gaps, avoid duplication and reduce clinical variation. This approach is supported by national research and best practice in relation to developing a whole system approach to improving emergency and urgent care for children, young people and their families.

The current system within Canterbury and Coastal CCG area is disjointed and parent carers have also stated that it is confusing and difficult to navigate. There are a range of access points within the health system for children, young people and their families including GP practice, minor injuries, A&E, Short Stay Paediatric Assessment Unit and out of hours, community children's nursing service, health visiting service and school nursing service. Through Canterbury and Coastal CCG patient and public engagement events there is also a demand to access services closer to home in the

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community, rather than always in a hospital setting. A new whole system approach between providers of healthcare (and for those with more complex needs providers of health, education and social care) is required to ensure services are more streamlined and provide seamless care which will lead to better outcomes.

We will align our paediatric transformation programme, and whole system approach for urgent and emergency care for children and young people, with the wider transformation programmes outlined above to maximise impact and promote effective transition to adult services.

Planned Care

Referral rates from GPs have reduced in the past number of years, with waiting times also consistently reducing. In order to ensure that waiting times reduction is maintained, as demands increase, we need to continue to consider alternative approaches to GP referral.

With this in mind analysis has shown that a number of patients are discharged from secondary care immediately following their first outpatient appointment. One of the reasons for this is that the GP is seeking additional advice on the management of a patient's condition, and for a number of these patients attending the outpatient department offers little real value.

GP's and other health professionals who refer patients to acute services will have access to acute care consultants via a mechanism that will be fast and easy to access by all involved. Currently there are schemes in place, and have been piloted previously, that utilise either Choose & Book (eBooking) or secure email (Nhs.net)

The objective is to formulate the exact mechanism which is acceptable to all uses and will provide outcomes of appropriate referral, first time for patients which will in turn also result in reduced referrals as some patients disease management will be better undertaken in primary/community care

Our patients also tell us that they are inconvenienced by a system which requires them to attend for outpatients, then separately for diagnostics, then again for follow-up. Not only is this inconvenience for them but it's not effective use of resources. Repeated visits are often clinically unnecessary and lead to increased anxiety for patients. In addition the capacity used leads to delays in the system for the delivery of 18 weeks.

Nationally 37 million follow up appointments where patients are asked to return to hospital to have their progress checked, to undergo tests, or to get test results. 75% of all out patient 'Did Not Attends' (DNA) are for follow-up appointments. The follow-up DNA rate varies between specialties and locations but a range of 10-40% is common. There are more than four million follow-up DNA's per annum, which cost the NHS more than £100 million a year.

With waiting times for diagnostics dropping significantly over the past few years, there is no longer the requirement for patients to attend outpatients, return for a diagnostic test and then return to outpatients for the results and treatment plan.

One Stop Services facilitate the assessment, diagnosis and commencement of treatment plan within one visit. Across our local health providers there are limited services where a one stop approach is undertaken. This results in the need for patients to make several visits to the provider before they commence treatment.

In order to ensure that providers are able to deliver one stop services it will be necessary to support the redesign of outpatient services particularly in relation to provision of same day diagnostics. Therefore it is anticipated that this project will take at least 15 months from commencement to completion across all specialties

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Whilst East Kent Hospitals University NHS Foundation Trust undertake the majority of outpatient services the project will require working with all providers to ensure that there is consistent approach and therefore equity of care. The CCG is committed to working with the organisations who provide planned care services to improve care and to look at different ways of ensuring high quality services that are centred on the patient and are available as close to their home as possible.

Mental Health

The majority of people with mental health needs in the Ashford CCG area are looked after by their GP. Where patients need more intensive support, they are predominantly treated in services provided by Kent and Medway NHS and Social Care Partnership Trust (KMPT).

We will continue to promote good mental health and wellbeing in the community, reduce the number of people who get common mental health problems, and lessen the stigma and discrimination associated with mental ill-health. We will ensure that prevention is targeted at those at higher risk but also that the right services are there when people need them.

Public services, the voluntary sector, and the independent sector will work together to improve mental health and wellbeing. Services will be personalised, will involve service users and their families in equal partnership, will aid recovery and will help people to reintegrate into their communities. They will promote the best care and promote accessible, supportive and empowering relationships. As with the CCG's underlying principle, wherever possible, services will be community-based and close to where people live.

We will improve the life expectancy and the physical health of those with severe mental illness, and improve the recognition of mental health needs in the treatment of all those with physical conditions and disabilities. We will reduce the number of suicides. We will ensure that all people with a significant mental health concern, or their carers, can access a local crisis response service at any time and an urgent response within 24 hours. We will ensure that all people using services are offered a service personal to them, giving them more choice and control. We will deliver better recovery outcomes for more people using services with care at home as the norm. We will ensure that more people with both mental health needs and drug and/or alcohol dependency (dual diagnosis) are receiving an effective service.

Working with Social Care – The Better Care Fund

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

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

- Together we will design and commission new systems and models of care that ensures the financial sustainability of health and social care services in Kent. These services will give people every opportunity to receive personalised care at, or closer to home to avoid hospital and care home admissions.
- We will use an integrated commissioning approach to buy integrated health and social care services where this makes sense.

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- The Kent Health and Wellbeing Board will be an established systems leader, supported by clinical co-design and strong links to innovation, evaluation and research networks. Integrated Commissioning will be achieving the shift from spend and activity in acute and residential care to community services, underpinned by JSNA, Year of Care financial model and risk stratification. We will have a locally agreed tariff system across health and social care commissioning.

- A proactive model of 24/7 community based care, with fully integrated multi-disciplinary teams across acute and community services with primary care playing a key co-ordination role. The community / primary / secondary care interfaces will become integrated.

- We will have a workforce fit for purpose to deliver integrated health and social care services. To have this, we need to start planning now and deliver training right across health, social care and voluntary sectors. We will also need to ensure that we link in with our partners within education

- An IT integration platform will enable clinicians and others involved in someone's care, including the person themselves, to view and input information so that care records are joined up and seamless. We will have overcome information governance issues. Patient held records and shared care plans will be commonplace.

- We will systematise self-care/self-management through assistive technologies, care navigation, the development of Dementia Friendly Communities and other support provided by the voluntary sector.

- New kinds of services that bridge current silos of working where health and social care staff can "follow" the citizen, providing the right care in the right place.

The Kent Health and Wellbeing Strategy has identified key performance measures, these are currently being updated and will include measures for integration. In addition there are local measures in place against existing projects which will support the BCF projects. As a Pioneer Kent will be undertaking a baseline assessment and delivering against the performance measures set out by the Programme. These will be combined with the metrics as outlined in the Better Care Fund plan to produce a robust performance and outcomes framework.

Centres of Excellence

To be completed with detail from NHS England Specialised Commissioning

Cancer Services

To be completed with input from NHS England Specialised Commissioning

Cardiovascular

To be completed with input from NHS England Specialised Commissioning

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Delivering Harm Free Care

Berwick, Francis and Winterbourne
Quality Monitoring
Hospital Acquired Infections
Never Events
Whistleblowing
Safeguarding
Patient Experience
Additional Quality Priorities

Berwick, Francis and Winterbourne Reviews

We will ensure that the recommendations from the Winterbourne View, Berwick and Francis reports are implemented within all local health providers and for ourselves as commissioners. We will have an additional focus on monitoring safer staffing levels throughout provider organisations and through contractual processes.

Quality Monitoring

We will work with our providers and use the contractual levers available to ensure that patients are treated in a safe environment, with an emphasis on zero tolerance of avoidable harm and ensuring that nursing care is of the highest standard;

We will ensure that systems are in place to monitor potential breaches of safety and improvements against the NHS Safety Thermometer, particularly in relation to pressure area care. We will ensure that provider organisations comply with national guidance in relation to the reporting of incidents to ensure that system wide learning can then be undertaken.

Hospital Acquired Infections

We will continue to reduce the number of Health Care Associated Infections (HCAIs) through the implementation of local action plans and we remain committed to a zero tolerance approach. We will employ expert resource in this field to bridge the gap between primary and secondary care and ensure that learning can be embedded throughout the health and social care sector.

Never Events

We will encourage a culture of transparency, openness and candour across the health system, to ensure that staff, patients and carers feel safe and secure when raising concerns and that we learn from patient safety incidents and 'never events' to prevent them from happening again.

Safeguarding

We will continue to work closely with our local authority partners to continually improve the safeguarding of children and vulnerable adults and to continue to be active members of the local safeguarding boards

We will continue to maximise opportunities for greater coordination and integration of adult and children's safeguarding arrangements

We will work with NHS England to ensure the recruitment of GP leads for safeguarding

We will work collaboratively to ensure the sharing and implementation of learning from serious case reviews and audits across the health community

We will continue to ensure that the continuing healthcare service is compliant with all national standards whilst retaining a focus on the quality of care being delivered.

Patient Experience

We will work with providers to put mechanisms in place to systematically gather real-time patient and carer feedback including ensuring the Friends and Family Test is in place across all providers.

We will continue to use real-time feedback from our patients and carers and build on this to assess the experience of people who receive care and treatment from a range of providers in a coordinated care package across health and social care.

Additional Quality Priorities

- The continued elimination of mixed sex accommodation and increased dignity for patients

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- full implementation of the NICE quality standards and the implementation of root cause analysis of any Venous Thromboembolism (VTE) occurrences
- reducing harm to patients, particularly pressure ulcers
- improve safety within maternity services

Performance

Contractual and Performance Management
Provider Development
CQUIN payments
Care Quality Commission
Friends and Family Test
Infection Control
Mixed Sex Accommodation
'Never Events'
Serious Untoward Incidents
NHS Constitution Standards
Waiting Times

Contractual and Performance Management

The CQC has launched their new Intelligent Monitoring report. This replaces the Quality Risk Profile (QRP). The new model monitors a range of key indicators about NHS acute and specialist hospitals. The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements but will be backed up by inspection. Each indicator has been analysed to identify two possible levels of risk ("risk" and "elevated risk").

East Kent Hospitals University NHS Foundation Trust (EKHUFT)were rated as a Band 3 organisation (the bands are 1-6 with 1 being the highest risk). There were four areas assessed at EKHUFT as showing an 'elevated' risk. These were:

- Mortality following hemi-arthroplasty repair of a fractured neck of femur - HMSR 125
- Patient experience and functional outcome following elective knee arthroplasty (PROMs)
- Response rate against the Friends and Family test
- Educational concerns reported to the CQC by the General Medical Council (GMC)

The CQC has subsequently written to EKHUFT with details of their forthcoming inspection. The CQC's inspection will start on 3 March 2014. The core site visit is likely to last between two and five days. Inspections take around two weeks in total, but this includes the CQC's team preparation day and any follow up work they will need to do. Within this ten day envelope, the CQC will spend around two to three days on site with a large team inspecting the eight key service areas. The CQC may add services to this depending on their assessment of risk and the number of acute sites. The CQC will be allocating leads to the inspection teams who will be the primary CQC contacts over the weeks running up to the inspection.

Friends and Family Test

The Friends and Family Test (FFT) aims to provide a simple, headline metric which, when combined with follow-up questions, can be used to drive cultural change and continuous improvements in the quality of the care received by NHS patients. Nationally, Trusts are measured using the Net Promoter Score (NPS) where a score of approximately 50 is deemed good.

EKHUFT's NPS was 64 in October, thus demonstrating overall satisfaction with Trust services. The company, 'iWantGreatCare', which reports FFT data on behalf of EKHUFT have converted the NPS into a "star score" value (ranging from 0 to 5) thus making the interpretation of FFT results easier. The star score is calculated using an arithmetic mean, so a ward that scores 4 stars has an overall average rating of "likely" to be recommended. EKHUFT score for October was 4.6 stars out of 5 stars.

EKHUFT is achieving the overall response rate for F&F with inpatients but not A&E. The use of texting within A&E indicates improved response rates. Early indications for maternity, suggests low response rates. The recovery plan continues to be delivered, overseen by the Task and Finish Group.

Infection Control

There was one Trust assigned MRSA case in November which brings the YTD total to 7. There was one case of C.difficile (post 72 hours), during November 2013 bringing the YTD total to 36 against a year end trajectory of 29 cases. A comprehensive recovery plan is in place to ensure EKHUFT is providing adequate prevention, screening and appropriate treatment at all times, particularly around identifying patients requiring a stool specimen on admission. Public Health England has been invited to undertake an external review of the C. difficile control programme and this took place on 20 Nov-13.

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Enhanced vigilance is being applied to infection prevention and control procedures given the current Trust performance against Department of Health targets. The Infection Prevention and Control Team (IPCT) use routine surveillance and the findings of Root Cause Analysis (RCA) and Post Infection Review meetings for MRSA bacteraemia and C.difficile cases to inform subsequent actions in providing support and challenge to wards and departments. Particular focus currently relates to antibiotic prescribing which is being audited. Clinical reviews of all inpatients with MRSA are being undertaken by the IPCT, which includes checking compliance with Trust policies in relation to the patient's management. The recently revised 'Diarrhoea Assessment Tool' has been introduced and is being applied in the management of all cases of diarrhoea. In addition enhanced surveillance of cleanliness standards in each of the sites is in progress. Site based briefings have taken place to emphasis adherence to policy.

Mandatory training performance for Infection Control is 85.2% Trust wide for October, against a 95% target. This remains a steady percentage, although the Divisions are working to action plans to improve the percentage. To date these action plans have not been received from EKHUFT.

Mixed Sex Accommodation

A performance notice has been issued to EKHUFT confirming that any previous agreement with the PCTs around the reporting of mixed sex accommodation breaches in CDU is no longer recognised, and that the national guidance clearly states that CDU is not exempt. In October 2013, there were 7 mixed sex breaches at WHH, 6 of which occurred in CDU, and 1 in the Richard Stevens Unit (RSU), affecting a total of 43 patients. None of these were reported by EKHUFT nationally to NHS England on the Unify2 system.

'Never Events'

One new Never Event has been reported in November 2013 for EKHUFT, this relates to a NG tube being misplaced which resulted in the patient death a few days later. Investigation is currently in progress.

EKHUFT have 4 on-going never events. These relate to 1 wrong site surgery, 1 incorrect chest aspiration, 1 retained swab post C-section, and 1 misplaced NG tube.

Serious Untoward Incidents

East Kent Hospitals University NHS Trust

EKHUFT has reported 3 Serious Incidents for the month of November, 2 at Kent and Canterbury, and 1 at William Harvey Hospital. All 3 have been categorised as Unexpected deaths. 1 was a mis-placed NG tube, and as such classified as a Never Event, one was a post-op Aortic Aneurysm patient, and 1 was a fall resulting in a head injury which led to the patient’s death. This fall occurred in October, but was not reported until November, and is believed to relate to the severe harm fall reported in the October board paper by EKHUFT. There was also a lack of clarity as it was categorised as an unexpected death, rather than a Slip/Trip of fall, which was the cause of the head injury. EKHUFT is awaiting the decision on the primary cause of death from the Coroner, and further information will be provided when the Root cause and analysis are received.

2 Grade 2 serious incidents were reported in November 2013, the 72 hour reports were received in deadline maintaining 100% compliance.

Kent Community Health NHS Trust

During the month of November 2013, 4 new SIs were reported by KCHT. This consisted of 1 allegation against a HC non-professional, 2 confidential information leaks, and 1 drug incident.

One grade 2 serious incident has been reported in November 2013, a 72 hour report has been received in deadline maintaining 100% compliance as per the previous month.

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Kent and Medway NHS Partnership Trust

During the month of November 2013 there were 6 SIs reported by KMPT , which is a slight decrease from the 7 reported in October, and a clear decrease from the 10 in September, 15 in August and 24 in July.

Overall, the majority of on-going KMPT serious incidents occur in patients' homes and public places. These two locations account for 57% of the on-going SIs for KMPT i.e. 25 of the 44 on-going serious incidents reported by the Trust.

Suicide by Outpatient (in receipt) is the highest category of on-going SIs for KMPT, with 34% of the total falling into this category. There is no apparent trend with regards to the area of Kent or team the clients were being treated by. Absconds are second highest with 23% of on-going KMPT SIs being attributed to this category. The highest number of these occurred at Medway Maritime Hospital, 4 in total, with 3 occurring on Sapphire Ward.

Despite absconds continuing to be one of the highest on-going categories in KMPT; there has been a decrease in their occurrence. Work is underway within KMPT to ensure that there is better management of Section 17 leave to try to avoid clients absconding when unescorted. Further agreement has also been reached between KMPT and West Kent CCG on which absconds are to be reported, as a number do not result in any harm to the patient who is returned within a matter of hours.

During November 2013, no Grade 2 SIs were reported.

South East Coast Ambulance NHS Trust

During November 2013 4 new SIs were reported; 2 (50%) were reported within the two working days deadline and 2 (50%) between 5-10 working days There were no Grade 2 SIs reported during November 2013.

NHS Constitution Standards

To be completed

Waiting Times

52-week

There has been a further reduction in the number of patients waiting more than 52 weeks for treatment, with 4 recorded as of end of October compared to 10 the previous month.

The Divisional Director for Surgical Services has confirmed that EKHUFT have an agreed action plan following the contract query notice which the CCGs have accepted. There is an agreed reduction trajectory in place which indicates that the backlog will be cleared by the end of December and details how this will be sustained going forward.

Despite the continuously improving position, it was confirmed in the month 5 contract performance letter that the appropriate breach penalties will continue to be applied until such times as the number of patients waiting beyond 52 weeks reaches zero. KMCS and the CCGs will monitor performance against the agreed reduction trajectory according to the contract query notice issued.

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4 Hour A&E Waits

EKHUFT has been struggling to achieve the 95% target for A&E 4 hour waits since April 2013 and have failed to meet the target for the second successive month, achieving only 92.71% in October. Despite this EKHUFT have managed to meet the 95% target for both Q1 and Q2, achieving 95.2% and 95.1% respectively and have therefore avoided any contractual penalties.

EKHUFT have identified a series of key challenges they believe have all contributed to the difficulties seen in achieving this target, and have detailed what actions are being undertaken in respect of each of them.

Cancer Waits

The current unvalidated position for October shows compliance across all standards with the exception of 31 day drug treatments, which is currently shown at 96.55% against the 98% target. EKHUFT reported that it had 1 patient breach against this target in October. The patient had to undergo a day surgery procedure to allow access for chemotherapy to be administered, which resulted in an extended pathway for the patient.

It has been identified that EKHUFT failed the 93% target for Q2 for the 2 week wait for symptomatic breast cancer standard, achieving only 88%. The consequence of this breach is '2% of revenue derived from the provision of the locally defined service line in the quarter of the under-achievement'. IPM has requested in the month 6 contract performance letter that EKHUFT detail what remedial actions have been put in place to address this issue and the trajectory by which EKHUFT hopes to maintain compliance. The CCGs have requested that EKHUFT present this update at the next contract performance meeting and would consider withholding the contractual penalty depending on how comprehensive an action plan has been developed.

Following non-compliance in both August and September, the 2 week wait for symptomatic breast cancer standard has returned to a compliant position for October, with unverified figures showing 93.75% against the target of 93%. EKHUFT report that this is as a result of rapid access referrals increasing significantly to cope with the additional demand.

For those tumour groups not meeting the relevant standard in October, each tumour site specialty has an action plan in place to address the issues and help deliver an improvement in performance. These action plans are being reviewed at Divisional Director and Divisional Medical Director level at monthly Cancer Compliance meetings.

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Sustainability

Provider Market
Capacity and Demand
Allocation Assumptions
2 Year Financial Plan
Expenditure Assumptions
Innovation Forum & Challenge Events
Clinical Leadership in Commissioning for GP Trainees

Provider Market

Canterbury and Coastal CCG commissions services from a wide range of providers with provision well distributed across the patch. Quality and performance are good but not consistent across all providers. There is an increasingly diverse provider market but the local geography and poor transport links can limit the willingness and ability of people to travel to receive care.

In addition to a number of GP practices, across the Canterbury and Coastal locality, who offer a wide range of services over and above their obligations under the GMS/PMS contracts (most notably, Whitstable Medical Practice, Northgate Medical Practice and Park Surgery, who each offer a number of additional services), detailed below are our main providers by area of care:

General Acute:

- East Kent Hospitals University Foundation Trust
- Medway NHS Foundation Trust
- Maidstone and Tunbridge Wells NHS Trust

Community:

- Kent Community NHS Trust
- ic24 (Out of Hours)

Mental Health:

- Kent and Medway NHS and Social Care Partnership NHS Trust
- South London and Maudsley NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust

Independent Sector:

- BMI Chaucer Hospital
- Spires Healthcare
- Benenden Hospital

The CCG are keen to work in partnership with major provider to ensure that we can protect essential services for our local population. However, we expect to see a shift towards more integration between provider and an increase in health and social care community providers. Within that context we will develop a local market where there in only a plurality of providers where appropriate and where that doesn't undermine the underlying system vision of integrated services for our patients.

In any provider market we wish to develop an environment conducive to high quality training, for *all* providers, which ensures that our patients will receive the highest quality of care both clinically and non-clinically.

Capacity and Demand

To be completed

Any Town CCG Analysis

Allocation Assumptions

The CCG is currently assuming a 20% move towards the new allocations formula. Although it is not known how much this will actually equate to, due to speed of implementation, it is felt that planning at this level is appropriately risk averse.

2 Year Financial Plan

Set out below is the expected allocation and expenditure for 2014/15 and 2015/16.

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	2014/2015	2015/2016
Final 13/14 Allocation	£238,247,000	£238,862,979
Less Non Recurrent Allocations	-£2,660,000	
2% Allocation Growth	£4,711,740	£4,538,397
CCG Funding for BCF	-£706,761	-£7,165,889
Assumption on Pace of Change for Allocations	-£729,000	-£729,000
Recurrent Baseline	£238,862,979	£235,506,486
Return of Surplus	£2,433,280	£2,464,163
£25 per head Running costs	£5,120,000	£4,608,000
Total Non-Recurrent Allocation	£246,416,259	£242,578,649
13/14 Forecast	£236,117,138	£234,519,812
Full Year Effect Issues (inc recurrent QIPP)	-£934,440	-£2,467,500
Non-Recurrent Spend	-£1,093,528	£0
Cost Pressures	£4,689,817	£2,483,088
1.5% Population Growth	£3,538,515	£3,517,797
1.6% Reduction in Tariff	-£3,774,416	-£3,752,317
QIPP	-£9,870,000	-£5,142,031
CQuin Impact	£1,534,441	£1,534,441
Expected 14/15 Programme Spend	£230,207,527	£230,693,289
£25 per head Running Costs	£5,120,000	£4,608,000
1.5% Non-Recurrent Transition Funding	£3,696,244	£2,425,786
1% Further Funding for BCF	£2,464,163	£0
1% Contingency	£2,464,163	£2,425,786
1% Surplus Requirement	£2,464,163	£2,425,786
Total Spend	£246,416,259	£242,578,649

Expenditure Assumptions

The start point for the planning is the 13/14 forecast out-turn position. The CCG is on target to make its surplus but has had to use all of the 1% contingency and the majority of the 2% strategic change funding to support this position. This is due to a number of factors including those within and external to the CCGs control. 13/14 QIPP delivery has not been as expected, a major contributor to the current position. For some areas of expenditure, for example prescribing despite QIPP delivery the position has been adversely affected by changes in Category M pricing and other factors.

The Full Year effect adjustments include both QIPP investment and savings expected to continue from the 13/14 financial year.

The adjustment for non-recurrent funding reflects the fact that the CCG will no longer receive is reablement funding. As reablement funding has been used to deliver a number of joint projects across the health economy a resultant cost pressure has been included in the plan to reflect the need for a proportion of this funding going forward.

Cost pressures include growth allocated to those areas recognised in the planning guidelines as expecting price inflation. Additionally the CCG is undertaking significant developments across some of the larger East Kent contracts moving to payment based on real usage rather than fair share to allow better commissioning decision making. Finally a significant cost pressure determined nationally is the move Payment by Results for mental health although these values are yet to be finalised.

Population Growth is expected to be at 1.5% and tariff has been reduced as advised in the guidance.

The total QIPP amount included in the plan equates to £11.5m, comprised of £1.2m schemes to be continued and £10.3m of new commissioning plans. This equates to 4.7% of the total budget. In 13/14 the 3% planned level of QIPP was recognised as significantly challenging and one of the highest plans in the region. The CCG recognises that the level of QIPP in the 14/15 plan exceeds this by 1.7% and represents a significant challenge that can only be delivered through fundamental changes in delivery of healthcare across providers, that is facilitated by utilisation of all contracting options available to commissioners.

The creation of the BCF fund included in the 2014/15 plans is assumed as a cost to the CCG, with no financial benefit in year through reductions in activity in the acute setting, this will need to be discussed with our Social Care Partners.

The plan also assumes that there will be 1.5% strategic funding available and a further 1% for the BCF (described below). As required the plan also assumes 1% contingency and 1% surplus. No additional funding has been assumed at this time for savings in primary care and any quality premium.

Running costs will be at the expected level of £25 per head of population.

The challenge is further compounded in 2015/16 as the full impact of the BCF is included and the expected resource growth reduces. However, in year 2 of the two year plan a number of the more substantial integrated service models will be implemented or part implemented, thus generating the major change needed to sustainably move the CCG to an affordable baseline.

The challenge therefore for the CCG is to deliver the very challenging significant QIPP target in 2014/15 before the large integrated system changes impact in 2015/16.

Innovation Forum

The NHS is currently faced with quality, efficiency and demand challenges on a scale that has never been seen before. Organisations across the NHS have already made significant progress in reducing delays, improving quality, and giving patients access to new services and technologies. However, in order to respond effectively to the scale of the current challenge, all parts of the health and care system will need to collaborate to apply innovative approaches to the problems they face.

Innovation, Health and Wealth (DH, 2011) defines innovation as:

> *"An idea, service or product, new to the NHS or applied in a way that is new to the NHS, which significantly improves the quality of health and care wherever it is applied"*

This gives clinical commissioners the dual role of championing the adoption of innovation and best practice seen elsewhere, alongside seeking to generate new ideas and ways to apply new opportunities creatively.

In recognition of this, NHS organisations now have a "duty to innovate". The commitment to champion innovation was included as part of the CCG authorisation process.

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Together with Ashford CCG we have established an Innovation Forum, through which we can:

- Generate new ideas
- Learn about best practice opportunities
- Agree new ways to address complex priority areas

The objectives of doing this are to:

- Accelerate the identification, adoption and diffusion of innovations that will improve patient outcomes and service quality in areas that the CCG defines as priorities
- Embed innovation into the CCGs' commissioning cycles
- Build an innovation climate within the CCGs and partner organisations
- Link with other organisations involved in health and care (commissioners and providers) so that they can also embed innovation and innovation projects in their business planning processes

The Innovation Forum brings together senior CCG decision makers along with agreed relevant external input from the academic community, technology industry and health and social care stakeholders. Participants are asked in advance to consider specific questions or focus areas, and to identify relevant information, research or case studies based on their own experience or areas of work. This also involves considering how existing practice or tools could be applied differently or in other areas. The aim of the Innovation Forum is not to carry out an in-depth review of opportunities, but to consider how they might impact on the health challenges that the group prioritises.

Innovation Challenge Events

Twice yearly an Innovation Challenge event will be run, bringing together a wider group of people to learn about opportunities in a particular area and consider how they will be applied for local people. Each Innovation Challenge event will have its own objectives, which will vary according on the questions being posed, however events will have a number of objectives in common:

Learn and challenge	Generate ideas
• Increase understanding of the presenting issue from different perspectives • Hear about alternative solutions (or components of solutions) from providers and users • Learn about what has worked – and what hasn't – in other areas • Consider why the approach in place locally does not fully meet the needs of service users	• Consider how new approaches or tools would impact the presenting issue • Discuss how existing tools (new or already in use in the area) could be improved • Review what could be done differently to address gaps in services • Learn from how other organisations or industries are addressing similar challenges • Probe the ideas considered: do they fully address the presenting issue or is there a way to enhance them further?
Agree actions	**Synthesise solutions**
• Agree what should be taken forward and how • Define specific actions and owners • Understand what inputs are required to make each action happen • Ensure clarity over who's leading on different solution areas • Confirm expectations of stakeholders	• Identify groups of linked opportunities • Prioritise the ideas raised • Gauge interest and consensus from different stakeholders • Gain stakeholder commitment to being involved in developing the opportunity from idea/pilot to broader diffusion

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The first Innovation Challenge Day was held in April, focussing on Dementia. Working with the Young Foundation, the event was attended by commissioners and provider organisations, local authority, third sector organisations, universities, and technology firms.

Our aim was to think differently and hear different things about ways to support people with dementia. Speakers presented on their innovative tools or services supporting different aspects of dementia care. Small group discussion to help review, understand or prioritise the innovative ideas presented. Participants were asked to identify ways in which they would take back the ideas generated and use them to influence change in their own organisations.

It is important to differentiate between an Innovation Challenge event and a patient co-design or consultation event. People who use services should be involved to raise their alternative perspectives of services and their ideas about what could make them better, as well as ensuring that the group understands the potential impact of opportunities. However, Innovation Challenge events should be focused on opportunities to deliver transformational change benefiting a large number of people, rather than redesigning elements of specific services in detail. A project initiated at an Innovation Challenge event could lead to a number of other engagement events during the development and delivery period.

Clinical Leadership in Commissioning for GP Trainees

The GP Clinical Leadership in Commissioning (CLIC) rotation is an innovative or integrative GP training post (ITP). ITPs and have been used for a number of years, and have been a feature of many areas in Kent, Surrey and Sussex. Educationally, they are an extension of the educational placement for trainees that are a regular part of the GP placement (such as attending an outpatient clinic, community clinic, or public health department). Previously, they have consisted of a combination of GP Trainer employed and hosted posts, or part placement (and employment) in a GP Training Practice and part placement in a hospital or community clinic post.

The commissioning rotation comprises 5 clinical sessions within a GP practice and 2 days within the commissioning setting. Most trainees will work on a Wednesday and Thursday within the commissioning component of the rotation, with the other five clinical sessions in GP. Mandatory sessions are structured with experts in areas of commissioning or workshops which relate to key aspects of leadership development. Each trainee is allocated a commissioning project which they work on alongside the CCG commissioning team.

Trainees are expected to demonstrate evidence of learning, teaching and team working as part of RCGP curriculum requirements and personal professional development. In this placement the trainees are invited to present to their supervisors and peers at the end of the 4m placement.

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Governance

Patient and Public Involvement
Delivery Architecture
Decommissioning and Disinvestment
Conflict of Interest
Complaints and Compliments
Freedom of Information
Equality and Diversity

Patient and Public Involvement

A communication and engagement strategy document has been developed to set out how C&C CCG will inform and involve residents, partners, health and social care professionals, voluntary and community sector groups to ensure that specific health care needs that have been identified in the Joint Strategic Needs Assessment are addressed. This document is to be found on the website:

www.canterburycoastalccg.nhs.uk

In summary though, our main means of engaging patients and public include:

Means of Engaging Patients and Public	Detail
Stakeholder engagement events	We regularly holds partnership and stakeholder engagement events. These are usually well attended with representatives from organisations that reflected the needs of everyone in the community, thus ensuring quality and diversity was maintained.
Patient participation groups (PPGs)	Each of the CCG's practices has a patient participation group. Representatives from the CCG attend these group meetings to listen and act on patient views.
Public Reference Group (PRG)	Consists of a representative from the PPGs as well as representatives from key groups and organisations such as Age UK, Home Start, Kent Student Union, Porchlight, Children's Centre, Citizen's Advice Bureau, and Rethink.
Friends of C4G (Canterbury and Coastal CCG)	Friends of C4G (Canterbury and Coastal Clinical Commissioning Group) is a virtual group of patients, members of the public and voluntary organisations who help make decisions about local health services.
Patient Newsletter	The CCG produces a quarterly newsletter which is automatically sent too everyone registered as a "Friend of C4G". Additionally, the newsletter is placed in a number of locations where our residents regularly attend – such as GP surgeries, community hospitals, council offices and libraries
Governing Body meetings	These are held in public where people can contribute to the meeting agenda.
Healthwatch Kent	Healthwatch Kent is run by a consortium of 'Kent and Medway Citizens Advice' (KAMCA), 'Voluntary Action within Kent' and 'Activmob'. The consortium aims to excel at providing advice and information to the public, supporting the voluntary sector, and engaging with the public in new and innovative ways. C&C CCG is looking forward to working with Healthwatch Kent as it continues to emerge in 2013.
Facebook	A Facebook Group with latest news, tips and advice for our local community
Twitter	Twitter account with latest news, tips and advice for our local community - @NHSCCCCG

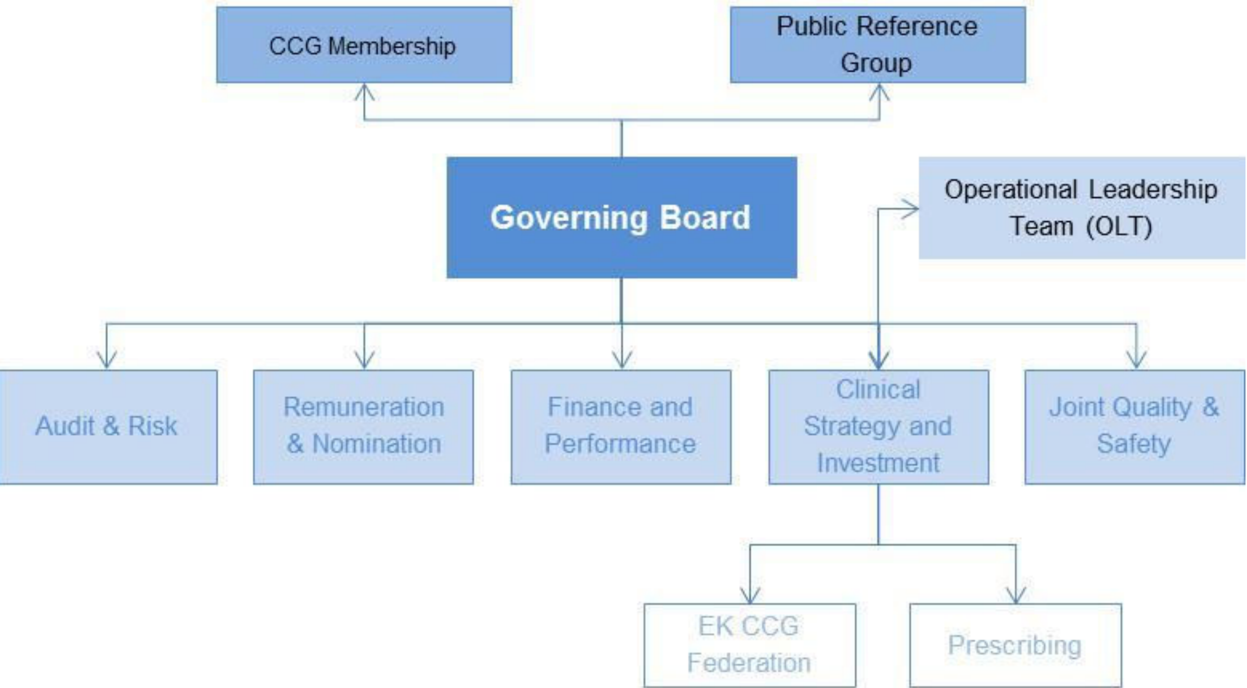
Delivery Architecture

To ensure that Canterbury & Coastal CCG remains focused on delivery of its plans throughout 2014/16 and beyond it will implement the following tracking mechanisms.

- Monthly review of project progress at operational team meetings, run by the Head of Commissioning Delivery
- Monthly meetings between the Clinical Programme Lead and Commissioners
- Monthly review of programme or project progress at CCG clinical strategy committee meetings
- Monthly review of how the CCG is doing against its Quality Premium indicators

Where possible, the benefits of each project should be tracked to monitor its effectiveness in achieving its objectives. The aforementioned fora will be used to check whether benefits have been realised. If they have not been realised, a decision will be taken about whether the project continues or is adapted.

To support the on-going development and delivery of the Strategic Commissioning Plan, the CCG has developed the following governance structure.



Decommissioning and Disinvestment

To ensure that limited resources are consistently directed to the highest priority areas the CCG have identified the need to develop a Decommissioning and Disinvestment Plan that sets out the agreed principles for decommissioning services to allow funds to be redirected where appropriate. There is a need to ensure that when approval has been given to decommission, or disinvest from, a service a clearly defined process is followed, with clear lines of accountability and responsibility.

> ***Decommissioning:*** *This relates to the withdrawal of funding from a provider organisation where the service is subsequently re-commissioned in a different format.*

> ***Disinvestment:*** *This relates to the withdrawal of funding from a provider organisation and the subsequent stopping of the service.*

In some circumstances there will be the need to re-commission part of the service or a modified service to ensure that there are no gaps in healthcare delivery.

The following points will be considered when making the decision to decommission a service.

- The patient experience and health need must be paramount and gaps in service provision minimised once the service ceases.
- The potential destabilising effect on other organisations e.g. third sector, of a decision to decommission/disinvest should be considered.

Conflict of Interest

The CCG takes conflicts of interest very seriously. Canterbury and Coastal's constitution details how conflicts of interest will be managed but in summary:

Declarations of interest are published on the Canterbury and Coastal CCG website: http://www.canterburycoastalccg.nhs.uk/

Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the Group's exercise of its commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the Head of Corporate Services.

The chair of the meeting will then determine how this should be managed and inform the member of their decision. Where no arrangements have been confirmed, the chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

Complaints and Compliments

Most medical care and treatment goes well, but things occasionally go wrong, and people may want to complain. They may want to make positive comments on the care and services that they or their family have received. These comments are just as important because they tell NHS organisations which factors are contributing to a good experience for patients.

We welcome complaints as a valuable means of receiving feedback on the services we commission for the people of Canterbury and Coastal and also on the way we go about our business. The CCG aims to use information gathered from complaints as a means of improving services and the effectiveness of the organisations. We seek to identify learning points that can be translated into positive action, and where necessary provide redress to set right any injustice that may have occurred.

Personal information may be anonymised for the purposes of monitoring the complaints process or improving service quality. The purposes for which identifiable information will be used is strictly for the processing of the complaint. This may include passing relevant information to a service provider in order that they can provide appropriate responses and comments on the circumstances set out in the complaint.

Patients and service users are encouraged to express complaints, concerns and views both positive and negative about the treatment and services they receive, in the knowledge that:

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- they will be taken seriously
- they will receive a speedy and effective response by a member of staff appropriately qualified and trained to respond
- appropriate action will be taken
- lessons will be learnt and disseminated to staff accordingly
- there will be no adverse effects on their care or that of their families

We are committed to dealing with all complaints fairly and impartially and to providing a high quality service to complainants.

Complaints received by NHS Canterbury and Coastal CCG are investigated by Kent and Medway Commissioning Support (KMCS). KMCS is hosted by NHS England, and provides a number of administrative functions including managing the complaints process. This may involve accessing your case records and disclosing relevant information to the CCG in order that we can discharge our duties to you under the NHS Complaints Regulations.

Freedom of Information (FoI)

The Freedom of Information Act 2000 (FOIA) came into force on 1 January 2005, and gives the public and other organisations the right of access to information held by NHS Canterbury and Coastal CCG. We are committed to openness and transparency in the conduct of all our business.

The Freedom of Information Act 2000 recognises that, **gives the public and other organisations** have the right to know how public services such as the NHS make their operational decisions and how public money is used. The Act gives anyone a general right to request access to see official information held by public authorities. The Act reflects a national policy to shift from a culture of confidentiality to one of openness, where information is routinely available, subject to certain exemptions, to anyone who wishes to see it.

Freedom of Information (FOI) requests are processed by Kent and Medway Commissioning Support (KMCS) on our behalf and we maintain a disclosure log on information that has already been published which is available through our website to download. However, if someone is unable to find what they are looking for on the publication scheme, then a written request should be sent to:

Freedom of Information Team
Kent House - 4th Floor
81 Station Road
Ashford
Kent
TN23 1PP
Email: foi@nhs.net

Equality and Diversity

We fully recognise the importance of the Public Sector Equality Duty (PSED) and have already developed our Equality and Diversity Strategy which includes our equality objectives, set in line with the four Equality Delivery System (DH Toolkit) goals. These are detailed below:

Goal	Narrative	Outcome
1. Better health outcomes for all	The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results	1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities 1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways

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Goal	Narrative	Outcome
		1.3 Changes across services for individual patients are discussed with them, and transitions are made smoothly 1.4 The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all 1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups
2. Improved patient access and experience	The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience	2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds 2.2 Patients are informed and supported to be as involved as they wish to be in their diagnoses and decisions about their care, and to exercise choice about treatments and places of treatment 2.3 Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised 2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently
3. Empowered, engaged and well-supported staff	The NHS should Increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better respond to patients' and communities' needs	3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades 3.2 Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work and work rated as of equal value being entitled to equal pay 3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately 3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all 3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives. (Flexible working may be a reasonable adjustment for disabled members of staff or carers.) 3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population
4. Inclusive leadership at all levels	NHS organisations should ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions	4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond 4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination 4.3 The organisation uses the "Competency Framework for Equality and Diversity Leadership" to recruit, develop and support strategic leaders to advance equality outcomes

We will review these annually and ensure our staff are supported to commission services which ensure equality of access to services and that meet the needs of our diverse population.

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South Kent Coast
Clinical Commissioning Group

NHS South Kent Coast CCG Strategy 2014-19

"Ensuring the best health and care for our community"

Contents

1. Welcome
2. Introduction
3. Our Profile
4. The National Environment
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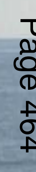
6. Understanding the Financial Challenge
7. Understanding the Quality Challenge
8. Vision for South Kent Coast
9. Our Strategy
10. Appendix 1 – Operational Delivery Plan 2014-16
11. Appendix 2 – Better Care Fund Plan

Welcome

This strategy sets out the high level ambitions and principles that will govern NHS South Kent Coast Clinical Commissioning Group (CCG) from 1st April 2014.



Dr Darren Cocker
Clinical Chair

Hazel Carpenter
Accountable Officer

Introduction

NHS South Kent Coast Clinical Commissioning Group (CCG) is a clinically led membership organisation, responsible for 70% of the local healthcare budget.

We consist of 31 member GP practices which are grouped into two geographical localities, serving a total registered population of around 200,000.

All our practices are members of the CGG and have signed up to our constitution. This sets out the governance arrangements for our organisation, how we will meet our responsibilities and how we will achieve our ambitions. It describes the key processes for decision making, ensuring transparency and managing conflicts of interest. A copy of the constitution can be found on our website;

www.southkentcoastccg.nhs.uk

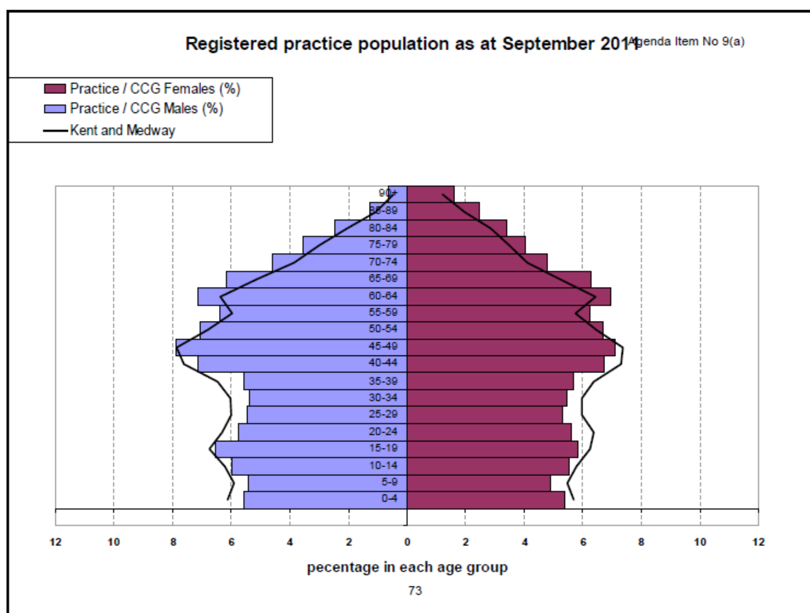
We share the same geographic area as our three local authority partners - Kent County Council, Shepway District Council and Dover District Council.

Our Profile

South Kent Coast CCG serves a population of 200,000 living in sparsely populated rural areas and within the urban coastal towns of Folkestone and Dover.

Overall the population of South Kent Coast enjoys relatively good health and is in line with the average life expectancy in England. However there is significant variation in life expectancy between those in the most affluent and deprived areas, with a gap of up to 13 years.

South Kent Coast has the highest proportion of over 65+ year olds in Kent and Medway at 21%. This is set to increase by 15% by 2016. The high number of older people in South Kent Coast poses a significant challenge for the local health and social care system.



The National Environment

The Department of Health has issued a mandate to the NHS in England which sets out the objectives for the NHS and highlights the areas of health and care where the government expects to see improvements

Through the mandate, the NHS will be measured, for the first time, by how well it achieves the things that really matter to people. Nationally commissioning organisations like NHS South Kent Coast CCG have been tasked with supporting delivery of five key outcome domains;

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

These are underpinned by seven outcome measures identified in the relevant domains in figure 1.

NHS England also describes the aspects of planning that it anticipates will support the achievement of the seven outcome measures:

- Delivering transformational service models and
- *Four essential elements*: access, quality, innovation and value

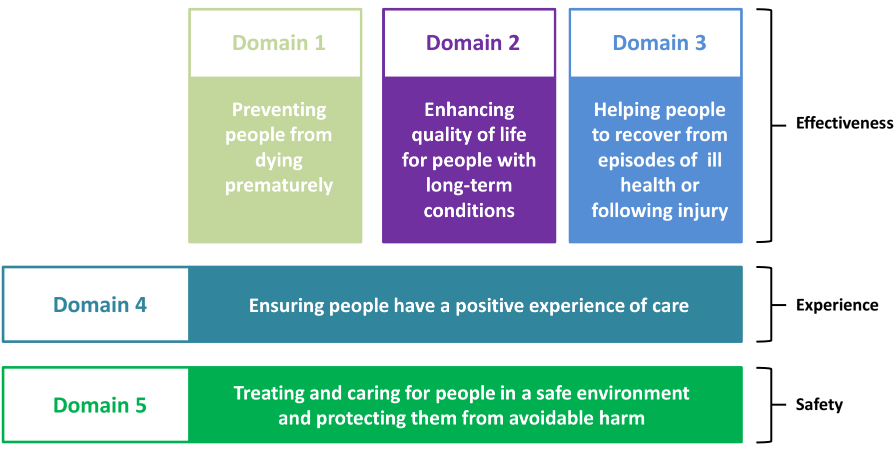


Figure 1

The National Environment

Delivering transformational service models is underpinned by *six characteristics* that are described in summary in figure 2:

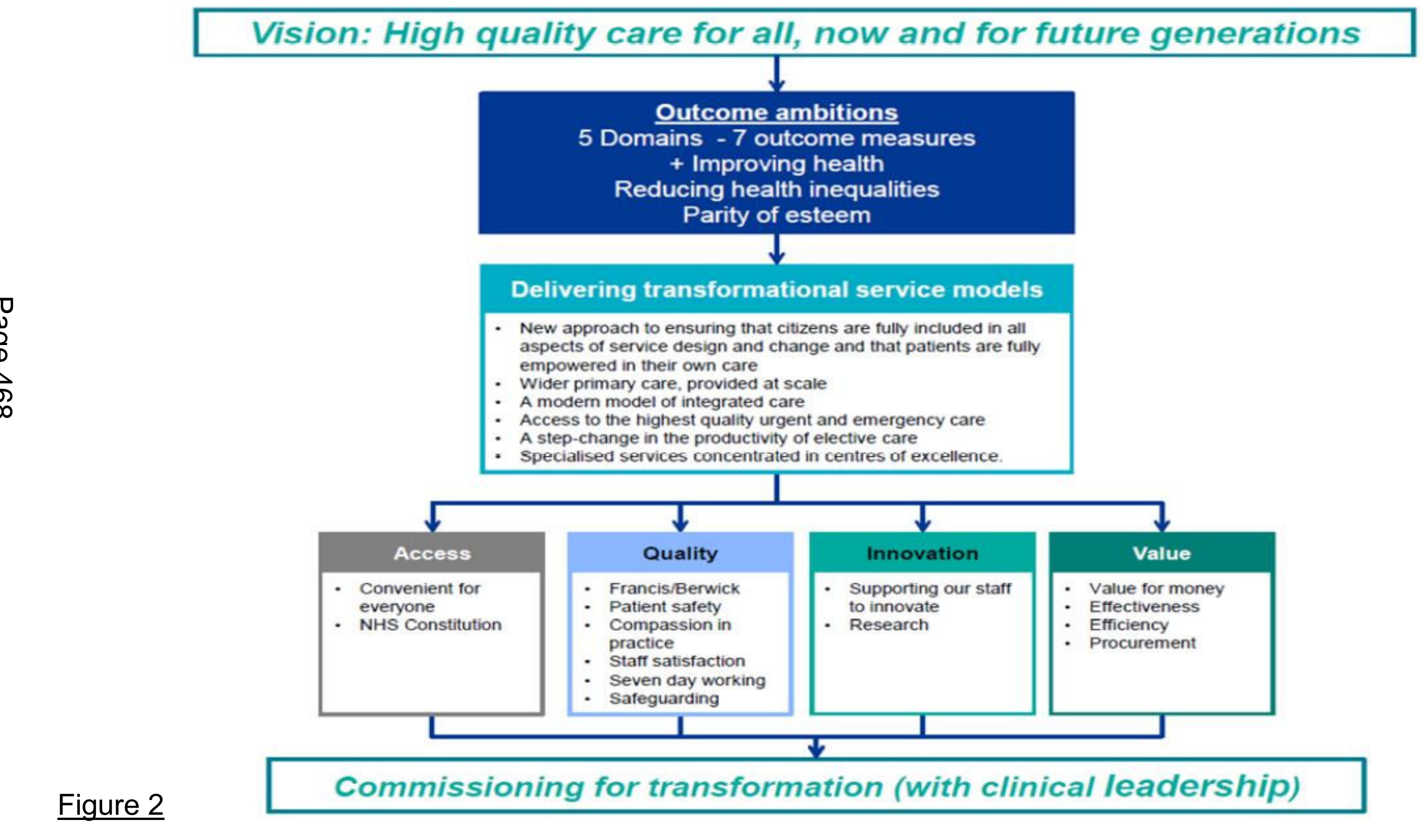


Figure 2

Understanding Local Health Needs

The CCG has to place the national context against our local health needs when defining our long term ambitions. Joint Strategic Needs Assessments (JSNAs) for the area are available on South Kent Coast CCG website (www.southkentcoastccg.nhs.uk). These assessments are used to inform us and our local authority partners about the potential health needs of the population.

SUMMARY – SKC POPULATION HEALTH CHALLENGES	
Population	• The proportion of SKC population aged 65+ is 21%, this is the highest proportion of over 65+ within Kent and Medway. 3% of the local population are over 85+.
	• Life expectancy from birth in the SKC area is estimated to be 80.5 years, marginally better than the East Kent average of 80 years.
	• However, the range between ward with the highest life expectancy – River (86) – and the lowest – Folkestone Harvey Central (73) – is 13 years.
Inequalities	• 53% of people in Dover, and 60% of people in Shepway are in the bottom 2 deprivation quintiles
	• SKC has statistically significant correlations between life expectancy and deprivation
	• Folkestone Harvey, Folkestone Harbour and Castle have over 25% unemployment
	• The biggest issue for the gap in life expectancy is Heart Disease
Causes of Death	• Circulatory Disease is now the main cause of death, followed by Respiratory Disease and Cancer.
Lifestyles	• Smoking rate ?%
	• Obesity rate ?%
	• SKC is high in Chlamydia prevalence and both has increasing teenage conception rates (particularly Shepway)
Long Term Conditions	• SKC: Higher than Kent average for premature deaths (<75) from CHD
	• Only 7 out of 31 GP practices come within 75% of the expected prevalence for patients registered with CHD
	• 15 of the 31 GP practices reach over 60% of the expected prevalence of COPD
	• 8% of GP practices reach 60% of expected prevalence for hypertension, only 1 reaches 70%
Dementia	• Estimates suggest 3250 people in SKC have Dementia. This is set against confirmed diagnosis of 1545.
	• The numbers of people with Dementia is set to increase by 83& by 2026

Understanding Local Health Needs: The Big Issues

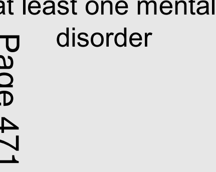
In assessing the health needs the CCG has identified 6 key issues which our strategy and plans will set out to address;

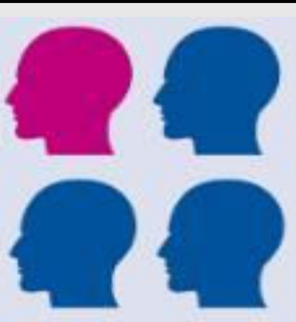
Understanding Local Health Needs: *Closing the gap between mental and physical health*

Improving mental health and wellbeing is a priority area for the CCG. Currently physical and mental health treatments tend to be viewed and delivered as separate health services. This not only reinforces stigma, but adds to the disjointed care patients often experience. What do we know already….

Mental health is widespread and common

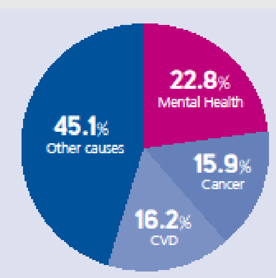
1 in 4 adults experience at least one mental disorder





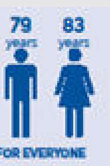
Mental health is a significant burden

Mental ill health is the single largest case of disability in the UK



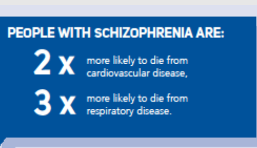
Mental health impacts on life expectancy

Average life expectancy in England and Wales for people with mental health problems is 60 years behind the national average



People with mental health problems have worse physical outcomes

People with mental illness are at increased risk of the top 5 five health killers



There are often long waits for mental health services

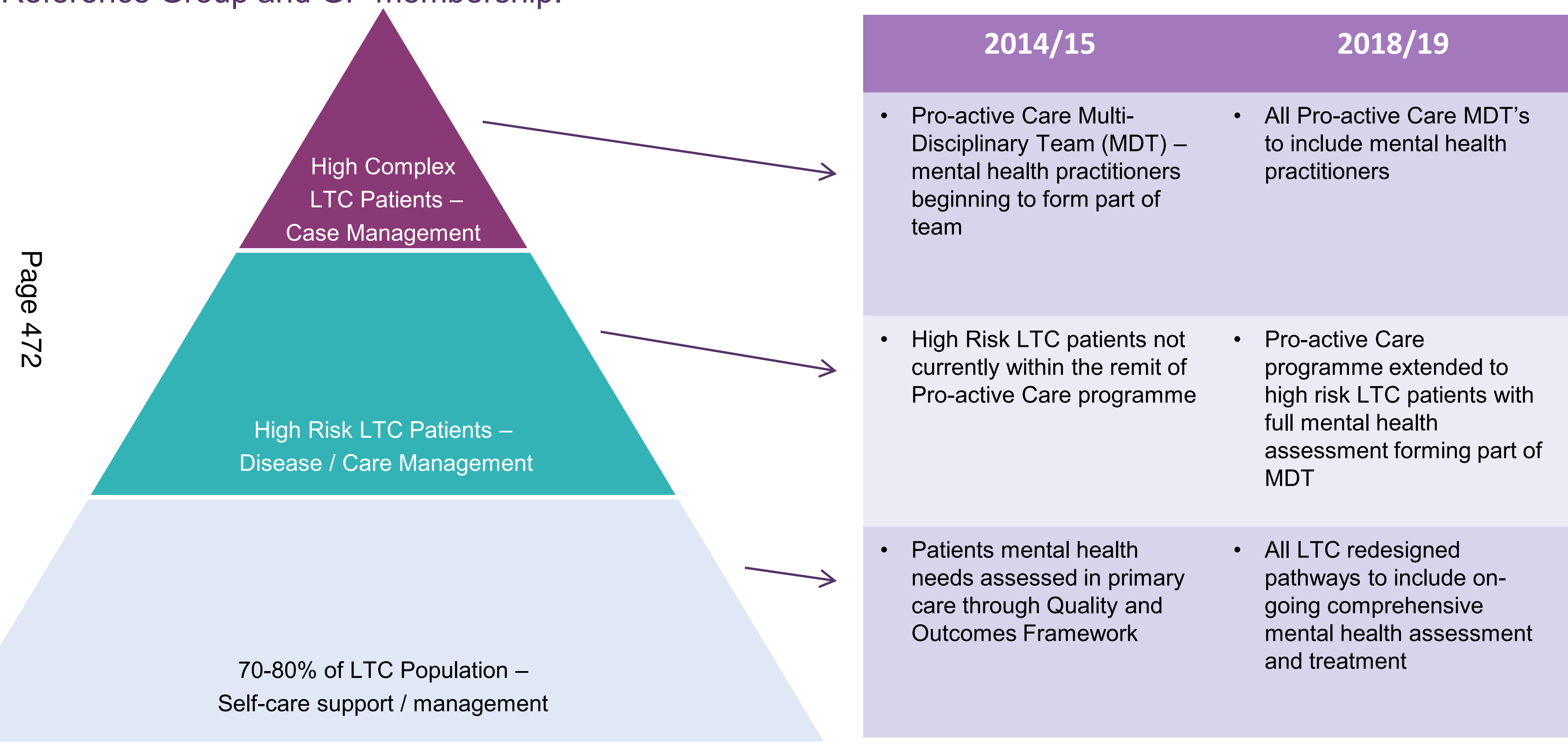
1 in 10 people wait over a year for access to talking therapies

There is a wider economic impact of mental health

The full costs of mental illness in England have been estimated to be £105.2 billion a year

Understanding Local Health Needs: *Closing the gap between mental and physical health*

The CCG has worked throughout 2013/14 to build capacity in our community mental health services. This has improved access to patients who have a mental need by 17%. Our goal is to significantly reduce the barriers that exist between physical and mental health services through continued co-design with our Health Reference Group and GP membership.



2014/15	2018/19
• Pro-active Care Multi-Disciplinary Team (MDT) – mental health practitioners beginning to form part of team	• All Pro-active Care MDT's to include mental health practitioners
• High Risk LTC patients not currently within the remit of Pro-active Care programme	• Pro-active Care programme extended to high risk LTC patients with full mental health assessment forming part of MDT
• Patients mental health needs assessed in primary care through Quality and Outcomes Framework	• All LTC redesigned pathways to include on-going comprehensive mental health assessment and treatment

Understanding the Financial Challenge

Like all of the public sector the NHS faces a substantial efficiency challenge of £30 billion for the NHS in England over the next five years. NHS South Kent Coast CCG's share of this challenge is around £x million.

It is very important that all our stakeholders understand the components of this challenge. In NHS jargon, efficiency is usually called QIPP (Quality, Innovation, Productivity and Prevention). QIPP has two components:

Provider QIPP: Efficiencies passed on to all providers. For the last three years and for the foreseeable future, providers have been expected to provide the same services with less funding. For example in 2014/15 providers will be given a 2.1% uplift in funding but are then expected to make 4% funding efficiencies. This means they will receive 1.9% less in absolute terms for the providing the same services. When QIPP was first introduced in 2011, finding the first 4% efficiency saving was relatively straight forward, but finding each additional 4% efficiency every year is increasingly challenging.

System Wide QIPP: Efficiencies that are the direct responsibility of the CCG. NHS financial allocations are expected to rise by around 0-1% each year over the next five years. The underlying rate of growth in health service activity and costs prior to 2010 was around 6%. Without QIPP we anticipate growth would continue at around 6% a year because of the ageing population, new medical technologies and rising expectations. System wide QIPP programmes are the actions required to keep overall growth at an affordable 0-1% level rather than the historical 6%. In SKC we split QIPP into six areas;

- Planned Care
- Urgent Care
- Long Term Conditions
- Mental Health
- Children's and Young People (includes Maternity)
- Older People

Understanding the Financial Challenge

The CCG budget for 2014/15 is £252m and we are expecting growth on this budget to decline over the 5 year strategy period.

To ensure the CCG remains within budget we must achieve £10m worth of QIPP efficiencies in each of the first two years.

This will be achieved through the redistribution of funds across the local health system. Our spend on hospital services will decrease and our spend on out-of hospital services will increase (See Figure 1 and 2).

This approach will be facilitated by the delivery of our out-of-hospital plans detailed within Appendix 1 and 2.

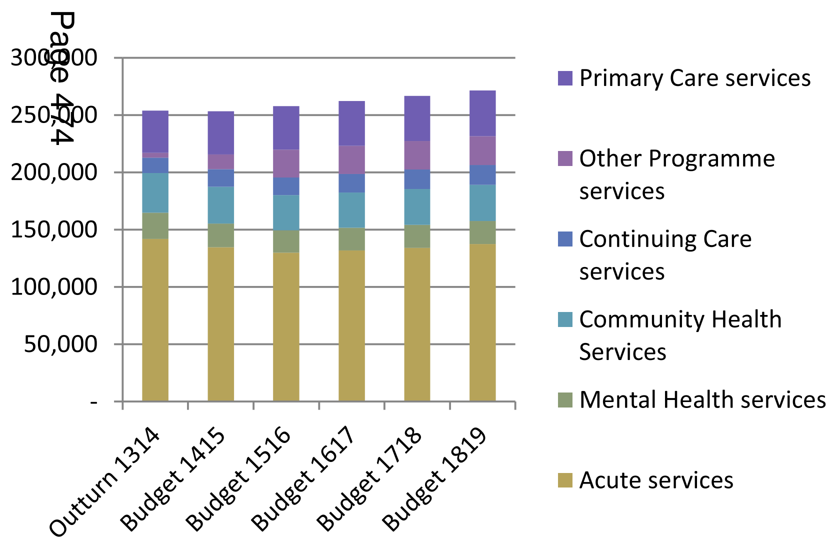


Figure 1

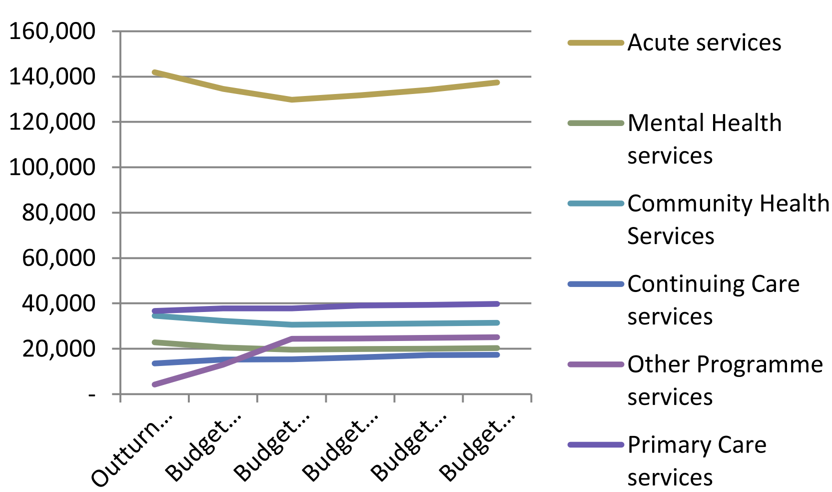


Figure 2

Understanding the Quality Challenge

Patients and the quality of the care they receive is the focus of everything we do. We will ensure that we commission services based on the quality of care they deliver and ensure that individuals are empowered to choose services on the basis of quality and outcomes. This involves providing clear information to the public about the quality of services which are commissioned on their behalf, including information about poor quality, unexplained variation and differential health outcomes.

As well as promoting on-going quality improvement, commissioners need to assure themselves that existing services meet acceptable standards. Whilst regulators play a key role in this arena, commissioners must still actively monitor the quality of services delivered by our providers.

Our approach to quality has been informed by 3 key national quality reports following incidents at Mid Staffordshire NHS Foundation Trust and Winterbourne View Hospital;

Francis Report

- Following an extensive inquiry into failings at Mid-Staffordshire NHS Foundation Trust, Robert Francis QC published his final report on 6 February 2013
- The report considers and makes recommendations on a range of issues;

- ❑ How to embed the patient voice throughout the system
- ❑ How to engage health care staff generally in the leadership of their organisations
- ❑ The standards set for safety and quality of care
- ❑ The collection, use and sharing of information and data

Berwick Report

- Following the Francis Report, Don Berwick led a national advisory group around Patient Safety. The report details the specific changes required in the NHS as a result of the Francis and Keogh inquiries;
- Four guiding principles fall out of this report;

1. Place the quality and safety of patient care above all other aims for the NHS
2. Engage, empower, and hear patients and carers throughout the entire system, and at all time
3. Foster wholeheartedly the growth and development of all staff
4. Insist upon, and model in your own work, thorough transparency

Winterbourne Report

- Report following the uncovering of years of physical and psychological abuse of patients with learning disabilities (LD) and challenging behaviour, at Winterbourne View Hospital
- Highlighted the need to stop hospitals becoming homes for LD patients
- CCG responsible for jointly reviewing with local authority partners all patients in NHS funded in-patient LD facilities
- CCG responsible for finding supported community placements with appropriate personal care planning in place for these patients

Understanding the Quality Challenge

South Kent Coast Quality Approach

Informed By

Francis Report	Winterbourne Report	Berwick Report
2014 (TBC – Baseline against measures)	2014 (TBC – Baseline against measures)	2014 (TBC – Baseline against measures)
2019 (TBC)	2019 (TBC)	2019 (TBC)

Our Vision

Our mission and vision has been developed through wide consultation and engagement with stakeholders and partners across South Kent Coast.

Mission	
'To ensure the best health and care for our community	
Vision	
Hospital Care	Out-of-Hospital Care
• Acute care requiring specialist facilities, whether for physical or mental health needs, will be highly expert to ensure high quality. • Hospitals will act as a hub for clinicians to work out from and utilise their skills as part of broader teams as close to the patient as possible.	• For services to integrate, wrapping around the most vulnerable to enable them to remain in their own home for as long as possible. • Patients will be supported by a package of care focussed on their personal health and wellbeing ambitions.

NHS South Kent Coast CCG Strategy and Plan

Our Strategy: Out-of-Hospital Care

OUT-OF-HOSPITAL - 2014		OUT-OF-HOSPITAL - 2019	
Variable access to primary care	Patients struggle to access GP practices for appointments. Defaulting to walk in facilities or A&E	**Easy Access to high quality, responsive primary care**	GPs and primary care will be at the heart of ensuring everyone who provides care does so to consistently high standards
Professionals confused as to the local services and pathways available to them	Local pathways for diagnostics and access to specialist opinion poorly defined, resulting in unnecessary hospital referrals	**Clearly understood planned care pathways**	Ensuring our of hospital care is not delivered in a hospital setting
Patients spend more time in hospital than necessary due to variable access to community services 7 days a week	Discharge into community often confused, lacking proper planning and robust information	**Patients will spend the appropriate amount of time in hospital when admitted**	Neighbourhood teams will provide well organised early supported discharge back into community
Neighbourhood Teams lack the capacity to respond to urgent health needs	Patients default to ambulance services or hospital emergency services	**Rapid response to urgent needs**	Fewer patients will need to access hospital emergency care. If a patient has an urgent need, a clinical response will be provided within 2 hours
Communication between health and social care professionals poor	Patients left confused by system with care fragmented	**Neighbourhood teams of health and social care professionals, working together**	With the patient at the centre, to manage proactively people with LTC's, the elderly and end of life care out of hospital

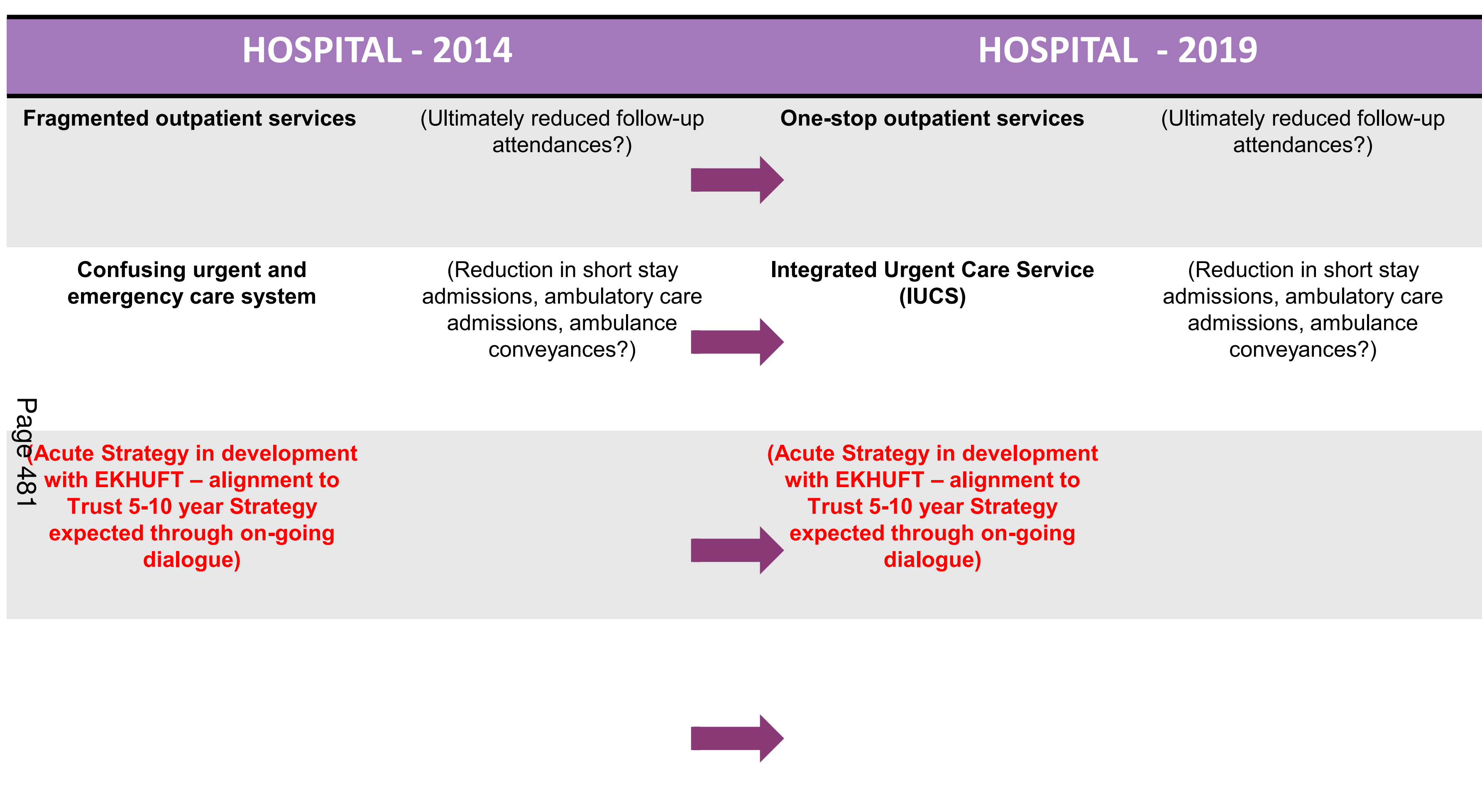
Our Strategy: Out-of-Hospital Care - Quality and Outcomes

OUT-OF-HOSPITAL - 2014		OUT-OF-HOSPITAL - 2019	
Variable access to primary care	5.80 patients per 100 currently reporting poor experience of General Practice and Out of Hours	**Easy Access to high quality, responsive primary care**	5.40 per 100 patients will report poor experience of General Practice and Out of Hours
Professionals confused as to the local services and pathways available to them	? patients currently discharged on first outpatient appointment	**Clearly understood planned care pathways**	? Patients will be discharged on first outpatient appointment
Patients spend more time in hospital than necessary due to variable access to community services 7 days a week	? patients per 100,000 currently are subject to delayed transfers of care from hospital to community	**Patients will spend the appropriate amount of time in hospital when admitted**	? per 100,000 will be subject to delayed transfers of care from hospital to community
Neighbourhood Teams lack the capacity to respond to urgent health needs	1774.9 patients per 100,000 currently are admitted to hospital as an emergency	**Rapid response to urgent needs**	1471.7 patients per 100,000 will be admitted to hospital as an emergency
Communication between health and social care professionals poor	People with one or more LTC's currently report 72.40 EQ-5D score as a measure for quality of life	**Neighbourhood teams of health and social care professionals, working together**	People with one or more LTC will report 69.30 EQ-5D score as a measure for quality of life

Our Strategy: Hospital Care

HOSPITAL - 2014		HOSPITAL - 2019	
Fragmented outpatient services	Patients make multiple hospital attendances for specialist input and diagnostics	**One-stop outpatient services**	Patients will make one single trip to receive assessment, diagnosis and treatment plan
Confusing urgent and emergency care system	Resulting in patients waiting longer than necessary in A&E, admitted with ambulatory conditions, delays in treatment with poor outcomes	**Integrated Urgent Care Service (IUCS)**	Patients have senior input early within A&E. GP presence to support signposting and management of LTC patients. IUCS works in partnership with Neighbourhood Teams to ensure patients are managed safely back home
(Hospital Strategy in development with EKHUFT – alignment to Trust 5-10 year Strategy expected through on-going dialogue between CCG and Trust)		**(Hospital Strategy in development with EKHUFT – alignment to Trust 5-10 year Strategy expected through on-going dialogue between CCG and Trust)**	

Our Strategy: Hospital Care – Quality and Outcomes



Our Strategy: Plan on a Page

NHS South Kent Coast CCG Mission:
'To ensure the best health and care for our community'

NHS South Kent Coast CCG Vision:
Out of Hospital Care – *Services will be integrated, wrapping around the most vulnerable to enable them to remain in their own home for as long as possible. Patients will be supported by a package of care focussed on their personal health and wellbeing ambitions.*

Hospital Care – *Acute care requiring specialist facilities whether for physical or mental health needs will be highly expert to ensure high quality. Hospitals will act as hub for clinicians to work out from and utilise their skills as part of broader teams as close to the patient as possible.*

All interventions are delivered following engagement activities with membership via Locality Groups / Membership Council and local patients via SKC Health Reference Groups and Locality Patient Groups

CCG Objective One
Reducing the number of years of life lost by the people of South Kent Coast from treatable conditions by X

→ Delivered through; Implementation of Health Inequalities Plan – Bi-annual Equity Audits, Targeted practice visits, Annual Reward Scheme, Education specific to health inequalities

CCG Objective Two
Improving the health related quality of life of people with one or more long term conditions by X

CCG Objective Three
Reduction in under 75 mortality rates from respiratory disease by X

→ Delivered through; Further roll-out of Pro-active Care Project, Improved Intermediate Care Service, Re-designed Pulmonary Rehabilitation Service, Re-designed Integrated Diabetes Care Pathway, Roll out of CCG Diabetes training programme, Increased community consultant geriatrician support to care homes, Re-designed Anti-coagulation Monitoring Service, Further roll-out of Personal Health Budgets

CCG Objective Four
Develop and deliver planned care which improves quality of life, reducing reliance on hospital services and improves the quality of primary care for physical and mental health

→ Delivered through; Community Pre-operative Assessments, Redesigned Musculoskeletal Pathways, Primary Care Gastroenterology Diagnostics, Redesigned Ophthalmology Pathways, Introduction of one-stop outpatient services, Redesigned Deal Hospital services

CCG Objective Five
Reduce the proportion of people reporting a very poor experience of care:
- Inpatient
- Outpatient
- Primary Care

→ Delivered through contractual levers; friends and family test, CSU acute contract management / performance meetings, collaboration with NHS England re primary care strategy, Quality Alerts / Surveillance

CCG Objective Six
Reducing the amount of time people spend avoidably in hospital through better and more integrated care out of hospital, covering both physical and mental health by X

→ Delivered through; Introduction of Integrated Urgent Care Centre (IUCC) within A&E departments, Redesigned MIU provision, Redesigned Out-of-Hours GP services, Increased Community Rapid Response Nursing Service, Continued roll out of ambulatory care pathways, Redesign of community mental health crisis services, Implementation of CCG End of Life Strategy, Redesigned community DVT service, Introduction of Community Falls Car Service

Overseen through the following governance arrangements
- Governing Body
- Performance and Delivery Committee
- SKC Health and Wellbeing Board
- SKC Integrated Commissioning Group
- SKC Locality Groups
- Health Reference Groups
- Whole System Board
- EK Clinical Forum
- Programme Boards for Urgent Care/LTC and Planned Care
- EK Diabetes Clinical Forum
- EK Mental Health Clinical Forum
- EK Childrens Strategy Gorup

Measured using the following success criteria
- Measured against NHS Domains 1,2,3 & 4
- Specific KPIs established for each contract (access, quality, clinical outcomes and patient experience)
- Financial balance & sustainability achieved

High level risks
- Maintaining and improving service quality and safety through significant service change
- Financial sustainability
- Ability of providers to respond to changes

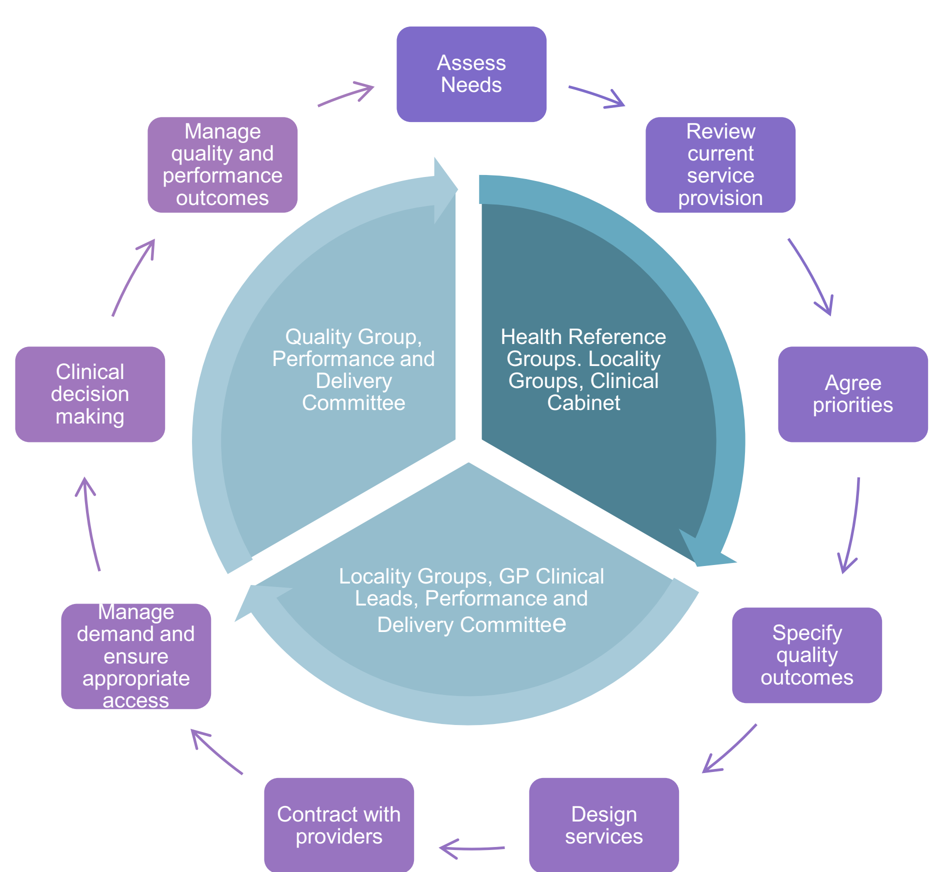
Our Strategy: Organising for Delivery

The commissioning of healthcare is organised within clinical commissioning programmes of work. These programmes are led by our GP clinical leads, with support from other GP members who bring together their knowledge and expertise to prioritise areas for redesign and service improvement.

- Our GP clinical leads work alongside the CCG staff team to drive forward the ambitions for improvement developed collaboratively with our members, patients and provider stakeholders.

- Strong clinical leadership within each of the programmes ensures our focus is always on improving quality and outcomes.

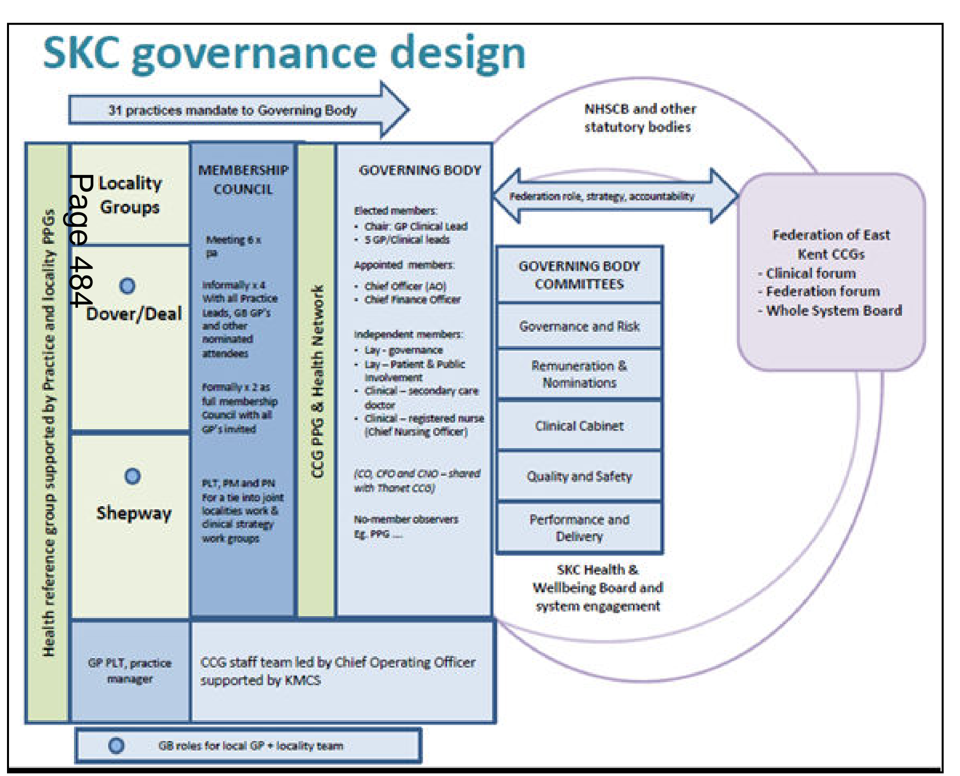
- The need to improve quality as a result of our actions as commissioners is fundamental to our organisational purpose. From ensuring no harm, to achieving the best outcomes in patient experience and clinical outcomes; consistently quality will be core to all the work we do.



Our Strategy: Organising for Delivery

A key element to the development of more joined up patient care will be effective communication between clinicians in different areas of the health system. The local governance arrangements have allowed our strategy and plans to be shaped through continued membership engagement and support.

We recognise the benefits of working collaboratively with our neighbouring CCG's in Ashford, Canterbury and Thanet. Structures are in place to support working and planning services across a wider footprint where it makes sense to do so;



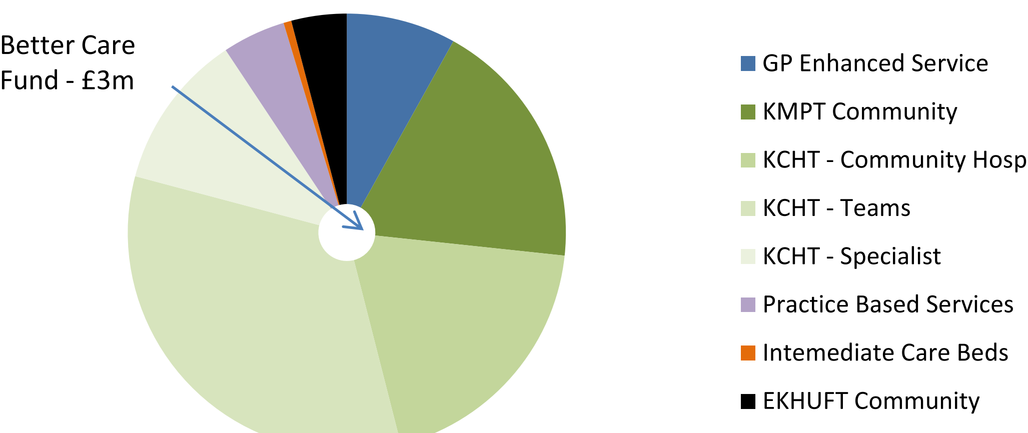
- Clinical Forum – Enables clinical discussion to explore areas where the four CCGs can work together in the development of strategy.
- 4 Integrated Care Board's (ICB's) – Planned Care / Urgent Care and LTC's, Mental Health, Maternity and Child Health. Provide a detailed planning and delivery mechanism for those work programmes which the CCG's have agreed to collaborate on.
- Federation Forum and Whole System Board – Provides strategic oversight of the collaborative work across East Kent.

Shaping Local Healthcare Supply

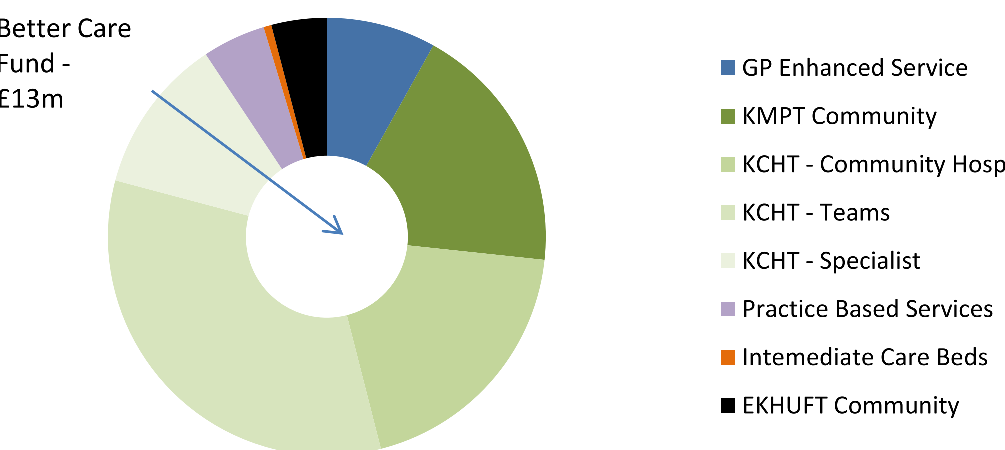
The CCG currently spends £114m on Out-of Hospital services with a range of providers.

- Over the next 5 years our ambition is to use the Better Care Fund to facilitate the level of integration we know is needed between these providers to improve health outcomes for our population
- In 2014/15 £3m of our total Out of Hospital spend will be used to increase capacity and levels of integration. This will increase to £13m in 2015/16
- Each year over our 5 year strategic period we aim to increase the Better Care Fund to further support alignment of workforce. This will enable historic organisational barriers to be broken down, allowing patients to be cared for holistically
- Workforce alignment is a key component of integration which will ultimately improve patient experience and quality of care
- Our intention is to support our Out of Hospital providers to work as closely together as possible to ensure we have joined up services

2014/15 planned CCG Non-hospital based spend split by provider



2015/16 planned CCG Non-hospital based spend split by provider



Our Strategy: Engagement

The views of the local population matter to us and we'll do all we can to make sure that they continue to be heard. We're committed to a decision-making process that's honest and transparent, and one that gives the patient an opportunity to have a say.

Our Lay Member for Patient Engagement – Brian Wash – has created a practical engagement structure which has allowed our patients to help shape our strategy and plans. This includes;

Patient Participation Groups

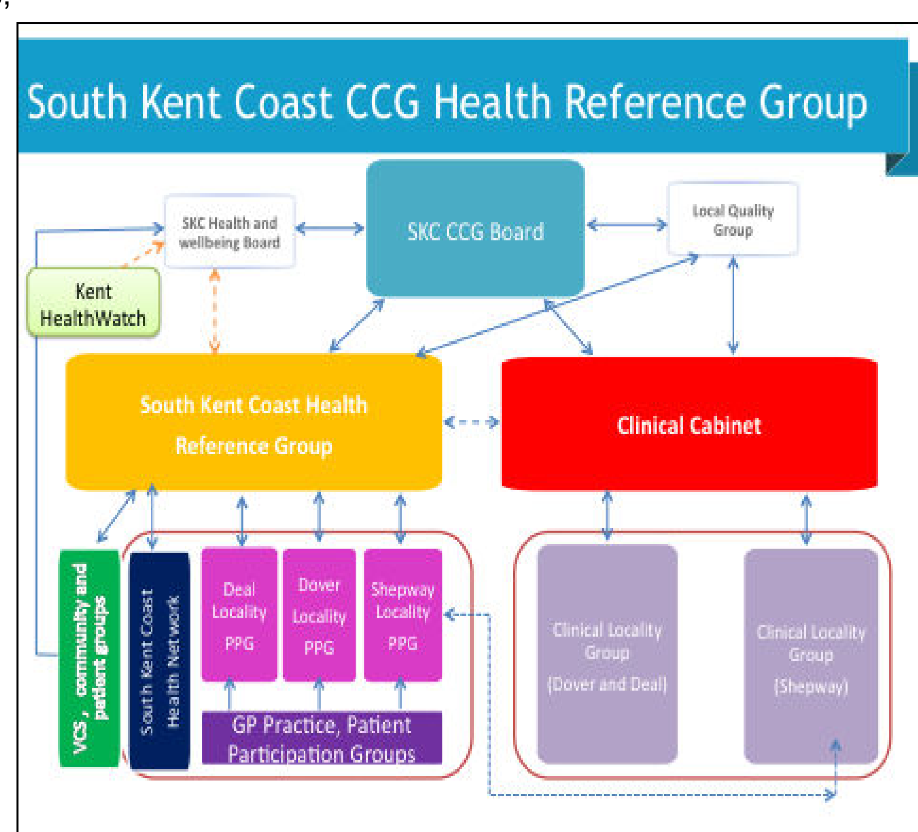
We have patient participation groups in Shepway, Dover and Deal. The have worked with the CCG to help plan and evaluate the local changes to health services described in our strategy.

Health Reference Group

This group ensures that patient participation group members and representatives from the community and voluntary sector have a key part in the work of the CCG. They have provided more intensive patient input on specific healthcare issues, supporting our GP leaders in shaping services which fit with local needs.

Public meetings

We have held meetings with our community to explore people's views on some of the larger areas undergoing transformational change, such as urgent care, mental health and out-of-hospital services.. These views have again supported us in ensuring our future ambitions are built around service users.



Appendix 1 – Operational Delivery Plan 2014-16

Commissioning and Contracting Approach 2014-16

The financial position for NHS South Kent Coast CCG in 2014/15 is very challenging, with QIPP estimated currently at £9.2m in order to secure the required surplus and retain top slice, call to action fund, Better Care Fund contribution and hold a 1.5% contingency.

- The commissioning approach to 2014/15 will be two-fold. Commissioning Intentions are worked up to build on 2013/14 schemes. These focus on specific pathway changes in areas such as DVT, Anti-Coagulation and one-stop outpatient clinics. The main QIPP drive, however, is centred around a major transformation of the way in which care will be delivered in the future.

- CQUINs of all major providers will be tailored towards adding capacity and capability to South Kent Coast's already successful neighbourhood teams, which currently bring together GPs, Social Services and Community Services.

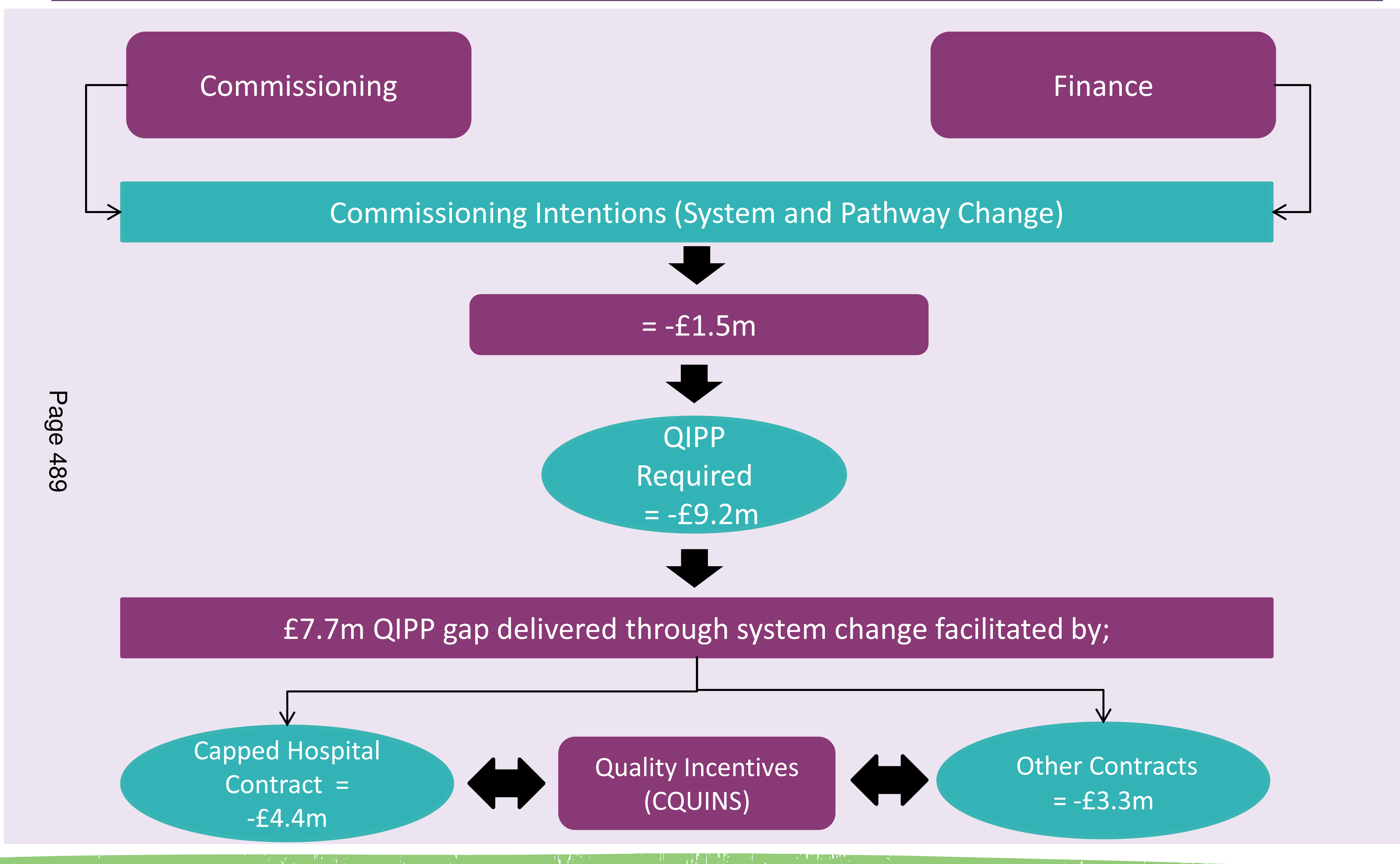
- The neighbourhood team approach has been delivering reduced A&E attendances and admission to hospital - by tailoring care around individual patient needs. It is planned for 2014/15 that secondary care consultants and their teams will join the neighbourhood teams to up-skill the GP and nursing teams and offer out-of-hospital advice and guidance to patients and neighbourhood teams.

- The contract form with the main acute provider will change in order to facilitate the move to out-of-hospital care. Discussions are beginning around setting caps and marginal rates around medical specialties in all points of delivery to deliver the expected savings to the whole system whilst incentivising the acute provider with marginal rates on under-activity.

- Coupled with a transformation of A&E provision, a start has been to integrate GPs into every A&E department in East Kent from April 2014. The neighbourhood teams will form the central pillar of patient care. They will manage term conditions and for urgent assessment, guidance and stabilisation of exacerbations - to ensure that patients are kept out of hospital as much as is possible.

- CQUINs will also incentivise a special focus around patients aged over 75, to compliment the named GP policy incentivised as part of change to GP contracts from April 2014.

Contracting and Commissioning Approach 2014-16 - Finance



Contracting and Commissioning Approach 2014-16 - Finance

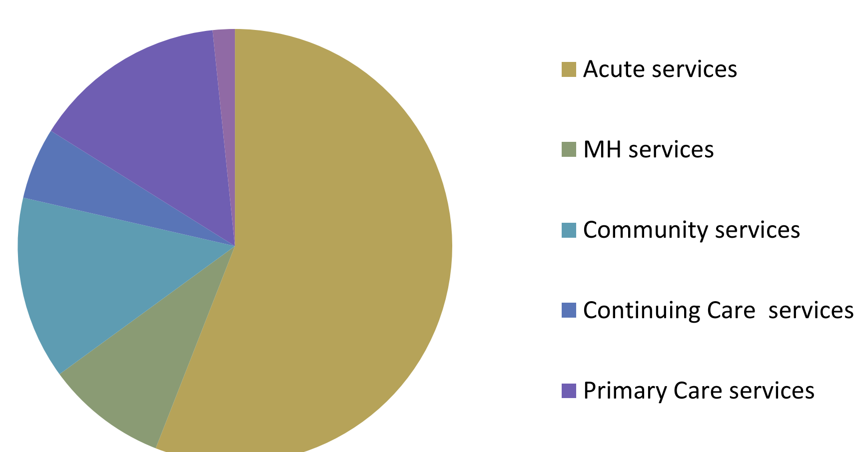
The CCG had a QIPP target of £6.1m for 2013/14. We are forecast to achieve £3.15m. This has left a shortfall, leading to the use of our 2% top slice and contingency.

- This will have a knock on effect to 2014/15 whereby additional QIPP savings will need to be identified in order to achieve financial balance.
- The main areas of overspend from 2013/14 which the CCG is addressing through our commissioning and contracting approach for 2014/15 continue to be;

❑ The local hospital provider – East Kent Hospitals University Foundation Trust (EKHUFT)

❑ Continuing Healthcare Placements (CHC)

❑ The local mental health provider – Kent and Medway Partnership Trust (KMPT)



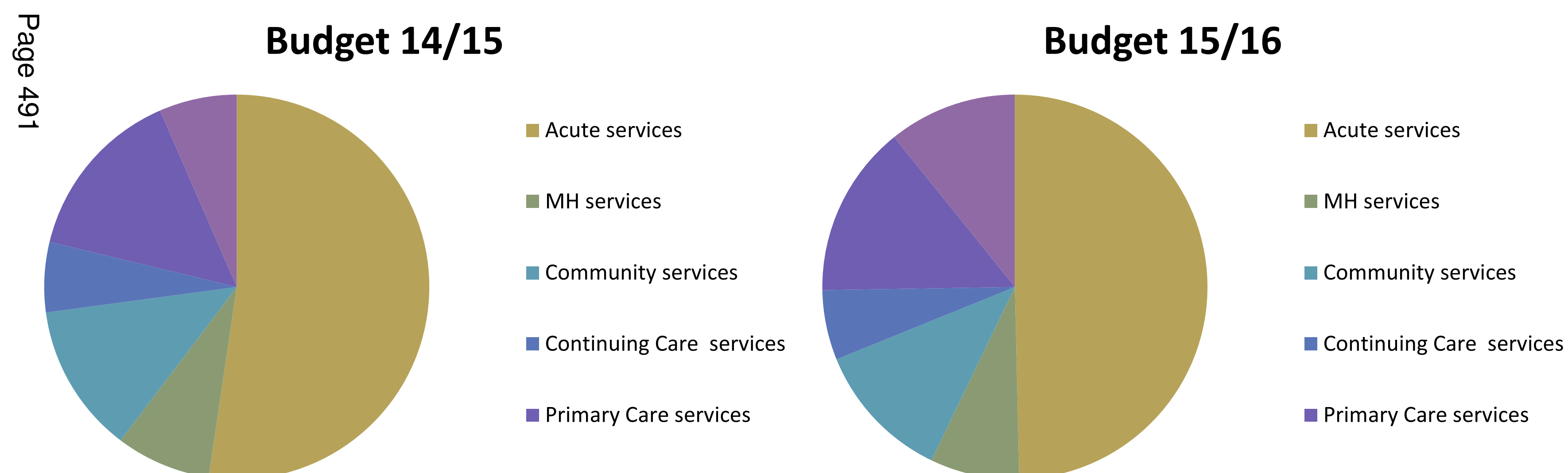
Contracting and Commissioning Approach 2014-16 - Finance

South Kent Coast CCG has a baseline budget of £261.7m for 2014/15; this delivers a 1% surplus of £2.63m.

The budget for 2014/15 is based on the budgets set for 2013/14. We have adjusted this budget for non-recurrent spend, growth, full year effects of QIPP schemes not delivered in 2013/14, cost pressures and required savings.

We have a predicted population increase of 0.87% as per Office of National Statistics figures. Further to this ambulance and continuing health care services have a demand uplift of 5% due to historic trends and prescribing has an uplift of 4% as per NICE guidance.

As with 2013/14, the CCG approach is based on delivering higher quality care with better value for money.



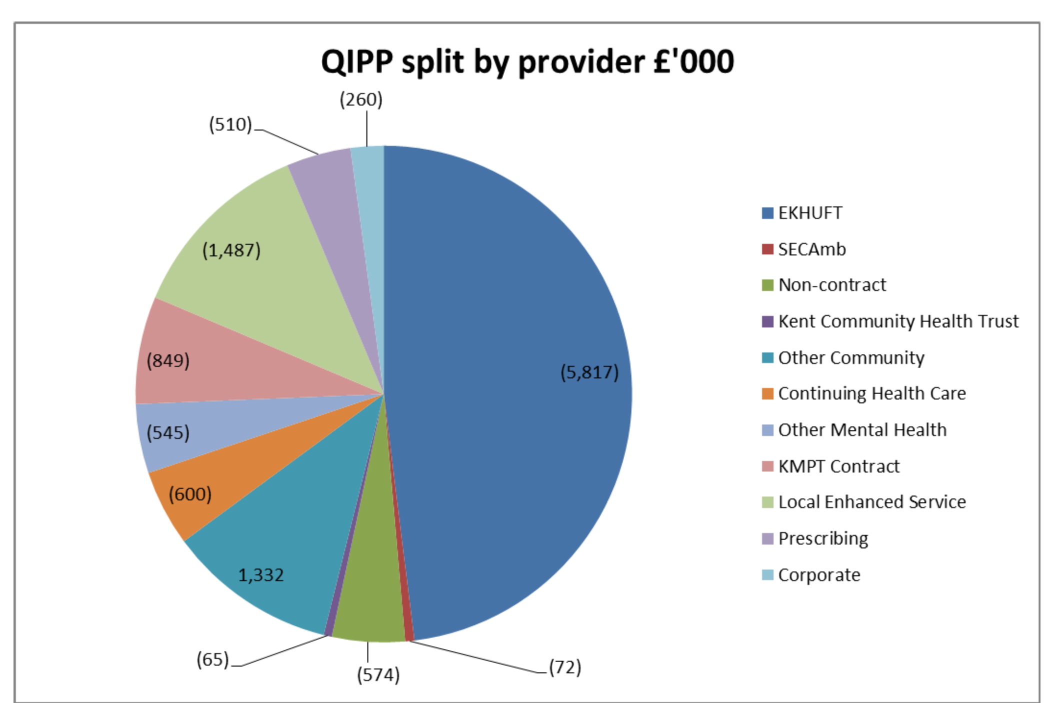
Contracting and Commissioning Approach 2014-16 – Finance QIPP

We are aiming to deliver a total saving of £5.8m on our main hospital contract in 2014/15 - EKHUFT. This is made up of already identified schemes (£1.375m) and blocking the contract (£4.442m).

In blocking the contract we recognise that it is below the 2013/14 outturn and as such EKHUFT will need to redesign services. To support EKHUFT in managing this transition we intend to use some of the 2% top slice in addition to the block payment.

We have already committed £1m against the top slice due to the inclusion of retrospective CHC claims within our allocation.

Provider	Total £'000
EKHUFT	- 5,817
Non-contract activity	-574
SECAmb	-72
Kent Community Health Trust	-217
Continuing Health Care	-601
CAMHS	20
Mental Health Placement and IAPT	-526
KMPT	-127
Out of Hours	-40
Local Enhanced Service Changes	20
Prescribing	-510
Patient Transport	-342
Physiotherapy & other AQP	-401
Children's Commissioning	-84
Running Costs	-26
	-9,297



Contracting and Commissioning Approach 2014-16 - Quality

Central to our 5 year strategic approach is our ambition is drive up the quality of care our patients receive. In the first 2 years we have chosen over and above nationally defined quality incentives to have 4 local incentives shared jointly between our two main hospital and out of hospital service providers. The quality incentives will;

- Focus on specific health needs and areas of pressure identified in our strategy
- Support the level of integration we expect between our hospital and out of hospital service providers
- Support the system change we require to make the local health system fit for the future

COPD	Over 75 years with LTC	Diabetes	Heart Failure
2014/15	**2014/15**	**2014/15**	**2014/15**
Work collaboratively to analyse the current COPD pathway of care provided by the Community Trust and the Acute Hospital Trust to identify gaps and issues and agree a future integrated pathway and outcome measures.	In relation to Share my Care (SMC), working with all contributors to the pathway, agree standard documentation to upload to SMC and responsibilities within this process. Agree a standard set of information to be uploaded and maintained on SMC.	Working with acute colleagues to analyse current pathways, in comparison to the new pathway identified by the CCG's. Identify areas which need change and undertake that change to deliver the new model within agreed contract.	Work collaboratively to analyse the current Heart Failure pathway of care provided by the Community Trust and the Acute Hospital Trust to identify gaps and issues and agree a future integrated pathway and outcome measures.
2015/16	**2015/16**	**2015/16**	**2015/16**
Work collaboratively to embed and measure performance of new integrated care pathway for COPD patients, with ultimate aims being to; • Reduce non-elective admission / re-admission By; • Delivering care close to home • Improving transfer of care • Improving self-management	Embed and measure performance, with ultimate aims being to; • Develop a collaborative shared care plan approach • Improve transfer of care between providers • Improve the safety and quality of patient care	Embed and measure performance, with ultimate aims being to; • Reduce non-elective admission / re-admission By; • Delivering care close to home • Improving transfer of care • Improving self-management	Work collaboratively to embed and measure performance of new integrated care pathway for Heart Failure patients, with ultimate aims being to; • Reduce non-elective admission / re-admission By; • Delivering care close to home • Improving transfer of care • Improving self-management

Contracting and Commissioning Approach 2014-16 - Quality

To further support our strategic ambition to close the gap between mental and physical health, we have devised 4 local quality incentives with our main mental health service provider – Kent and Medway Partnership Trust (KMPT). The quality incentives will; (Mental Health CQUINS still under negotiation with KMPT)

- Focus on….
- Support….
- Support….

2014/15	2014/15	2014/15	2014/15
2015/16	2015/16	2015/16	2015/16

Out of Hospital Programme: Vision / Future Operating Model

From:	By doing what:	To:

From:

'The professionals involved in my care do not appear to communicate with one another. I have to repeat my story every time.'

'I do not know who the main person in charge of my care is.'

'When I was discharged from hospital to my home, I was not clear on what would happen next.'

'I panic when my condition deteriorates. I do not know who to contact.'

'The care and support I receive has made me dependent on others. I feel no longer able to live my life independently.'

By doing what:

SYSTEM CHANGES

- **Integrated Teams and Reablement** - Revised Intermediate Care Pathway, Enhanced Community Rapid Response Teams, Revised rehabilitation and non-weight bearing pathway
- **Enhanced Neighbourhood Care Team (NCT)** - Further roll our of Pro-active Care Programme, Hospital specialists integrated into NCT's
- **Enhanced Primary Care** – Integration of GP practices within NCT, Greater support from hospital teams within primary care using technology, Improved primary prevention and signposting, Promotion of Personal Health Budgets, Pre-operative Assessments in primary care
- **Enhanced Support to Care Homes** – An integrated local community based Consultant Geriatrician and specialist nursing team providing support to care homes
- **Local Integrated Urgent Care** – Revised MIU service, Integrated MIU / Out of Hours primary care model re-procurement, Increased access to primary care
- **Mental Health –** Primary Care MH Specialist pilot, Community link workers in primary care, Targeted community development work
- **Winterbourne –** Implementation of joint plan with KCC, discharge of patients currently within in-patient facilities to community placements with providers able to support people with complex needs

To:

'The professionals involved with me talked to each other. I could see that they worked as a team'

'I had one first point of contact. They understood both me and my condition(s). I could go to them with questions at any time.'

'When I moved between services or settings, there was a plan in place for what happened next.'

'I had systems in place so that I could get help at an early stage to avoid a crisis'

Taken together, my care and support helped me live the life I want to the best of my ability'

Out of Hospital Programme: Vision / Future Operating Model

From:

'I do not know what to do and where to go in an emergency.'

'I was not provided with good information about my condition following diagnosis. I no longer feel able to manage without support.'

'I was not given the opportunity to input into future care arrangements should my condition worsen.'

'I only have a quick review of my care and treatment once a year. '

'I struggled to keep on top of my medicines regime. Are they all still working?'

By doing what:

PATHWAY SPECIFIC CHANGE

- **Community DVT Service –** town based model integrated with existing MIU facilities
- **End of Life –** Improved co-ordination and timeliness of care, Palliative care education programme, Increased specialist bereavement counselling service, Procurement of system wide electronic palliative care system
- **COPD –** Increased provision of Pulmonary Rehabilitation Services across SKC
- **Diabetes -** Type 2 Diabetes primary care training programme, Integrated Diabetes care pathway implementation
- **Anti-coagulation Services -** Re-procured model ensuring both initiation and on-going monitoring within the community
- **Gastroenterology –** Introduction of faecal calprotectin testing in primary care
- **Dermatology** – Review of community pathway with a view to re-procuring service
- **ADHD –** Re-procurement of community specialist ADHA service for adults and children
- **Dementia –** New out-of-hours service for older people with MH problems and Dementia
- **Falls Prevention –** Implementation of falls response vehicle
- **Children with Challenging Behaviour –** New multi-agency intensive support team model
- **Looked After Children –** Re-procurement of LAC service

To:

'I could plan ahead and stay in control in emergencies'

'I had the information and support I needed in order to remain as independent as possible'

'Information about me, including my views and preferences and any agree care plan, was passed on in advance'

'I has regular reviews of my care and treatment, and of my care plan'

'I had regular, comprehensive reviews of my medicines'

Out of Hospital Programme: Performance and Delivery Summary

PERFORMANCE INDICATOR	Baseline	2014/15 Target	2015/16 Target
Patient Experience - GP / Out of Hours Primary Care	5.80	5.72	5.64
Proportion of people feeling supported to manage their condition	64.8%	70.0%	n/a
Long Term Conditions - Quality of Life Scores (EQ-5D)	72.40	72.25	71.63
Under 75 Respiratory Mortality	TBC	TBC	TBC
Years of Life Lost (Treatable Conditions)	2073.2	2055.2	2037.1
Permanent admissions of older people to residential and nursing care homes	156.2	154	n/a
Proportion of older people who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	88.10%	90.0%	n/a
Delayed Transfers of Care	38.5	36.4	n/a
Emergency Admissions (Activity)	1774.9	1759.7	1699.1
Dementia Diagnosis (% of expected diagnosed)	38%	47%	55%
Access to Psychological Therapies	17.1%	17.1%	17.1%

RISKS	RATING	MITIGATING ACTIONS
Workforce - Reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the out-of-hospital work programmes and 24/7 availability of NCT's.	HIGH	Each provider has been required to develop a detailed workforce plan to support the delivery of each scheme within this programme.
Communication – Patients and providers may not know how to access services within an integrated system to ensure services are used appropriately	HIGH	Communication plan to be developed to support delivery of each scheme.
IT – Systems across services not integrated and therefore do not enable shared care plans between organisations to support integrated outcome measurement and monitoring.	HIGH	Integrated system to support sharing of care plans to be developed as a priority. Integrated performance monitoring and reporting to be enhanced to take into account all schemes.
Finance – Non-delivery of the projects within this programme will have significant effect on the CCG's ability to meet its statutory obligations.	HIGH	Current QIPP monitoring processes will continue to ensure delivery and early identification of slippage / risk.
Population Health – Failure to delivery key projects aimed at reducing health inequalities will result in the continued health gap between the poorest and the most affluent wards in SKC.	HIGH	Primary Care Group in place to drive forward schemes across the member practices.

WORKFORCE IMPLICATIONS

- **See risks.**

RESOURCE IMPLICATIONS

	Investment £'000	Savings £'000
2014/15	000,000	1,0309,618
2015/16	000,000	000,000
Total	000,000	1,309,618

Out of Hospital Programme: Milestone Tracker

KEY MILESTONES FOR 2014-16	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Integrated Teams and Reablement								
Enhanced NCT's								
Enhanced Primary Care								
Enhanced Support to Care Homes								
Local Integrated Urgent Care								
Mental Health								
Winterbourne								
Community DVT								
End of Life								
COPD								
Diabetes								
Anti-coagulation								
Gastroenterology								
ADHD								
Dementia								
Falls Prevention								
Children with Challenging Behaviour								
Looked After Children								

Hospital Programme: Vision / Future Operating Model

From:

'I had to make 3 or 4 trips to hospital to receive consultations and tests before I was diagnosed.'

'I was admitted to hospital over night when my condition worsened. I had to wait longer than expected for my discharge arrangements to be made.

'I was not asked my view on my treatment post-discharge. I was placed in a bed miles away from my home and family.'

'I was not told about the side effects of my medication. I became unwell again and went back to A&E.'

By doing what:

SYSTEM CHANGES

- **One-stop outpatient services –** Urology, Breast, Colorectal one-stop services across East Kent
- **Integrated Urgent Care Service –** Multi-disciplinary service within hospital consisting of GP, Hospital Specialists, Mental Health and Health and Social Care Teams. Improving the co-ordination and flow of patients through the urgent care system, with 24/7 care co-ordination centre and enhanced ambulatory care services.

PATHWAY SPECIFIC CHANGES

- **Ophthalmology –** Review of hospital eye services with a view to re-procurement of specific pathways suitable for management in the community. Macular Oedema – A central acute site to deliver treatment and drug administration, with hub and spoke community model to provide monitoring
- **MSK –** Lead provider model for MSK across primary to secondary care
- **Early Pregnancy –** Improve awareness of pathway and services to reduce the level of EPAU in A&E
- **Dementia –** A sustainable dementia buddy scheme within acute hospital

To:

'There were no big gaps between seeing the doctor, going for a test, getting the results and a treatment plan.'

'My condition was stabilised and I was discharged back home and visited by my community nurse on the same day.'

'I was involved in the discussions and decisions about my out of hospital care and treatment before I was discharged.'

'On discharge I was given information about any medicines I was taking with me – their purpose, how to take them, potential side effects.'

Hospital Programme: Performance and Delivery Summary

PERFORMANCE INDICATOR	Baseline	2014/15 Target	2015/16 Target
Improved inpatient experience	139.9	139.5	139.0

RISKS		
Workforce	HIGH	Provider led workforce group set up to map the impact of the transformational change around both urgent care and outpatients.
Communication	HIGH	Communication plan to be developed to support delivery of each scheme.
Finance – Non-delivery of the projects within this programme will have significant effect on the CCG's ability to meet its statutory obligations.	HIGH	Current QIPP monitoring processes will continue to ensure delivery and early identification of slippage / risk.

WORKFORCE IMPLICATIONS

- See risks.

RESOURCE IMPLICATIONS

	Investment £'000	Savings £'000
2014/15	000,000	198,308
2015/16	000,000	000,000
Total	000,000	198,308

Hospital Programme: Milestone Tracker

KEY MILESTONES FOR 2014-16	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
One-stop outpatient services								
Integrated Urgent Care Service								
Ophthalmology – Hospital Eye								
Ophthalmology – Macular Oedema								
MSK Pathway Redesign								
Early Pregnancy								
Dementia								

Appendix 2 – Better Care Fund Plan

Vision

The South Kent Coast vision for integrated health and social care is for patients to always be at the heart of their care and support, receiving coordinated services without organisational barriers that are easy to access 24/7, of high quality and that maximises their ability to live independently and safely in their community and in their own homes wherever possible. We will ensure service users and their carers can navigate the services they need and that their health and well-being needs are always met by the right service in the right location.

We will achieve this by building integrated health and social care teams around every patient. These teams, linked to every GP practice, will undertake integrated health and social care assessments and coordinated care planning to pro-actively manage patient's conditions and needs in the community helping people to stay out of hospital or to recover more quickly after a hospital stay.

Our plans for the Better Care Fund will be achieved by a number of schemes aimed at services working together to provide better support for people with long term conditions, older people and people with disabilities at home to maintain independence and earlier treatment in the community to prevent people needing emergency care in hospital or care homes and education and empowering people to make decisions about their own health and well-being. We will deliver this by:

- Building on and enhancing some of the local projects already implemented or planned and;
- Introducing other schemes to ensure faster evolution of what we are already setting out to achieve.

Changes to service configuration

As set out in the CCGs five year strategy the overall vision to ensure the best health and care for our community will result in changes to current service configuration. Achieving the CCGs vision will require building sufficient capacity in the community, including the workforce, whilst reducing capacity in acute hospitals in order to deliver the following:

- Out of hospital services to be integrated and wrapped around the most vulnerable to enable them to remain in their own home for as long as possible. Patients will be supported by a package of care focussed on their personal health and wellbeing ambitions;
- Acute hospital services will be specialist facilities whether for physical or mental health needs and will be highly expert to ensure high quality. Hospitals will act as hubs for clinicians to work out from and utilise their skills as part of broader teams as close to the patient as possible.

Patient and service user outcomes

By working in new and innovative ways we aim to achieve the following:

- Focus on prevention and targeted interventions to support peoples overall health and well-being;
- Ensure services respond rapidly and more effectively to patient's needs, especially at times of crisis;
- Support carers and empower individuals to do more for themselves;
- Improve the overall patient experience of the delivery of care.

Aims and objectives of an integrated system

With a high elderly population in South Kent Coast and increasing numbers of people who have one or more long-term condition we aim to focus the Better Care Fund on prevention, reducing the demand and making the most efficient and effective use of health and social care resources.

Our plans for the Better Care Fund support the delivery of the CCGs five year strategy which has a strong focus on the management of long term conditions and the subsequent impact long term conditions has on the local health systems. The plan will also support the delivery of the five year East Kent Strategic Plan (2014-2019).

Given the extent of integration set out in our plans, there are considerable changes to the current ways of working and the existing workforce across multiple organisations. This will require us to undertake work to re-shape the supply of the market to enable delivery of our plans over time; this may take the form of an Integrated Care Organisation.

South Kent Coast CCG has developed an Integrated Commissioning Strategy in partnership with the local authority and both Dover and Shepway District Councils. This Strategy identified four shared aims which are working together toward:

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

Measuring improved outcomes

By delivering the above aims to will achieve the following outcomes:

Reduced hospital admissions;	Reduction in duplication;	Carers will have access to good quality information and advice;	Improved end of life care for people with dementia and long term conditions.
Reduced length of stay in hospital;	People will have access to local quality housing that meets their needs;	Carers will be supported to access services to support them in that role;	Ensure services respond rapidly and more effectively;
Timely access to local health and social care services;	People will be able to get around and access facilities in their local communities;	Carers will be supported to stay mentally and physically well and treated with dignity;	Support carers and empower individuals to do more for themselves;
Improved access to information which allows people to make decision about their own lives;	People will have more choice and control over the health and social care services they use;	Improve end of life care for people living in residential, nursing and extra care housing;	Improve the patient experience of the delivery of care
Thriving and self-reliant communities;	After people are discharged from hospital they will return home to a safe and accessible environment as quickly as possible;	More people die in the place of their choice having received the care appropriate to their needs;	

The above measures will be monitored using an integrated performance dashboard for the Better Care Fund, this will be developed and piloted during 2014/15.

Integrated Teams and Reablement

Integrated teams available 24 hours a day seven days a week will be contactable through single access points. Patients will know who they should contact within these teams whenever they need advice and support. The teams will undertake single assessments and coordinate onward referrals and comprehensive care planning and will provide enhanced rapid response to patients at high risk of hospital admission providing intermediate care and rehabilitation in the community. The teams will integrate with the hospital discharge planning and referral processes seven days a week and coordinate post-discharge support into the community linking with the community based Neighbourhood Care Teams, primary care and the voluntary sector.

SCHEME REQUIREMENTS:

Integrated Intermediate Care Pathway & flexible use of community based beds

- Integrated pathway to coordinate referral management, admissions avoidance and care coordination across health and social care, supported by single access points;
- Integrated assessments to ensure responsive onward referral to either rapid response services or intermediate care services ensuring transfer to most appropriate care setting (including patients own home);
- Intermediate care provision to be provided at patients own home wherever possible by professional carers or by a multidisciplinary team of therapists and nurses;
- Community hospital beds only to be used for comprehensive assessments, for patients needing 24/7 nursing rehabilitative care and for carer respite;
- Community based beds (in any local setting) will provide 60% step down from hospital and 40% step up to support timely hospital discharge and prevent avoidable hospital admissions and re-admissions. These beds will be used flexibly to effectively respond to changes in demand.

Enhanced Rapid Response – supporting acute discharge/preventing readmission

- Enhanced Rapid Response teams supporting admissions avoidance as part of intermediate care provision as well as respond directly to A&E referrals;
- The teams will be integrated with Emergency Care Practitioners to ensure enhanced skills are available and supporting the ability to keep sub-acute patients at home;
- The teams will include medicine management support as well as medical leadership and input from hospital consultants to enable continuous support at home;
- The teams will integrate with the Dementia Crisis Service which can receive referrals 24/7 providing support 24/7 to patients with Dementia and carers of people with Dementia to prevent hospital or care home admissions.

Integrated rehabilitation & Non Weight Bearing Pathway

- Integrated approach to support timely hospital discharge, rehabilitation and intermediate care for patients including non-weight bearing patients;
- Proactive case management approach to support timely transfer of patients from acute beds into the community and preventing admissions into acute from the community;
- Integrated step up and step down beds supported by a dedicated multi-disciplinary team, including therapists, social care and primary care input, to ensure timely patient flows.

<u>Enhance Neighbourhood Care Teams and Care Coordination</u>

This model builds a team around the patient who focus holistically on the patients overall health and well-being and pro-actively manages their needs. These teams will be further enhanced to ensure wider integration with other community and primary care based services as well as hospital specialists working out in the community and mental health teams to ensure people can be cared for locally and in their own homes wherever possible and using technology for virtual ward rounds or consultations and remote guidance for GPs rather than patients attending hospital. The teams will be aligned to every GP practice, will undertake Multi-disciplinary Team meetings and will include designated care coordinators for all patients.

SCHEME REQUIREMENTS:

Risk Profiling to enable Proactive Care of patients who are at both high and low risk of hospital admission to deliver more coordinated patient care in the community (see section d below for further details of the South Kent Coast Pro-Active Care Programme)

- Aligned to every GP practice the Neighbourhood Care Teams will be accessible 24 hours a day, seven days a week and will coordinate integrated proactive care management of patients through a multi-disciplinary approach with patient involvement at every stage of the process including the development and access of anticipatory care planning to ensure patient centred care and shared decision making;
- The Neighbourhood Care Teams function as integrated teams and provide continuity of care for patients who have been referred for support in the community and form the main structure in providing post hospital discharge care and some pre-admission interventions as well as seamless coordination and delivery of End of Life care;
- The Neighbourhood Care Teams will form the main structure in providing post hospital discharge care and some pre-admission interventions and will be integrated with pathways to assess a patients home environment;
- Access into and out of the Neighbourhood Care Teams will be coordinated through clinically supported single access points. Patients who require assistance by more than one professional will receive coordinated integrated assessments. This single point of access will be integrated with social services and will be linked with secondary care via a flagging system to report when patients known to the teams have been admitted to secondary care;
- Each Neighbourhood Care Team will include input from the wider community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, and Social Care Managers as part of the multi-disciplinary approach;
- The teams will support patients with complex needs to better manage their health to live independent lives in the community, including supporting and educating patients with their disease management by using technology, for as long as possible empowering them to take overall responsibility for managing their own health;
- The Neighbourhood Care Team will be able to access the relevant care package required to support the person for the time required.

Specialists to integrate into community based generalist roles

The enhanced Neighbourhood Care Team model requires specialist input from acute in the community to enable the management of care for more patients in the community for a range of specialisms (respiratory, diabetes, heart failure and COPD) including the care of the over 75s, this will include undertaking clinics and reviews of patients in or close to their own homes rather than in hospital. This could include actual and remote approaches supported through the use of technology, such as video conferencing with acute specialists.

Enhance Primary Care

Integrated community models of care centred on GP practices requires significant change in primary care working patterns. Different models need to be developed to ensure the right levels of support and capacity is available within general practice and to support the development of sustainable local communities. This will include a hub of practices in every community to improve access to a full range of local health and social care services to support the move from a medical focused model of care and shifting towards a health and well-being focus.

SCHEME REQUIREMENTS:

Develop primary care based services with improved access and integrated with other community and specialist services

- GPs to undertake proactive case management of patients including regular medication reviews, proactive working with patients to avoid admissions. This will require closer working with social services, working with at risk patients to avoid crisis and better use of carer support services. This could also include a virtual ward round of at risk patients following hospital discharge;
- GP practices to be clustered in hubs and configured in a way that enables different access opportunities for patients to include open access and access to other practices in the hub to improve responsiveness of service provision;
- Develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by primary care. This will require stronger integration with the Neighbourhood Care Teams as well as stronger links with and signposting to the voluntary sector;
- Integrated primary care provision will have greater support from specialist hospital teams to ensure on-going medical care for patients after hospital discharge by creating shared on-going care plans to avoid hospitals readmissions and stronger links with rapid response services to enable patients to remain out of hospital.
- GP practices to link with the support to care homes pathways to provide more intensive support

Primary care service will support and empower patients and carers to self manage their conditions

- Professionals in primary care will promote the use of integrated personal health budgets for patients with long term conditions and mental health needs to increase patient choice and control to meet their health and social care needs in different ways;
- Primary care and the Neighbourhood Care Teams will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the community;
- The Neighbourhood Care Teams will educate patients about preventative services such as weight management and alcohol services as part of the multidisciplinary assessment;
- Patients will be supported by the Neighbourhood Care Teams and primary care to inform and take ownership of their care plans this includes electronic sharing of care records with the patient and between health and social care professionals;
- Improved signposting and education and access to signposting and education will be available to patients through care coordinators and Health Trainers to ensure patients are given information about other opportunities to support them in the community, including the voluntary sector, and community pharmacies. GPs will signpost patients with early signs of mental health to the right services;
- Develop a Health and social care information advice and guidance strategy to enable people to access services without support from the public sector if they choose to.

Enhance support to Care Homes

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

SCHEME REQUIREMENTS:

An integrated local community based Consultant Geriatrician and specialist nursing team providing support to care homes;

- The integrated team can be referred to directly and is aligned to the Neighbourhood Care Teams and the Integrated Intermediate Care teams to undertake reviews all care home discharges from hospital and A&E and ensure appropriate community based services are in place to support patients as part of their discharge planning. These discharge plans will be in place for every patient and known to all community based teams. The team will also undertake anticipatory care planning with the patients and their carers;
- The consultant works in the community providing advice to GP in the treatment and support for patients and along with the wider team provides additional support, advice and guidance to care homes;
- Access to specialist services such as Dementia Crisis will be available to support care homes

Integrated Health and Social Housing approaches

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

SCHEME REQUIREMENTS:

An integrated approach to local housing and accommodation provision supported by a joint Health and Social Care Accommodation Strategy, to enable more people to live safely in a home and other environments and to enable people to be discharged from hospital in a timely manner into the appropriate place for their needs

- Current bed based facilities (step up and step down) to be flexible and broadened to use housing schemes;
- Responsive timely adaptations to housing;
- Preventative pathways to enable patients and service users to return to (following hospital and care home admissions) and remain in their homes safely including full holistic home safety checks;
- Flexible housing schemes locally;
- Increased provision of extra care housing locally, including a facility to support patient rehabilitation or carer respite for short periods of time with clear criteria and processes for accessing such facilities;
- Different types of supported accommodation for those with learning disabilities and mental health needs

Falls prevention

Development of falls and fracture prevention services for older people to undertake screening and comprehensive assessment aimed at identifying and treating the underlying causes of falls, such as muscle weakness, cardiovascular problems, medication and housing issues.

SCHEME REQUIREMENTS:

Development of a local specialist falls and fracture prevention service

- This service will work closely with the Neighbourhood Care Teams, Rapid Response and Intermediate Care and will undertake proactive and responsive screening and multi factorial assessments to identify causes of falls and make arrangements for preventative approaches.

Local integrated falls prevention pathways

- Level of current services across locally will be more integrated to include the increased level of input from geriatrician for integrated management and integration with other professionals e.g., pharmacists, chiropodists, podiatrists, opticians and audiologists;
- Develop an Integrated Ambulance Falls Response Service;
- Improve availability and awareness of therapeutic exercise programmes (postural stability classes) via community classes and domiciliary based.

Success factors and timeframes for delivery

Each of the above schemes has a range of outcome measures to demonstrate success. The key measurements of success are as follows:

- Reduced A&E attendances;
- Reduced hospital admissions and re-admissions for patients with chronic long term conditions and Dementia;
- Reduced length of stay;
- Improved transfers of care;
- Reduced long term placements in residential and nursing home beds;
- Reduced need for long term supported care packages;
- Increase patients returning to previous level of functionality in usual environment;
- Increase levels of patient self management of long term conditions;
- Reduction in falls and secondary falls;
- Reduction in hip fractures;
- Improve patient satisfaction and well-being;
- Increase levels of patients with personal health budgets and integrated budgets;
- Improve health outcomes by better use of prevention services;
- Reduce unnecessary prescribing.

To ensure the delivery of the above schemes in 2015/16 a programme plan setting out details of the key milestones is in development and will be refined during 2014/15 to ensure clarity of when the changes come into effect and the implications of these changes as well as the expected outcomes. The programme plan will also include contingencies if the plans are not delivered.

Alignment with local JSNA and local commissioning plans

The schemes outlined in this plan which have been developed in partnership with social care commissioners. The schemes, along with the CCGs overall commissioning plans, will support addressing the pressing needs identified through the local Joint Strategic Needs Assessment, particularly around the care of people with long term conditions and for those families and individuals supporting them. These health priorities are as follows:

- Being ready to respond to the impact of our aging population;
- Tackling increasing inequalities;
- Improving access to primary care services;
- Managing patients mental health (including Dementia);
- Increasing access to care closer to home;
- Tackle patients' long term conditions;
- Tackle unnecessary and unfair variations in care;
- Improve management and identification of diabetes;
- Pro-active general practice (smoking, weight, alcohol, health checks etc.);
- Work closely with partners to tackle patients and carer wellbeing.

Implications on the acute sector

The plans align with the delivery of the CCGs strategy, as outlined in section 2a above. The majority of the NHS savings will be realised by the reduced emergency attendances and admissions and a reduction in length of stays within the acute setting and therefore there will be a reduced investment in secondary care.

The plans will not have a negative impact on the CCGs constitutional targets as set out in the Everyone Counts: Planning for Patients 2014/15-2018/19. The plans should enable the delivery of some of these targets, in particular the A&E waiting times and the proportion of older people at home 91 days after discharge from hospital into Reablement / rehabilitation services.

Governance

The local Better Care plans will be implemented and monitored using a commissioning project management framework. The delivery of the schemes will be supported by the local Integrated Commissioning Group which will report progress to the local Health and Well Being Board. Delivery of the plans will ultimately be the responsibility of the CCGs Governing Board.

All defined milestones and outcomes of the plan will be monitored at a CCG's Governing Body committee level via the Performance and Delivery Committee and reported for assurance purposes to the Governing Body. The Better Care Fund schemes and metrics will be included within the body of the Integrated Quality and Performance Report which is a standing agenda item on the Performance and Delivery Committee.

The committee feeds into the CCG's risk register and any risk to delivery or expected outcomes will be included via output from the committee. Whilst many of the metrics are nationally defined and officially reported annually, proxy measures will be used to monitor them in year, including the Levels of Ambition Tool, Atlas of Variation and SUS data.

Protecting Social Services

The Better Care Fund plans set out a vision for a fully integrated health and social care system. The delivery of these plans will not have an adverse impact the care on the adult social care services and therefore patients and service users eligible for social care services will continue to receive the care they need.

By managing to reable people back to a level of care that means they can manage in the community this will reduce the impact on social care freeing up capacity for the increased demand on services.

Development of a Self Care Strategy will support the prevention agenda which will benefit all organisations as will the development of a joint information advice and guidance strategy which signposts people to the right place.

7 day services to support discharge

The Kent Joint Health and Wellbeing Strategy sets out a number of outcomes aimed at providing seven day health and social care services across the local health economy, for example:

- Ensure all agencies who are working with people most at risk of admission to hospital and long term care have access to anticipatory and advanced care plans and 24/7 crisis response services in order to provide the support needed;
- Ensure all people with a significant mental health concern, or their carers, can access a local crisis response service at any time and an urgent response within 24 hours.

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

In South Kent Coast the enhanced multidisciplinary Neighbourhood Care Team is the main structure for providing post hospital care for any reason and some pre-admission intervention in the community.

Data Sharing

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

NHS

At present all NHS organisations must ensure that a minimum of 95 per cent of all active patient records have an NHS number. The NHS Information Standards Board mandates the use of the NHS number on both general practice and secondary care organisations.

The NHS standard contract states:
"Subject to and in accordance with guidance the provider must ensure that the service user health record includes the service user's verified NHS number. The provider must use the NHS Number as the primary identifier in all clinical correspondence (paper or electronic). The provider must be able to use the NHS Number to identify all activity relating to a service user."

Social Care

A 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.

The NHS number is predominately used to facilitate the matching of data sets for Year of Care and Risk Stratification, not for correspondence or to undertake client checks, the numbers are too low. We would use name: address and date of birth as the key identifiers at present. Further work will be required to ensure NHS number is used across all correspondence.

KCC achieved approx. 80% matching of records to NHS numbers when we started, improvement to this percentage would need significant additional resource. 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).

South Kent Coast CCG, along with all other East Kent CCGs, is committed to using the Medical Interoperability Gateway (MIG) as its preferred solution to interoperability. This is provided by a joint venture between EMIS and INPS Vision, in a company called Healthcare Gateway. Not only will this be within the CCG's Information Technology Strategy, ensuring all new systems utilise this technology, contracts with providers will also require a commitment of their agreement to utilise the MIG. Data sharing (with GPs as the data controllers) have been developed as have governance protocols for the viewing of patient identifiable data and patient consent. In the main consent will be requested at the point of treatment, but protocols are in place for patients who are physically unable to give consent i.e. unconscious.

The project first stage is the integrated use with EKHUFT's A&E and pharmacy departments, stages 2 and 3 will widen this to other providers, as well as allow viewing of provider data at the GP practice site.

Joint assessment and accountable lead professional

In South Kent Coast the accountable lead professional for people at high risk of hospital admissions is their GP. Risk stratification is undertaken by practices and shared with community nursing teams to identify those patients most at risk. These patients are recommended for Proactive Care to ensure coordination of all their health and social care needs to prevent hospital admissions. If the patients are under the care of the community nursing or intermediate care teams they are informed on how to contact a member of these teams 24/7 if they need to. All patients at high risk of hospital admission and put forward for Proactive Care have a joint care plan in place.

Risk Profiling (Pro-Active Care)

South Kent Coast CCG has been running a programme called Pro-Active Care which almost all practices are participating in. Pro-Active Care is a 12 week intervention by a multi-disciplinary health and social care team for risk stratified patients with multiple co-morbidities. The aim is to improve patient's self-management, their quality of life, medicines compliance and reduce A&E and associated hospital admissions.

Through risk stratification Pro-Active Care targets the patients at highest risk of hospital admission and then works its way through the lower risk patients. This is something that, over a year on, the first practices to run pro-active care are now starting to achieve after having seen all of their highest risk long term condition patients. In turn this means that the amount of clinical time and intervention decreases with lower risk patients and there is an expectation that such intervention will go some way to preventing these lower risk patients from deteriorating as fast thus prolonging their health and quality of life over the long term.

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

Risks

Risk	Risk Rating	Mitigating Action
Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability.	High	Each responsible organisation to develop a detailed workforce plan to support delivery of each scheme.
Different skills and training required across multiple professionals and organisations.	High	Training and skills requirements for each scheme to be linked to workforce plan to support the delivery.
Governance of the plans and the delivery of a fully integrated health and social care system should be clinically led and clearly defined.	High	The plans will be governed jointly by the CCG and the local authority using joint metrics. The CCG will report delivery of the plans through existing assurance frameworks.
Communication – need to ensure robust communication with the public and across organisations to ensure people know how to access services within the integrated system to ensure services are used appropriately	High	Robust communication plan to be developed to support delivery of each scheme.
IT systems across services not integrated and therefore do not enable shared care plans between organisations and support integrated outcome measurement and monitoring.	High	Integrated system to support sharing of care plans to be developed as a priority. Integrated performance monitoring and reporting to be enhanced to take into account all schemes.

Risks

Risk	Risk Rating	Mitigating Action
Transition of service capacity changes to be planned and implemented in stages to prevent destabilising the system.	High	Detailed modelling required to fully understand impact on acute capacity and requirements of community capacity to inform transition over a defined period of time including investment and dis-investment requirements.
The investment required into primary care for the full benefits of the plan falls outside the remit of the pooled budget and sits with NHS England.	High	To be discussed with NHS England.
Cultural change – significant shift in how systems need to work in the future requirement large culture change	High	Ensure whole health and social care system has shared vision and values to enable the delivery of required changes. Communication with organisations, staff and service users to be included in communication plan.
Regulatory and legislative environment – current arrangements not always looking at how the overall system works	High	Provide feedback to NHS England on this issue via the Kent Pioneer Programme.

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Thanet Planning 2014 – 2019

Executive Summary

Introduction

This document summarises a number of planning activities which have been undertaken in Thanet. Whilst still in draft, these plans are designed to ensure we are clear about, and focussed on, the correct issues in order to drive the local health system to deliver our strategic objectives for commissioning and redesign.

It draws together the strands contained within our 5 year plan, our 2 year operating plan and the Better Care Fund (BCF) and paints the picture of how we intend to influence the quality and provision of care and where it is delivered.

Our Priorities

Shaping Supply

<u>Acute Hospital Care</u>

The planned and urgent care audits we have conducted this year have demonstrated that a significant amount of activity is being undertaken in hospital which either does not need to happen or would be better done in primary care, community care or social services. From April we will see a fundamental shift away from hospital towards out of hospital solutions.

<u>Primary & Out of Hospital Care</u>

Specific schemes designed to build capacity out of hospital to manage this transition are set out in the documents accompanying this summary and these are being worked on to describe how the system will look in increasing detail.

Outcomes

From the Joint Strategic Needs Assessment (JSNA) it is clear that we need to improve health outcomes for Thanet residents. The following have been chosen by Thanet Health and Wellbeing Board

- Mental Health
- Over 75's
- Children and Maternity

Our Approach

We are determined to commission positively to ensure that regardless of who is providing care it is wrapped around the person receiving it.

To achieve this, it will be necessary to ensure that organisational boundaries become invisible with payment and incentives driving high quality care delivered as close as possible to where the person lives.

Whilst everything we do will be based around what's right for Thanet, we recognise that we will be far more effective working in partnership with other colleagues in East Kent on the issues which require whole system strategic solutions.

Our Intentions

From next year on we will see a radical reduction in the number of people having to go to hospital to receive their care.

- We will develop an out of hospital strategy and a primary care strategy which together will form the basis of a step change in the ability to care for people in their natural community
- We will implement and integrated urgent care system that will respond to need 24 hours a day 7 days a week to keep people out of hospital
- We will use our resources to provide a rapid access integrated health and social care response which is available 7 days a week. This will be based on 3 universal care teams, who's boundaries are consistent with those of social care
- We will provide primary care support to A&E to achieve a faster, more appropriate service to those who attend but do not have life threatening conditions
- We will use the current joint monies between health and social care (s256) to facilitate the transition to the implementation of the BCF which starts running from April 2015
- We will refresh our mental health strategy which will inform our priorities for improving services
- We will develop a strategy of the over 75's which will enable us to redesign the integrated support arrangements for this group
- We will ensure health services for children are provided in a way that enables them to fulfill their potential through effectively accessing education. (Not disabling them through dislocating their education opportunities.)

We have used the contracting round this year to pave the way to making rapid progress with these intentions. Our providers are demonstrating an understanding of the need for change and a willingness to cooperate, which is fundamental to our success.

The contracts we sign will have system wide CQUIN's in 4 areas: frail elderly; diabetes; COPD and mental health. They will also contain service development and improvement plans which will enable us to do the detailed work necessary to achieve our ambition.

What will be different?

- Services will move around the individual not the other way round
- Extended hours and 7 day working not Monday to Friday 9 – 5
- Specialist advice available to the multi-disciplinary team not out patient referral
- Rapid response to care homes not calling an ambulance to convey to A&E
- Shared clinical information not multiple assessments
- GP's acting as care coordinators not individuals falling down gaps
- Integrated budgets not arguments about who pays

Making it happen

We are developing a work plan which will support each of the five major priorities we have described. Detailed action plans with clear outcomes and timescales for achievement are being worked up. Progress on delivery of these plans will be the subject of regular reporting to the Governing Body of Thanet CCG and subsequently, Thanet Health and Wellbeing Board, East Kent Whole Systems Delivery Board and Kent Health and Wellbeing Board as appropriate.

Next steps

The Governing Body is asked to consider the detail of the plans and suggested way forward and, taking account of any comments, agree the suggested approach.

We have received detailed feedback from the Area team which we will ensure is taken account of in the final submission on 4 April.

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Thanet CCG – high level commissioning intentions 2014-16 – Plan on a page

Thanet CCG Mission:
'Working Towards a Healthier Thanet'

Thanet CCG Vision:
To transform the health of people living and working in Thanet, we will work with local people, communities and our partners to deliver high quality services that are patient centred, safe and innovative. We want all our local communities to be ambitious about their own health and to challenge us to commission the best possible care I the best possible environments with our resources.

All interventions are delivered following engagement activities with GP membership Groups and local patients via Thanet Health Network, Individual Patients Groups and public engagement events

CCG Objective One
To deliver high quality integrated Primary and out of hospital care that is patient centred and avoids the need for patients to access secondary care.

→ **Delivered through**; GP practice initiatives; Admission avoidance schemes; Integrated provision through multidisciplinary teams; Single point of access; Integrated care pathways; Self care; Appropriate use of the voluntary and community sector; Care homes (including Westbrook House); Advanced care planning; 7 day service procurement

CCG Objective Two
To ensure that inappropriate attendance for Acute Hospital Care is minimised.

→ **Delivered through;** Reducing referrals and elective care; Reduction in A&E attendance; Integrated Urgent Care Centre; Ambulatory Care pathways

CCG Objective Three
Ensure that patients receive high quality Mental Health care in the most appropriate setting.

→ **Delivered through;** IAPT review; Primary Care mental health workers; East Kent mental health strategy; Mental Health service redesign; Pathway review

CCG Objective Four
Improve patient experience of Children and Maternity Services

→ **Delivered through CAMHS pathways, Common Assessment Framework roll out in primary care; Acute paediatrics; Early Pregnancy Unit**

CCG Objective Five
To put in place the key Enablers to deliver transformational change.

→ **Delivered through;** Clinical information sharing supported by appropriate use of IT and integrated platforms; Whole systems Medicines management; Integrated commissioning with social care; Year of Care Tariff and other more appropriate contract forms; Quality in primary care; Primary care development scheme

Overseen through the following governance arrangements
- Governing Body
- Operational Leadership Team
- Clinical Leadership Team
- Performance and Delivery Committee
- Thanet Health and Wellbeing Board
- Thanet Integrated Commissioning Group
- Health Reference Groups
- Whole System Board
- EK Clinical Forum
- EK Dementia Forum
- Programme Boards for Urgent Care/LTC and Planned Care
- EK Diabetes Clinical Forum
- EK Mental Health Clinical Forum
- EK Children's Board

Measured using the following success criteria
- Measured against NHS Domains 1,2,3 & 4
- Specific KPIs established for each contract (access, quality, clinical outcomes and patient experience)
- Financial balance & sustainability achieved

High level risks
- Maintaining and improving service quality and safety through significant service change
- Financial sustainability
- Ability of providers to respond to changes

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Meeting:	**Kent Health and Wellbeing Board**
Date of Meeting:	**26th March 2014**
Title of Report:	**Swale CCG 2 Year Operating Plan**
Reporting Officer:	**Patricia Davies – CCG Accountable Officer**

This paper is for *(Please annotate)*							
Assurance	x	Agreement	x	Discussion		Note for Information	

Executive Summary:

(Please annotate comments / recommendations of sub-committee, if appropriate)

The following report aims to provide an outline of the key programmes within the CCGs Commissioning Plan for 2014/15 to 2015/16.

From 1st April 2013 Swale Clinical Commissioning Group became a statutory body responsible for commissioning health services on behalf of the population of Swale. The establishment of the CCG has enabled our local GPs, who understand the health needs of our patients, to influence and monitor how our resources are spent on improving the health of our population. In addition we have agreed a strategic alliance between both Medway CCG and Dartford, Gravesham and Swanley CCG as a North Kent System, to support the transformational system wide change that is required to deliver improved quality and care for our patients within the ever challenging financial envelope. We have also developed a strong strategic partnership with Dartford, Gravesham and Swanley CCG that includes the sharing of both management and clinical resources.

Swale CCG aims to clinically lead the commissioning of high quality, safe and effective health services for our local residents and we believe that using our local clinical experts in leading the planning and delivery of high quality healthcare, that we can make a real difference to people's lives.

Our commissioning plan indicates what the key priorities are for the period of 2014/15 to 2015/16 and beyond. It incorporates the views of the public, our providers as well as Social Care and Local Authority stakeholders, and is in line with the Health and Wellbeing Strategy to which we have contributed with our key local authority partners. Based on the information we have received through the processes mentioned above, these priorities include making sure that all groups in the population have equal access to high quality services as close to home as possible, improving integrated working between our providers to deliver real patient centred care, continuously increasing the quality of healthcare services for optimum patient experience and ensuring best value for money.

In line with the current health needs of our local population, outlined within the JSNA, and

based on the expected increase in the local population, our plan includes a number of key actions:

- Implementing a programme to identify and provide focussed support for those groups of people most at risk of developing, or potentially with undiagnosed, long term conditions. Thereby reducing the health inequalities between the least and most deprived areas of our CCG
- A transfer of care from the acute setting to a community setting:
    - Moving to a prevention / self-management model of care for people with long term conditions,
    - Providing support for people via their GP and health and social care integrated teams, with swift access to expert intervention to support episodes of crisis
    - Ensuring patients are transferred to the most appropriate setting of care for their needs, reducing unnecessary stay in hospital
    - Including for patients with mental health issues who no longer need secondary care input, people with long term conditions including dementia, and children.
- For patients requiring planned care, ensuring we enable earlier diagnosis and swift treatment in the most appropriate setting for a patient's needs.

This is an exciting but challenging time for us all, but by working together we can make a difference and improve our local health services and health outcomes for our population.

Proposal and / or Recommendation

The Health and Wellbeing Board is asked to:

- Note the key elements of the Operating Plan.
- AGREE the proposed actions and levels of ambition against the
- Note the actions taken to:
    - ensure plans reflect the JSNA and Health and Wellbeing Strategy
    - engage with a variety of stakeholders including local Health and wellbeing Boards
    - Reflect the health and Social Care Integration – as per the Integration Pioneer and Better Care Fund work.

Development of the CCG Two Year Operating Plan

1. Background:

In line with national guidance for the development of NHS Strategic and Operational plans as described in 'Everyone Counts: Planning for Patients 2014/15 to 2018/19', Swale Clinical Commissioning Group has developed its two year Operational Plan, to:

- Deliver high quality care
- Meet the needs of the local population, as outlined within the Joint Strategic Needs Assessment, and agreed within the local Health and Wellbeing Board
- Reflect integrated commissioning plans across health and social care
- Deliver the aims of the Health and Wellbeing Strategy
- Address issues identified with, and feedback from, our patients, public, GPs, healthcare providers, Social Care and local authority partners, and the voluntary sector.
- Deliver the NHS England vision and ambitions, as summarised in the diagram below:

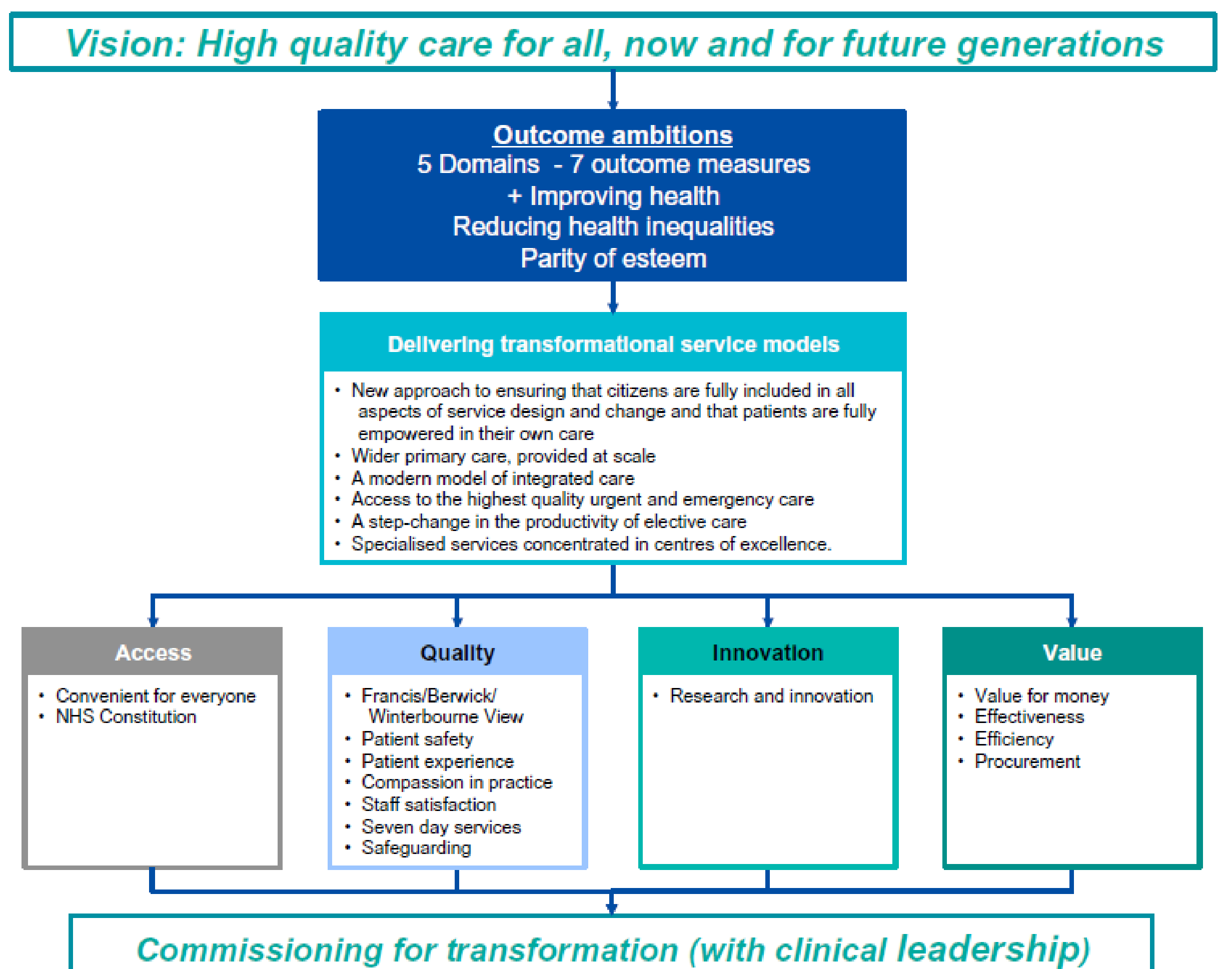

Figure 1: Extract from 'Everyone Counts: Planning for Patients 2014/15 to 2018/19

The following diagram outlines the CCGs key priorities for 2014-2016, linked to the Health and Wellbeing Strategy priorities

NHS Swale CCG 2014-2016 Summary

HWB Strategy

Programme Strategy

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

Priority Programmes

Urgent Care	Long term Conditions and Integrated commissioning	Planned care	Prescribing	Children & Young People	Improving mental Health and Wellbeing

QIPP delivery is £2.3m (14/15) and £1.9m (15/16)

Priority Initiatives

- Continuation of targeted preventative screening prioritising Cardiovascular & COPD patients.
- A&E Model of care – Integrated discharge
- Pulmonary Rehab model
- Redesign of Dementia pathway
- End of Life Care /care Homes
- Yr 1 - Clinical Pathway Review – paeds / dermatology repatriation Yr2 clinically agreed priorities
- Mental Health – Urgent Care re
- Community Ophthalmology service
- Mental Health Primary MH Workers
- CAMHs / YHM – single point of Access & CAF co-ordination
- Mental Health Urgent Care Model in place
- Integrated Community Services Model & capacity modelling
- Integrated Community Services
- Integrated Health & Social Care Teams
- (1 & 2) Prescribing efficiencies
- Primary Care Strategy development
- Review Walk in centres /OOH

Health & Wellness - Primary Prevention and partnership working with Local HWBB and Public Health

Health & Wellness – Increasing Independence (self-care and carers)

Quality Improvements in all services including prescribing quality reviews with GP practices

Commissioning Innovation – use of technology to support sharing of clinical information to support patients care

Service Improvement
On-going Commissioning
Strategic Transformational

Operating Plan

Op plan year 1 – QIPP DELIVERY £2.3M)

Implement community model / capitation contracting
Full implementation integrated discharge Team
Children's Community Nursing Model implementation
Implement community Ophthalmology service
Out of Hours / Walk in Centre re-design

Op plan year 2 – QIPP DELIVERY £1.9 M)

Primary Care Strategy implementation
Full Implementation of community model / capitation contracting
Review further clinical pathways and implement improved models of care-
Implementation of new OOH service
TBC

2. Our Vision for 2016

Our vision is to commission health services that meet the needs of the Swale population, provide value for money, address health inequalities, and improve health outcomes, to enable the population of Swale to lead healthier and more independent lives.

To achieve this we will:

- Keep patients at the heart of everything we do
- Ensure all commissioning is clinically-led
- Aim to commission local services where viable
- Focus on partnership working with a range of health and social care partners
- Integrate services to avoid duplication
- Maximise resources at every opportunity

This vision cannot be delivered in isolation by the CCG, but requires a whole system approach to the delivery of care. The proposed commissioning intentions outlined within this plan, therefore, reflect the joint view and intentions from the Health Economy developed through partnership forums and clinically led workshops with providers.

This vision is set in the context of the CCGs longer term 5 year vision and Better Care Fund plans, to provide care and support to the people of North Kent (Swale and Dartford, Gravesham and Swanley) 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 communities.

3. The Case for Change

An ageing population and increased prevalence of chronic diseases requires health services to move from the current emphasis on acute and episodic care, towards prevention, self-care, more consistent standards of primary care and care that is well co-ordinated and integrated.

In addition there is the need to:

- Meet increasing clinical need and patient expectations
- Achieve strong performance from our providers tailored to the local population
- Increase efficiency of services and value for money
- Give people choice and control
- Ensure local services and interventions are effective
- Provide systematic and pro-active management of chronic disease within primary care to contribute to reducing health inequalities
- Commission more integrated models of care in order to improve the quality of care for patients and reduce waste.
- Consider prioritising the integration of mental and physical health care more closely as a key part of its strategy to improve quality and productivity in health care.

As mentioned above, the NHS is subject to increasing financial constraints, especially in the current economic climate. Therefore we will need to review how services are provided and how they link up with other services such as social care to develop the most optimum pathways designed around the needs of our patients. Only by reducing inefficiencies and duplication will we be able to provide the best possible services for the funding available to our population.

In order to deliver on the above, we need to work very closely with both patients and the public in Swale CCG, as well as the providers of services, and organisations in the voluntary (third) sector.

We will also need to have an on-going conversation with the population of Swale so that we create an increasing awareness and understanding of the things everyone can do to prevent illness. If we can enhance everyone's sense of responsibility for their own health and that of their families, we can not only tackle some of the most intractable health issues, but also prevent significant suffering, and deliver more and better quality services for our population.

The NHS Mandate is structured around five key areas where the Government expects the NHS Commissioning Board to make improvements:

- preventing people from dying prematurely
- enhancing quality of life for people with long-term conditions
- helping people to recover from episodes of ill health or following injury
- ensuring that people have a positive experience of care
- treating and caring for people in a safe environment and protecting them from avoidable harm.

3.1. Transformational Change

The need for transformational, system wide change is clearly recognised, and as such, is a key element of the CCG plans going forward. Following feedback from our member practices a review of community services was implemented during 2013. In order to fully identify the key issues, and develop sustainable, transformational change a review of acute and community services across North Kent was undertaken. This work has commenced with an audit by The Oaks Group, followed by stakeholder workshops facilitated by the Kings Fund, in November 2013 and February 2014.

For the Swale / Medway urgent care system, the review identified that:

- Up to 30% of adult admissions could have been avoided:
  - 70% were due lower levels of care not being considered
  - 47% of acute admissions could have been avoided by providing a variety of services at home.
  - 20% of acute admissions could have been provided for on sub-acute (e.g. community) wards.
  - Additionally, 10% of all admissions required supported living environments.
- 48% of the continuing stay days were avoidable
  - 17% of continuing stay days were due no available beds at alternate levels of care to Some delays due to discharge planning issues.
  - 46% of continuing stay days could have been avoided by providing a variety of services at home.
  - Additionally, 25% of continuing stay days required were for supported living environments.

- For paediatric patients 38% of admissions and 50% of continuing days of stay could have been avoided.

One of the key elements agreed following this review is the need, and potential, to reduce non-elective admissions by:

- 10% in 2014/15, equating to 928 admissions, or £1.662m
- With a further 5% reduction in 2015/16 equating to 418 admissions and £748,000
- i.e. a reduction of 1,346 admissions at a cost of £2.41m over two years.

The agreed areas of focus and plans – including KPIs, milestones, and system wide impact – have been used to underpin commissioning plans for 2014-16 and beyond. This level of change in admissions is only possible by true integration across health and social care providers, and therefore the North Kent proposals for the Better Care Fund underpin delivery of this operating plan.

3.2. Integrated Care:

The Joint Health and Well Being Strategy identifies integrated commissioning as a key priority and to support the delivery of this, Kent County Council and the CCG have developed a North Kent Strategic Commissioning Group to enable review and discussion of services that could be improved for patients and clients through integration. This aligns with the Integration Pioneer agenda for Kent, and will involve the CCGs GP Clinical leads (from Swale and Dartford, Gravesham and Swanley CCGs) and senior KCC and CCG managers to enable the development of a clear plan on how this will be developed to achieve improved outcomes for our patients/ clients and to monitor the impact of the current services that are being jointly funded.

The key integration projects outlined within the Better Care Fund for 2014/15 are:

- **Integrated Discharge Team model expansion –** to ensure that patients receive the treatment they need and are rapidly discharged with health, social and voluntary sector care and housing support to return back to independent living.

- **Integrated Primary Care teams –** 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. The integrated primary care teams will be based around the General Practice networks and focused on the needs of patients. They will deliver robust rapid response where this is appropriate, long term condition management, geriatrician, mental health, social and voluntary sector care, equipment and housing support. They will actively support GP practices to identifying people who are at risk of admission to hospital or residential / nursing home care where indications are that, with some immediate intensive input, equipment and support, such admissions can be avoided.

- **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.

- **Access to records** – a shared IT infrastructure and record is seen as an enabler to achieve the above. This work has been commenced and a full timeline for implementation is being developed.

3.3. Key Programmes:

Our key programmes are based on addressing issues or areas of concern identified through:

- Health outcomes data
- The Joint Strategic Needs Assessment
- Patient feedback
- Service review – through the Kings Fund / Oak Group work.

The following table aims to summarise the issues identified for the Swale population and the key actions we have identified within our commissioning plans:

Issue	Key actions being taken
• Significant health inequalities with areas of high deprivation • Significant population increase by 2020, especially in the older age group • Higher potential years of life lost[1] • Prevalence of hypertension and COPD[1] • Fewer people feeling supported to manage their condition[1] • Poorer health related quality of life for people with long term conditions[1] • Higher rates of diabetes and obesity[1] • CVD • COPD • Readmission within 30 days of discharge from hospital	1. Continuation of health inequalities programme aiming to reduce the variation in health across the CCG, and provide focussed support to ensure the early identification of people at risk of developing, or with, long term conditions reducing incidence of complications. 2. Integrated primary care team, and dementia specialist team, to provide support to patients, particularly those with long term conditions, to more effectively manage their condition; this is linked to the Better Care Fund to support integration across health and social care. In addition, we are working with Public Health and the Health and Wellbeing Board to review wider health issues for our local population, and identify key actions.
• The need for improved communication between health and social care providers; and greater integration of care • Identified reduction in emergency admissions to acute care and length of stay in hospital	Feedback from patients identified the need to improve communications – both between health and social care teams; but also to enable people with long term conditions to manage their health more effectively. This feedback underpins the Better Care Fund projects summarised in section 3.2.

• Higher under 75 death rate from CHD and Cancer[1]	We are working with the Strategic Clinical Networks to review local service provision and identify key actions. Early identification remains a significant aspect of this work; our health inequalities programme aims to address some of the key risk factors for these diseases
• Healthcare associated infections	This remains an area of focus for our Quality and Safety Team who are working with all providers to minimise the incidence of MRSA and C difficile
• Patient experience of GP OOH services	Service model being developed during 2014/15 for a new service to commence in 2015/16 – the model will be developed based on insight from our patients and GPs
• Unplanned hospitalisation in under 19's for asthma, diabetes and epilepsy[1]	Development of a Community Childrens Nursing Service to ensure children and young people receive the right care in the right setting for their needs

[1] denotes performance in comparison with England data.

4. Outcomes Indicators:

The national planning guidance - 'Everyone Counts: Planning for Patients 2014/15 to 2018/19 - outlined a number of key ambitions for the NHS in relation to the delivery of health improvements for local people and ensuring the delivery of:

- **An outcomes focused approach**, with stretching local ambitions expected of commissioners, alongside credible and costed plans to deliver them

We have therefore reviewed the current level of performance and have outlined the improvements we expect to deliver during 2014/15 and 2015/16, which is also aligned to our expectations for the impact of plans over the next five years to 2018/19. The following diagrams summarise these expectations, and the projects identified to deliver these levels of ambition, which align with the aims of the Better Care Fund and integrated working across Health and Social Care.

1. r
educing potential years of lives lost through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality

Projects

- review of health inequalities across the CCG, aiming to prevent incidence, or enable early detection and treatment of key conditions, including dementia
- enhancement of integrated neighbourhood teams
- further development of telehealth / telemedicine
- development of integrated childrens community nursing service

Measures

- reduce gap in life expectancy across the CCG
- prevalence of key conditions

Impact

- Potential years of life lost rate per 100,000 to reduce by 4.6% (from a baseline of 1728.3 to 1648.8) *NB this reduction is currently based on national guidance - local data currently under review to confirm levels of ambition*

2. R
educing avoidable emergency admissions

Projects

- redesign of the emergency pathway, including consultant presence in A&E 24/7 and pathways for redirection to community teams
- enhancement of integrated neighbourhood teams, and implementation of a named healthcare professional and care plan for patients with LTCs
- development of integrated childrens community nursing service

Measures

- reduction in emergency admissions and readmissions
- reduction in length of stay in acute care

Impact

- reduce emergency admissions by a total of 15% over two years
- links with the emergency admissions compostie indicator - move from current baseline (2070.1) to the next (improved) quartile range over 5 years.
- 2014/15 targets
- Q1 2014/15 = 1952.2
- Q2 2014/15 = 1942.8
- Q3 2014/15 = 1933.3
- Q4 2014/15 = 1923.9

3. improving access to psychological therapies;

Projects

- Continued implementatoin of talking therapies

Measures

- The proportion or people who have received psychological therapies out of the total numbe of people who have depression and / or anxiety disorders

Impact

- achieving 17.5% by the end of 2014/15 (total of 1,700 people receiving psychological therapy):
- via treating 425people per quarter (4.4%)

4. Demonstrating Improvement in patient experience: addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in 2014/15 and showing improvement in a locally selected patient experience indicator

Projects

- ongoing review of clinical pathways including dermatology and ophthalmology
- implementation of telephone follow up appointments
- development of 7 day services
- Implementing dementia support workers within the Integrated Discharge Team

Measures

- NHS Constitution access targets achieved
- Friends and family test

Impact

- achievement of national target for friends and family test
- *locally determined indicator*

5. improving the reporting of medication-related safety incidents based on a locally selected measure

Projects

- ongoing assurance of providers incident reporting processes and identification of themes and trends in incidents.

Measures

- *currently being finalised*

Impact

- *locally determined indicator*

6. The number of multidisciplinary care plans in place for people with dementia

Projects	• implementeation of Specialist Dementia Teams as outlined in the Better Care fund, linked with the Integrated Primary Care Teams and GPs / Social Care / dementia
Measures	• The number of people with a care plan as a proportion of the expected total number of patients diagnosed.
Impact	• 75% of people with dementia to have a care plan in 2014/15 - therefore enabling coordinated care impacting on both health outcomes for the individual and patient / carer experience. • The North Kent Better Care Fund aims for 90% of people with dementia to multidisciplinery care plan; for 2014/15 this is set at 75% acknowledging the time for implementation of the above teams.

In order to ensure that these indicators addresses and aligns with the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy, the Kent Health and Wellbeing Strategy is asked to comment and approve on the above levels of ambition.

5. Development of Plans

The following table aims to provide assurance on the development of the Operating Plan against key criteria:

Evidence of links to Pioneer and BCF	The Operating Plan recognises the key role integration between health – including primary, secondary and community care – and social care as key to delivering improved care pathways, reducing system inefficiency and, most importantly, improving health outcomes and patient / carer experience. The Better Care Fund – and therefore Pioneer plans – forms the core of our plans for the next two to five years.
Assurance that scrutiny by local HWBs has been carried out	Commissioning plans have been presented to the Swale Health and Wellbeing Board on an ongoing basis over recent months. In addition, plans have been shared at subgroups of the Board enabling input from a variety of stakeholders.

Evidence of compatibility with the HWBS and JSNA	The basis for the development of the Operating Plan is the JSNA and Health and Wellbeing Strategy. This is evidenced within the Operating Plan via: 6. Plan on a Page for 2014/15 to 2015/16 (see page 4) 7. Summary of governance arrangements with the Health and Wellbeing Board outlining links with the Health and Wellbeing Strategy 8. Outline of the local health needs
Evidence it has been discussed with a range of stakeholders	Stakeholder engagement forms an important aspect in the ongoing review and development of health services. In addition to public events – at which local authority, health care provider, social services and voluntary sector providers are also invited – we have undertaken a number of actions to ensure we share, and gather feedback on, plans – this remains an ongoing process and continues throughout the commissioning process. Discussions may focus on specific elements of plans e.g. integration or urgent care; or the plan in its entirety. Examples of forums for discussion with stakeholders include: Through existing governance frameworks: • Executive Programme Boards – Social Care, health care providers and commissioner (including Bexley CCG) • Programme Delivery groups – social care, health care providers and commissioners • Protected Learning Time events with GPs and practice nurses • County and local Health and Wellbeing Boards and subgroups Through events or dedicated sessions: • Better Care Fund – workshops with GPs, healthcare providers and commissioners, Social Care • Kings Fund workshops - workshops with GPs, healthcare providers and commissioners, Social Care • Voluntary sector events – April 2013, October 2013 and planning for next event in Q1 2014/15 • Public Events held July 2013 and February 2014 – as well as working with local Patient Participation Groups and their Chairs to share information and seek feedback.

6. Recommendations

The Health and Wellbeing Board is asked to:

- AGREE the proposed actions and levels of ambition against the Outcomes Indicators outlined in section 4.

- Note the actions taken to:
    - ensure plans reflect the JSNA and Health and Wellbeing Strategy
    - engage with a variety of stakeholders including local Health and wellbeing Boards
    - Reflect the health and Social Care Integration – as per the Integration Pioneer and Better Care Fund work.

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Dartford Gravesham and Swanley
Clinical Commissioning Group

Meeting:	**Kent Health and Wellbeing Board**
Date of Meeting:	**26th March 2014**
Title of Report:	**Dartford, Gravesham and Swanley CCG 2 Year Operating Plan**
Reporting Officer:	**Patricia Davies – CCG Accountable Officer**

This paper is for ***(Please annotate)***							
Assurance	x	Agreement	x	Discussion		Note for Information	

Executive Summary: **(Please annotate comments / recommendations of sub-committee, if appropriate)**
The following report aims to provide an outline of the key programmes within the CCGs Commissioning Plan for 2014/15 to 2015/16. From 1st April 2013 Dartford, Gravesham and Swanley Clinical Commissioning Group became a statutory body responsible for commissioning health services on behalf of the population of Dartford Gravesham and Swanley. The establishment of the CCG has enabled our local GPs, who understand the health needs of our patients, to influence and monitor how our resources are spent on improving the health of the Dartford, Gravesham and Swanley population. In addition we have agreed a strategic alliance between both Medway CCG and Swale CCG as a North Kent System, to support the transformational system wide change that is required to deliver improved quality and care for our patients within the ever challenging financial envelope. We have also developed a strong strategic partnership with Swale CCG that includes the sharing of both management and clinical resources. Commissioning is the process of assessing heath needs, funding health services that meet those needs and of monitoring the quality and performance of the services that are provided. Dartford, Gravesham and Swanley CCG aims to clinically lead the commissioning of high quality, safe and effective health services for our local residents and we believe that using our local clinical experts in leading the planning and delivery of high quality healthcare, that we can make a real difference to people's lives. This commissioning plan indicates what the key priorities are for the period of 2014 and beyond. It incorporates the views of the public, our providers as well as Social Care and Local Authority stakeholders, and is in line with the Health and Wellbeing Strategy to which we have contributed with our key local authority partners. Based on the information we have received through the processes mentioned above, these priorities include making sure that all groups in the population have equal access to high quality services as close to home as possible, improving integrated working between our providers to deliver real patient centred care, continuously increasing the quality of healthcare services for optimum patient experience and ensuring best value for money.

In line with the current health needs of our local population, outlined within the JSNA, and based on the expected increase in the local population, our plan includes a number of key actions:

- Implementing a programme to identify and provide focussed support for those groups of people most at risk of developing, or potentially with undiagnosed, long term conditions. Thereby reducing the health inequalities between the least and most deprived areas of our CCG
- A transfer of care from the acute setting to a community setting:
  - Moving to a prevention / self-management model of care for people with long term conditions,
  - Providing support for people via their GP and health and social care integrated teams, with swift access to expert intervention to support episodes of crisis
  - Ensuring patients are transferred to the most appropriate setting of care for their needs, reducing unnecessary stay in hospital
  - Including for patients with mental health issues who no longer need secondary care input, people with long term conditions including dementia and children.
- Enabling acute care providers to focus on patients suffering acute episodes of ill health, or requiring planned surgery.

This is an exciting but challenging time for us all, but by working together we can make a difference and improve our local health services and health outcomes for our population.

Proposal and / or Recommendation

The Health and Wellbeing Board is asked to:

- Note the key elements of the Operating Plan.
- AGREE the proposed actions and levels of ambition against the
- Note the actions taken to:
  - ensure plans reflect the JSNA and Health and Wellbeing Strategy
  - engage with a variety of stakeholders including local Health and wellbeing Boards
  - Reflect the health and Social Care Integration – as per the Integration Pioneer and Better Care Fund work.

Development of the CCG Two Year Operating Plan

1. Background:

In line with national guidance for the development of NHS Strategic and Operational plans as described in 'Everyone Counts: Planning for Patients 2014/15 to 2018/19', Dartford, Gravesham and Swanley Clinical Commissioning Group has developed its two year Operational Plan, to:

- Meet the needs of the local population, as outlined within the Joint Strategic Needs Assessment, and agreed within the local Health and Wellbeing Board
- Deliver high quality care,
- Reflect integrated commissioning plans across health and social care
- Deliver the aims of the Health and Wellbeing Strategy
- Address issues identified with, and feedback from, our patients, public, GPs, healthcare providers, Social Care and local authority partners, and the voluntary sector.
- deliver the NHS England vision and ambitions, as summarised in the diagram below:

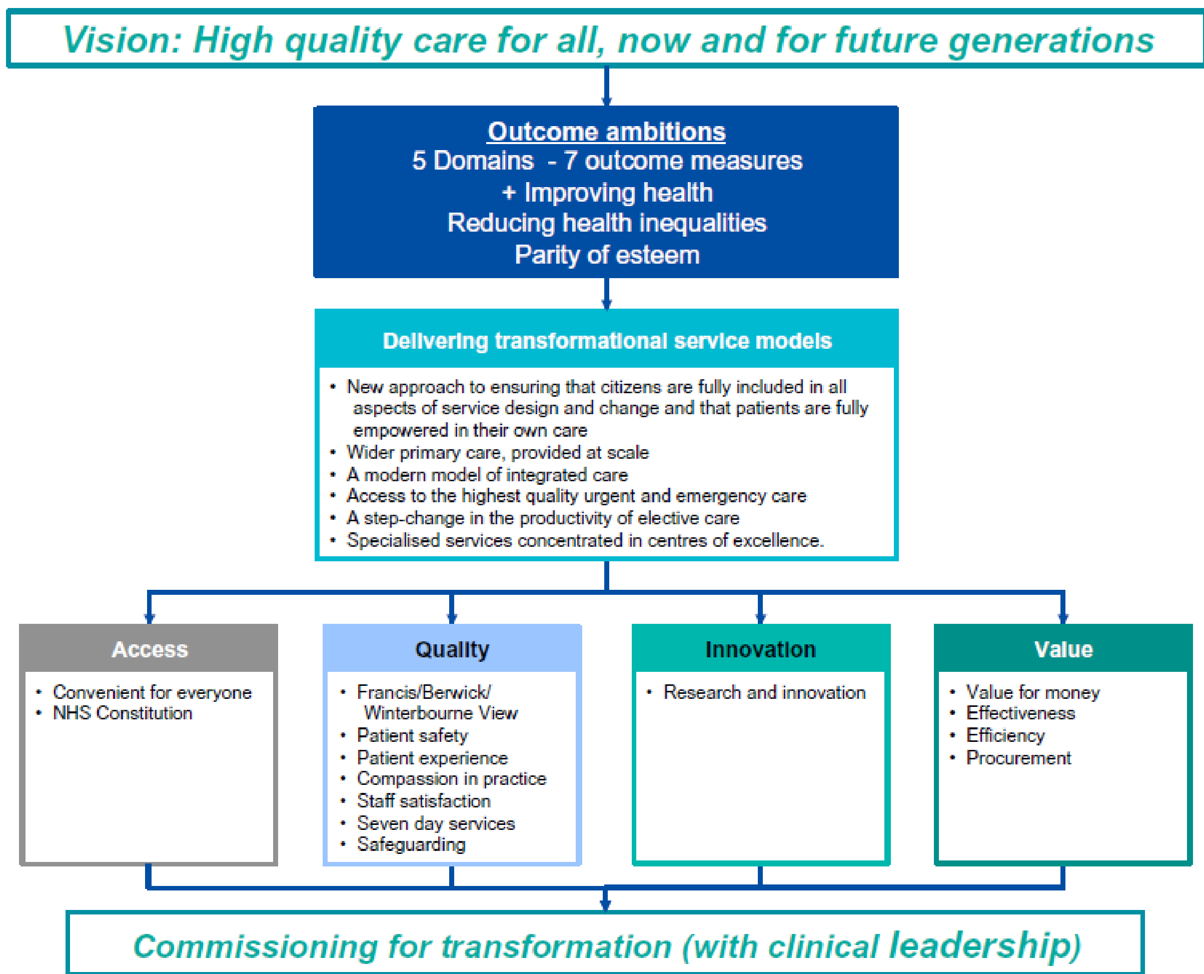
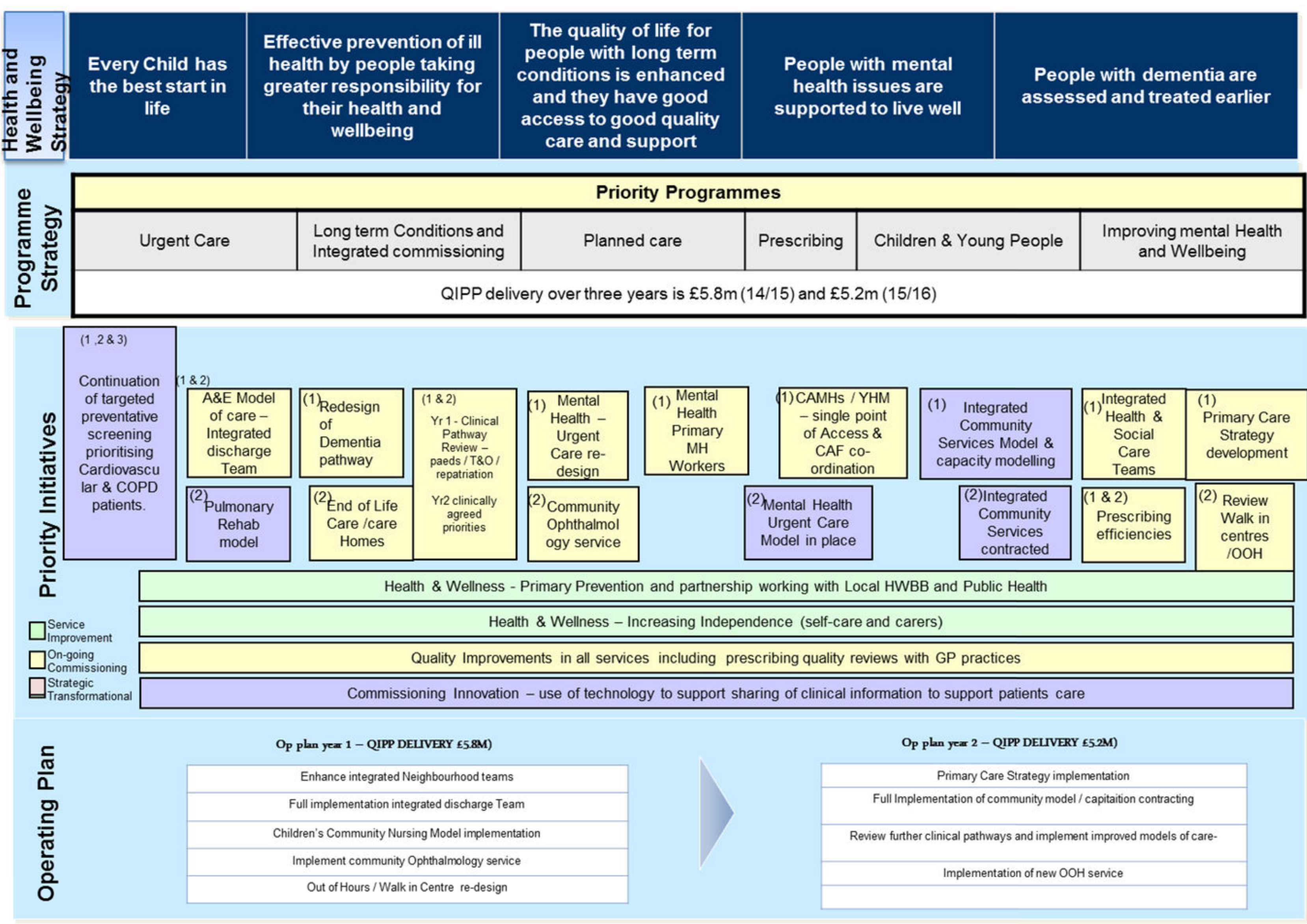


Figure 1: Extract from 'Everyone Counts: Planning for Patients 2014/15 to 2018/19

The following diagram outlines the CCGs key priorities for 2014-2016, linked to the Health and Wellbeing Strategy priorities


NHS DGS CCG 2014-2016
Health and Wellbeing Strategy
Every Child has the best start in life
Effective prevention of ill health by people taking greater responsibility for their health and wellbeing
The quality of life for people with long term conditions is enhanced and they have good access to good quality care and support
People with mental health issues are supported to live well
People with dementia are assessed and treated earlier
Programme Strategy
Priority Programmes
Urgent Care
Long term Conditions and Integrated commissioning
Planned care
Prescribing
Children & Young People
Improving mental Health and Wellbeing
QIPP delivery over three years is £5.8m (14/15) and £5.2m (15/16)
Priority Initiatives
(1 ,2 & 3) Continuation of targeted preventative screening prioritising Cardiovascular & COPD patients.
(1 & 2) A&E Model of care – Integrated discharge Team
(1) Redesign of Dementia pathway
(1 & 2) Yr 1 - Clinical Pathway Review – paeds / T&O / repatriation Yr2 clinically agreed priorities
(1) Mental Health – Urgent Care re-design
(1) Mental Health Primary MH Workers
(1) CAMHs / YHM – single point of Access & CAF co-ordination
(1) Integrated Community Services Model & capacity modelling
(1) Integrated Health & Social Care Teams
(1) Primary Care Strategy development
(2) Pulmonary Rehab model
(2) End of Life Care /care Homes
(2) Community Ophthalmology service
(2) Mental Health Urgent Care Model in place
(2) Integrated Community Services contracted
(1 & 2) Prescribing efficiencies
(2) Review Walk in centres /OOH
Health & Wellness - Primary Prevention and partnership working with Local HWBB and Public Health
Health & Wellness – Increasing Independence (self-care and carers)
Quality Improvements in all services including prescribing quality reviews with GP practices
Commissioning Innovation – use of technology to support sharing of clinical information to support patients care
Service Improvement
On-going Commissioning
Strategic Transformational
Operating Plan
Op plan year 1 – QIPP DELIVERY £5.8M)
Enhance integrated Neighbourhood teams
Full implementation integrated discharge Team
Children's Community Nursing Model implementation
Implement community Ophthalmology service
Out of Hours / Walk in Centre re-design
Op plan year 2 – QIPP DELIVERY £5.2M)
Primary Care Strategy implementation
Full Implementation of community model / capitaition contracting
Review further clinical pathways and implement improved models of care-
Implementation of new OOH service

2. Our Vision for 2016

Our vision is to be a clinically led and innovative commissioning organisation that puts patients first, improves their healthcare outcomes, and operates with minimal bureaucracy.

Key within the CCGs clinical vision is to:

- Ensure the healthcare system works better for patients, with a focus on right care, right time, right place, providing seamless, world class, integrated care for patients, particularly with complex needs
- Safeguard vital services, prioritising patients' with the greatest health needs and ensuring that there is clinical evidence behind every decision.
- Improve or maintain quality whilst making efficient use of available resources.
- More care closer to home
- Practices feel that they have been supported in the process of improving care
- Patients and the community take responsibility for their care

This vision cannot be delivered in isolation by the CCG, but requires a whole system approach to the delivery of care. The proposed commissioning intentions outlined within this plan, therefore, reflect the joint view and intentions from the Health Economy developed through partnership forums and clinically led workshops with providers.

This vision is set in the context of the CCGs longer term 5 year vision and Better Care Fund plans, 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 communities.

3. The Case for Change

An ageing population and increased prevalence of chronic diseases requires health services to move from the current emphasis on acute and episodic care, towards prevention, self-care, more consistent standards of primary care and care that is well co-ordinated and integrated.

In addition there is the need to:

- Meet increasing clinical need and patient expectations
- Achieve strong performance from our providers tailored to the local population
- Increase efficiency of services and value for money
- Give people choice and control
- Ensure local services and interventions are effective
- Provide systematic and pro-active management of chronic disease within primary care to contribute to reducing health inequalities
- Commission more integrated models of care in order to improve the quality of care for patients and reduce waste.
- Consider prioritising the integration of mental and physical health care more closely as a key part of its strategy to improve quality and productivity in health care.

As mentioned above, the NHS is subject to increasing financial constraints, especially in the current economic climate. Therefore we will need to review how services are provided and how they link up with

other services such as social care to develop the most optimum pathways designed around the needs of our patients. Only by reducing inefficiencies and duplication will we be able to provide the best possible services for the funding available to our population.

In order to deliver on the above, we need to work very closely with both the patients and the public in DGS CCG, as well as the providers of services, and organisations in the voluntary (third) sector.

We will also need to have an on-going conversation with the population of DGS so that we create an increasing awareness and understanding of the things everyone can do to prevent illness. If we can enhance everyone's sense of responsibility for their own health and that of their families, we can not only tackle some of the most intractable health issues, but also prevent significant suffering, and deliver more and better quality services for our population. Our approach to engagement with the public is outlined in section 7.

The NHS Mandate is structured around five key areas where the Government expects the NHS Commissioning Board to make improvements:

- preventing people from dying prematurely
- enhancing quality of life for people with long-term conditions
- helping people to recover from episodes of ill health or following injury
- ensuring that people have a positive experience of care
- treating and caring for people in a safe environment and protecting them from avoidable harm.

3.1 Transformational Change

The need for transformational, system wide change is clearly recognised, and as such, is a key element of the CCG plans going forward. Following feedback from our member practices a review of community services was implemented during 2013. In order to fully identify the key issues, and develop sustainable, transformational change a review of acute and community services across North Kent was undertaken. This work has commenced with an audit by The Oaks Group, followed by stakeholder workshops facilitated by the Kings Fund, in November 2013 and February 2014.

For DGS, the review identified that:

- Up to 38% of adult admissions could have been avoided:
    - 64% were due the consultant related issues
    - 58% of acute admissions could been avoided by providing a variety of services at home.
    - 15% of acute admissions could have been provided for on sub-acute (e.g. community) wards.
    - Additionally, 8% of all admissions required supported living environments.
- 65% of the continuing stay days were avoidable
    - 36% due to discharge planning issues.
    - 37% of continuing stay days could have been avoided by providing a variety of services at home.
    - Additionally, 24% of continuing stay days required were supported living environments.
- For paediatric patients 32% of admissions and 45% of continuing days of stay could have been avoided.

The agreed areas of focus, and plans – including KPIs, milestones, and system wide impact – have been used to underpin commissioning plans for 2014-16 and beyond, as well as the development of the Better Care Fund proposal.

One of the key elements agreed following this review is the need, and potential, to reduce non-elective admissions by:

- 10% in 2014/15, equating to 2,672 admissions, or £4.662m
- With a further 5% reduction in 2015/16 equating to 1,180 admissions and £2.063m
- i.e. a reduction of 3,853 admissions at a cost of £6.725m over two years.

This level of change in admissions is only possible by true integration across health and social care providers, and therefore the North Kent proposals for the Better Care Fund underpin delivery of this operating plan.

3.2 Integrated Care:

The Joint Health and Well Being Strategy identifies integrated commissioning as a key priority and to support the delivery of this, Kent County Council and the CCG have developed a North Kent Strategic Commissioning Group to enable review and discussion of services that could be improved for patients and clients through integration. This aligns with the Integration Pioneer agenda for Kent, and will involve the CCGs GP Clinical leads (from Swale and Dartford, Gravesham and Swanley CCGs) and senior KCC and CCG managers to enable the development of a clear plan on how this will be developed to achieve improved outcomes for our patients/ clients and to monitor the impact of the current services that are being jointly funded.

The key integration projects outlined within the Better Care Fund for 2014/15 are:

- **Integrated Discharge Team model expansion** – to ensure that patients receive the treatment they need and are rapidly discharged with health, social and voluntary sector care and housing support to return back to independent living.

- **Integrated Primary Care teams** – 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. The integrated primary care teams will be based around the General Practice networks and focused on the needs of patients. They will deliver robust rapid response where this is appropriate, long term condition management, geriatrician, mental health, social and voluntary sector care, equipment and housing support. They will actively support GP practices to identifying people who are at risk of admission to hospital or residential / nursing home care where indications are that, with some immediate intensive input, equipment and support, such admissions can be avoided.

- **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.

- **Access to records** – a shared IT infrastructure and record is seen as an enabler to achieve the above. This work has been commenced and a full timeline for implementation is being developed.

3.1. Key Programmes:

Our key programmes are based on addressing issues or areas of concern identified through:

- Health outcomes data
- The Joint Strategic Needs Assessment
- Patient feedback
- Service review – through the Kings Fund / Oak Group work.

The following table aims to summarise the issues identified for Dartford, Gravesham and Swanley population and the key actions we have identified within our commissioning plans:

Health Issue	Key actions being taken
• Higher potential years of life lost[1] • Prevalence of hypertension and hyperthyroidism[1] • Prevalence of chronic kidney disease[1] • Proportion of people with long term conditions feeling supported to manage their condition[1] • Incidence of CVD	Development of: 1. Health inequalities programme aiming to reduce the variation in health across the CCG, and provide focussed support to ensure the early identification of people at risk of developing, or with, long term conditions reducing incidence of complications such as chronic kidney disease in people with diabetes. 2. Integrated primary care team to provide support to patients, particularly those with long term conditions, to more effectively manage their condition; this is linked to the Better Care Fund to support integration across health and social care. In addition, we are working with Public Health and the Health and Wellbeing Board to review wider health issues for our local population, and identify key actions.
• The need for improved communication between health and social care providers; and greater integration of care • Identified reduction in emergency admissions to acute care and length of stay in	Feedback from patients identified the need to improve communications – both between health and social care teams; but also to enable people with long term conditions to manage their health more effectively. This feedback underpins the Better Care Fund projects summarised in section 3.2.

hospital	
• Patient experience of GP OOH services	Service model being developed during 2014/15 for a new service to commence in 2015/16 – the model will be developed based on insight from our patients and GPs
• Incidence of Cancer and Cardiovascular disease	We are working with the Strategic Clinical Networks to review local service provision and identify key actions. Early identification remains a significant aspect of this work.
• Endocrine, nutritional and metabolic problems	For DGS CCG, diabetes remains a significant issue – and work continues to further develop the care pathway, including ensuring education provision and support for patients (links with the development of Integrated Primary Care Teams as outlined in section 3.2)
• Emergency admissions for children	Development of a Community Children's Nursing Service to ensure children and young people receive the right care in the right setting for their needs
• MRSA	This remains an area of focus for our Quality and Safety Team who are working with all providers to minimise the incidence of MRSA and *C difficile*

[1] denotes performance in comparison with England data.

4. Outcomes Indicators:

The national planning guidance - 'Everyone Counts: Planning for Patients 2014/15 to 2018/19 - outlined a number of key ambitions for the NHS in relation to the delivery of health improvements for local people and ensuring the delivery of:

- **An outcomes focused approach**, with stretching local ambitions expected of commissioners, alongside credible and costed plans to deliver them

We have therefore reviewed the current level of performance and have outlined the improvements we expect to deliver during 2014/15 and 2015/16, which is also aligned to our expectations for the impact of plans over the next five years to 2018/19. The following diagrams summarise these expectations, and the projects identified to deliver these levels of ambition:

1. reducing potential years of lives lost through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality

Projects

- review of health inequalities across the CCG, aiming to prevent incidence, or enable early detection and treatment of key conditions, including dementia
- enhancement of integrated neighbourhood teams
- further development of telehealth / telemedicine
- development of integrated childrens community nursing service

Measures

- reduce gap in life expectancy across the CCG
- prevalence of key conditions

Impact

- Potential years of life lost rate per 100,000 to reduce by 4.6% (from a baseline of 1946.9 to 1857.3) *NB this reduction is currently based on national guidance - local data currently under review to confirm levels of ambition*

2. Reducing avoidable emergency admissions

Projects

- redesign of the emergency pathway, including consultant presence in A&E 24/7 and pathways for redirection to community teams
- enhancement of integrated neighbourhood teams, and implementation of a named healthcare professional and care plan for patients with LTCs
- development of integrated childrens community nursing service

Measures

- reduction in emergency admissions and readmissions
- reduction in length of stay in acute care

Impact

- reduce emergency admissions by a total of 15% over two years
- links with the emergency admissions compostie indicator - move from current baseline (2070.1) to the next (improved) quartile range over 5 years.
- 2014/15 targets
- Q1 2014/15 = 2055.2
- Q2 2014/15 = 2040.4
- Q3 2014/15 = 2025.5
- Q4 2014/15 = 2010.6

3. improving access to psychological therapies;

Projects

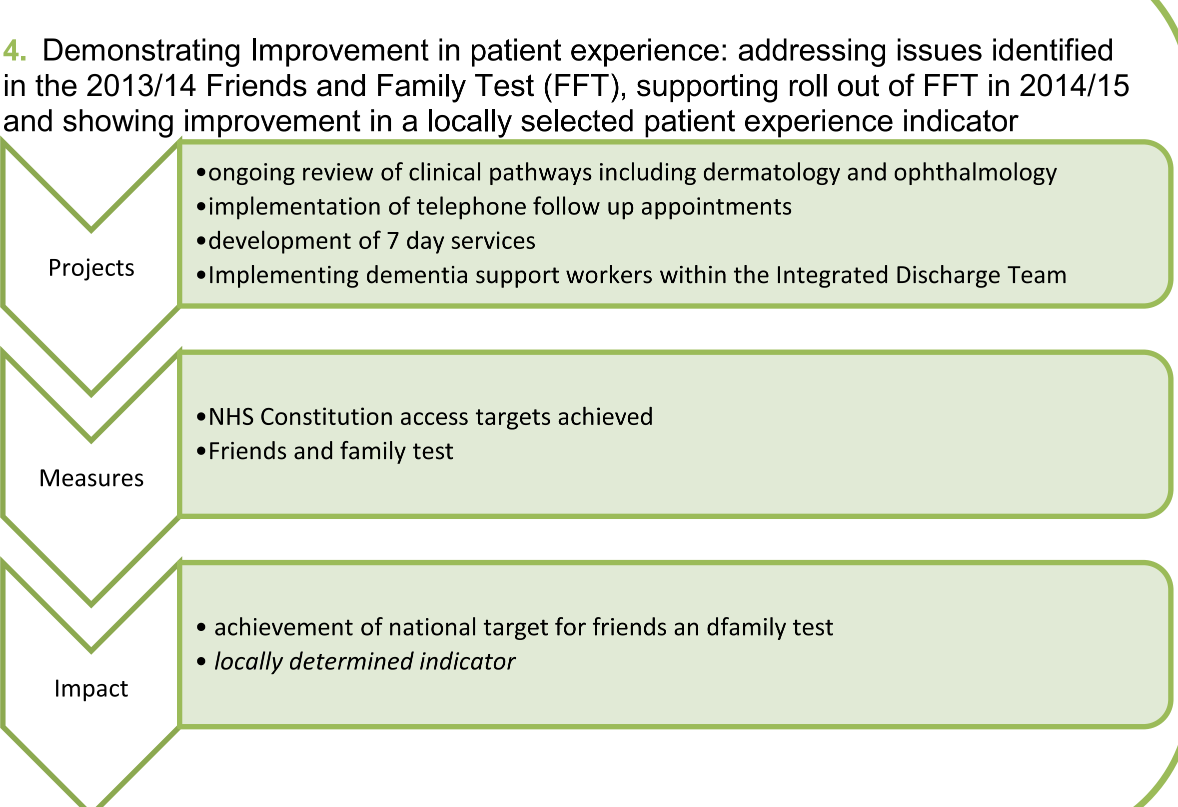
- Continued implementatoin of talking therapies

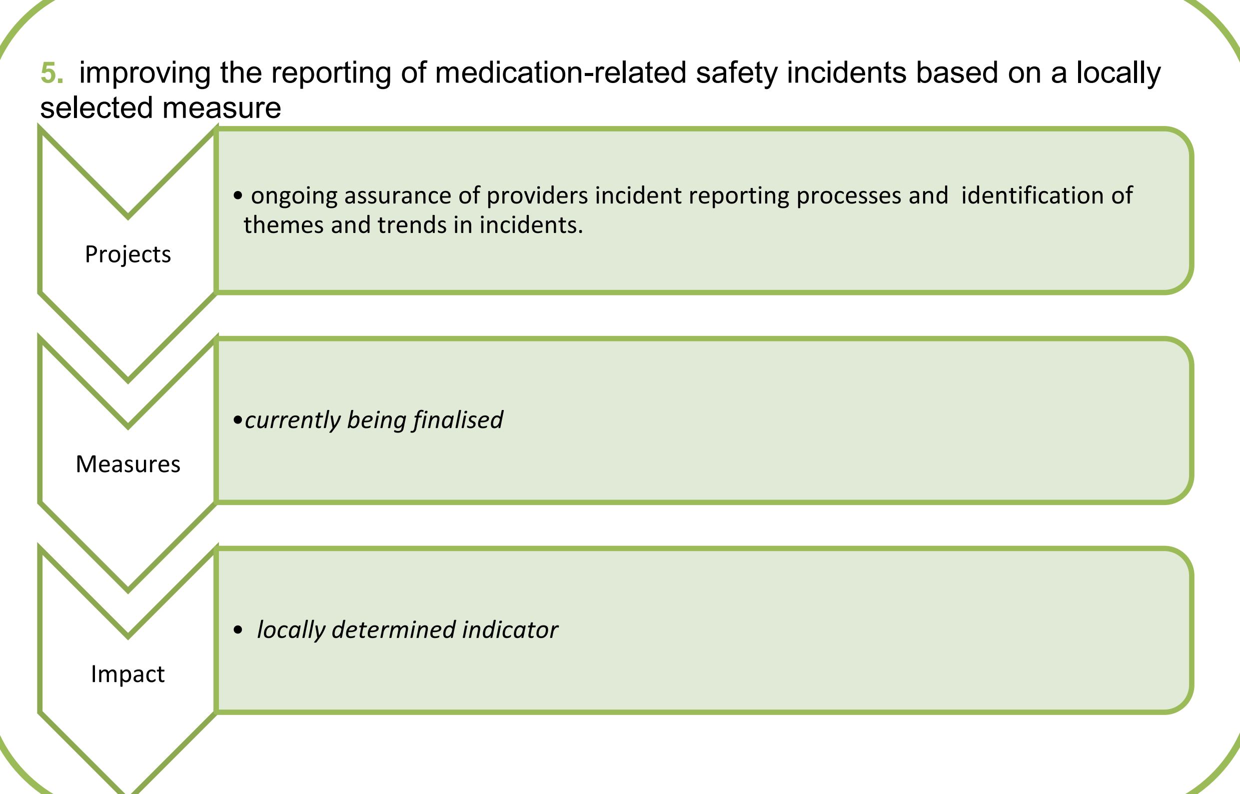
Measures

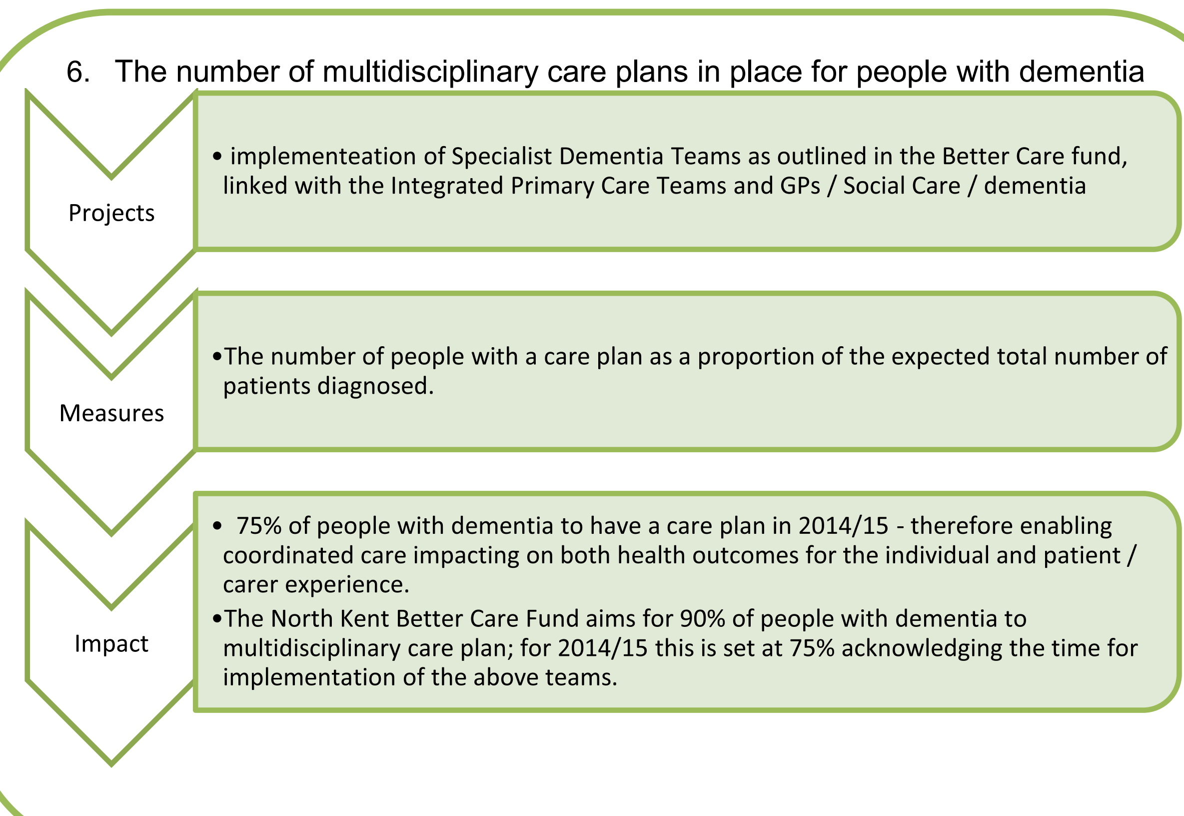
- The proportion or people who have received psychological therapies out of the total numbe of people who have depression and / or anxiety disorders

Impact

- achieving 15% target by the end of 2014/15 (total of 3,330 people receiving psychological therapy):
- via treating 765 people per quarter (3.5%)




5. improving the reporting of medication-related safety incidents based on a locally selected measure
Projects
• ongoing assurance of providers incident reporting processes and identification of themes and trends in incidents.
Measures
•currently being finalised
Impact
• locally determined indicator


6. The number of multidisciplinary care plans in place for people with dementia
Projects
• implementeation of Specialist Dementia Teams as outlined in the Better Care fund, linked with the Integrated Primary Care Teams and GPs / Social Care / dementia
Measures
•The number of people with a care plan as a proportion of the expected total number of patients diagnosed.
Impact
• 75% of people with dementia to have a care plan in 2014/15 - therefore enabling coordinated care impacting on both health outcomes for the individual and patient / carer experience.
•The North Kent Better Care Fund aims for 90% of people with dementia to multidisciplinary care plan; for 2014/15 this is set at 75% acknowledging the time for implementation of the above teams.

In order to ensure that these indicators addresses and aligns with the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy, the Kent Health and Wellbeing Strategy is asked to comment and approve on the above levels of ambition.

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5. Development of Plans

The following table aims to provide assurance on the development of the Operating Plan against key criteria:

Evidence of links to Pioneer and BCF	The Operating Plan recognises the key role integration between health – including primary, secondary and community care – and social care as key to delivering improved care pathways, reducing system inefficiency and, most importantly, improving health outcomes and patient / carer experience. The Better Care Fund – and therefore Pioneer plans – forms the core of our plans for the next two to five years.
Assurance that scrutiny by local HWBs has been carried out	Commissioning plans have been presented to the Dartford, Gravesham and Swanley board on an ongoing basis over recent months. In addition, plans have been shared at subgroups of the Board enabling input from a variety of stakeholders.
Evidence of compatibility with the HWBS and JSNA	The basis for the development of the Operating Plan is the JSNA and Health and Wellbeing Strategy. This is evidenced within the Operating Plan via: 6. Plan on a Page for 2014/15 to 2015/16 (see page 4) 7. Summary of governance arrangements with the Health and Wellbeing Board outlining links with the Health and Wellbeing Strategy 8. Outline of the local health needs

Evidence it has been discussed with a range of stakeholders	Stakeholder engagement forms an important aspect in the ongoing review and development of health services. In addition to public events – at which local authority, health care provider, social services and voluntary sector providers are also invited – we have undertaken a number of actions to ensure we share, and gather feedback on, plans – this remains an ongoing process and continues throughout the commissioning process. Discussions may focus on specific elements of plans e.g. integration or urgent care; or the plan in its entirety e.g. public event held February 2014. Examples of forums for discussion with stakeholders include: Through existing governance frameworks: • Executive Programme Boards – Social Care, health care providers and commissioner (including Bexley CCG) • Programme Delivery groups – social care, health care providers and commissioners • Protected Learning Time events with GPs and practice nurses • County and local Health and Wellbeing Boards and subgroups Through events or dedicated sessions: • Better Care Fund – workshops with GPs, healthcare providers and commissioners, Social Care • Kings Fund workshops - workshops with GPs, healthcare providers and commissioners, Social Care • Voluntary sector events – April 2013, October 2013 and planning for next event in Q1 2014/15 • Public Events held July 2013 and February 2014 – as well as working with local Patient Participation Groups and their Chairs to share information and seek feedback.

9. Recommendations

The Health and Wellbeing Board is asked to:

- Note the key elements of the Operating Plan.

- AGREE the proposed actions and levels of ambition against the Outcomes Indicators outlined in section 4.

- Note the actions taken to:
  - ensure plans reflect the JSNA and Health and Wellbeing Strategy
  - engage with a variety of stakeholders including local Health and wellbeing Boards
  - Reflect the health and Social Care Integration – as per the Integration Pioneer and Better Care Fund work.

By:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health Andrew Ireland, Corporate Director, Families and Social Care
To:	Kent Health and Wellbeing Board
Date:	26 March 2014
Subject:	ADULT SOCIAL CARE COMMISSIONING PLAN EXECUTIVE SUMMARY
Classification:	Unrestricted

Summary: This report presents the Adult Social Care Commissioning Plan Executive Summary against the backdrop of KCC's 'Facing the Challenge: Whole Council Transformation, the Adult Services Transformational Programme, the Better Care Fund and Pioneer initiatives.

The Commissioning Plan is also informed by the relevant key priorities described in the Kent Joint Health and Wellbeing Strategy.

The Strategic Priorities Statement for 2014/15 (the Business Plan) and the Adults Transformation Portfolio Blueprint are the vehicles for delivering the objectives contained in this executive report.

Recommendation(s)

The Health and Wellbeing Board is asked to COMMENT on the Adult Social Care Commissioning Executive Summary

1. Introduction

(1) The purpose of this report is to present the Adult Social Care Commissioning Plan Executive Summary as part of the full spectrum review being undertaken by the Health and Wellbeing Board.

(2) The Families and Social Care Directorate, in particular Adult Services takes an active role in the current work being taken forward under the Better Care Fund and Pioneer programme.

(3) Adult Services has the lead role in discharging KCC's statutory responsibilities for social care. The principal responsibilities of the service include undertaking needs assessment, commissioning and the provision of a range of services and safeguarding vulnerable adults.

(4) Our aim is to ensure that Kent's population of older people, people with physical disabilities, people with learning disabilities and people with mental health issues and their carers live healthy, fulfilled and independent lives and are socially and economically included in the community. We consider that individuals

should be at the heart of joined up service planning, and be empowered to make choices about how they are supported.

2. Background

(1) In connection with the main responsibilities described above, Adult Services

- provide care for over 6000 people enabling them to live safely in their own homes,
- enable over 3000 older people and those with disabilities and mental health issues, choice and control over their care needs through personalised budgets and direct payments,
- support 400 people a month following discharge from hospital into intermediate care
- support over 3000 adults with telecare services, maintaining independence and reducing hospital admissions,
- provide day care services to over 2000 adults, including social and educational activities enabling people to live healthy and fulfilled lives,
- support over 2500 adults with a learning disability live independent lives in their own homes or with family carers
- support 60 18 year olds with a learning disability to achieve their goals as they move into adulthood,
- provide supported accommodation for over 700 adults with a learning disability enabling them to have choice about where they live,
- have increased the proportion of people with mental health needs who live in a stable environment, on a permanent basis to 85%
- have reduced admissions to permanent residential or nursing care to 120 per month; ensuring people can continue to live safely in their own community.

3. Priorities

(1) The commissioning intention is to drive, promote and support transformational change through commissioning strategically in order to ensure that there is provision of a range of high quality, cost effective, outcome based services for adults with care and support needs and their carers.

(2) We have adopted the following guiding principles in the effort to realise the objectives found in the Commissioning Plan These principles are as follows:

- Maximising independence
- Managing the market and demand
- Maximising value for money
- Integrating services

4. Commissioning Plan

(1) The context of the taking forward the objectives of the Commissioning Plan is that in 2014/15 Adult Services must achieve a £13million

saving (excluding Supporting People). The long term aim is for Adult Social Care to put in place sustainable model of integrated Health and Social Care services which offer integrated access, integrated provision and integrated commissioning. Managing this well will mean that we will have improved outcomes for people across Kent by maximising people's independence and promoting personalisation. Furthermore, we will seek to maximise value for money through effective demand management and shaping the market through strategic engagement with key suppliers.

(2) The Commissioning Plan is based on four core components of the programme covering (1) home care, (2) residential market, (3) enablement provision and (4) telecare installations and monitoring.

(3) Specifically, we are taking steps to reshape the provider markets and externalise a broader suite of services throughout the support pathway. The services involved will be commissioned through prime providers, who will work with a network of local supply, judged on the achieving service user outcomes by moving away from 'time and task' contracting arrangements.

(4) We are also placing greater emphasis on services that support self-care, recovery, rehabilitation and recuperation which reduce the need for high intensity care and supporting people to live independently in the community within the acceptable bounds of their changing needs and circumstances".

(5) Enablement based care service therefore form a centre piece of how we are 'shifting the gravity' of spend towards planned packages of time-limited support (personal (integrated) budgets / choice & control) away from long term care. The underpinning policy intention is that such services will focus on increasing the chances of people retaining or regaining independence and avoiding, or at the very least delaying, the need for a permanent move into a residential setting or temporary move into hospital care. Enablement based services will be, where appropriate integrated with NHS based rehabilitation services

(6) Where KCC seeks to retain direct provision this will incorporate the integration of front line services, as well as the development of joint strategic commissioning arrangements. Integration, both in direct provision and commissioning, will build on the foundations of the changes we have already made regarding alignment with CCG boundaries.

(7) We intend shaping the market to ensure outcome-focused service delivery models aligned with current and future service requirements, this includes integrated commissioning with partners, pooled budget arrangements and strategic commissioning and better procurement.

(8) Above all, will make changes to the existing operating model by putting a much stronger emphasis on the role that prevention and early intervention can make as part of the offer that people in Kent should receive before they are assessed as being eligible for longer term care and support.

(9) In this endeavour we are considering a suite of preventative based services delivered by community or voluntary sector organisations funded by KCC

and /or the NHS or local councils to help people to maintain independence and maximise their ability to self-care. We intend to revisit our approach and engagement with the voluntary and community sector, especially in the context of the implementation of the Care Bill requirements regarding the new preventative duty.

For those who seek a Direct Payment we will arrange for support and advice to be available.

(10) In brief, our Commissioning Plan looks to develop local services that can assist whatever anyone's circumstance – this may include specific services and support to assist older people with dementia, will help those who have longer term conditions, will help frail elderly people, or those with past chaotic lifestyles. We will assist those recovering from mental ill health, people with autism and with learning or physical disabilities and support young people in during transition into adulthood. For people in transition billed on the 0-25 integrated direct payments arrangement and apply the lessons learned in other areas. We will work with informal carers at all times to ensure that we are clear on the part that the Adult Services can play in helping them care for the person their relative or friend. Finally, we will safeguard vulnerable adults and provide advocacy for them and their carers.

5. Links to Pioneer and Better Care Fund

(1) The integration of Health and Social Care services is being managed as part of a wider Adults Transformation within the Care Pathway work stream, meaning that the redesign of our services will facilitate integration with the NHS. This is now fully reflected in Pioneer and Better Care Fund activities. We believe that by bringing together CCGs, KCC, district/borough councils, acute services and the voluntary sector we will move to care and support provision that will promote greater independence for patients, whilst reducing care home admissions. In addition, a new workforce with the skills to deliver integrated care will be in place.

(2) We are advancing plans for the Better Care Fund during 2014/15. This represents a significant opportunity to invest in preventative and intervention activity and support our strategy to manage demand for adult social care.

(3) We have made the case that 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.

(4) We support and have taken steps in commission a model of community based integrated health and social care provision, which is accessible 24.7

(5) For 14/15 and beyond 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.

(6) As part of the move forward consideration will be given to the workstreams of the Adult Transformation Programmes to ensure that activity to transform adult social care is aligned with the reforms being brought in by the Care Bill which is a component of the Better Care Fund.

6. Engagement of Local Health and Wellbeing Boards

(1) At a local level there is been sustained involvement with the public through participation groups and the local health and social care integration implementation groups. Health and Social Care Integration Steering Groups at the local level have patient and service user representatives and as part of the operational integration programme regular surveys on integrated care are undertaken.

7. Links with the Health Wellbeing Strategy and the JSNA

(1) The commissioning intentions relate well to the priorities of the Health and Wellbeing Strategy. In particular, Priority 4 which is to do with "Transforming services to improve outcomes, patient experience and value for money". Similarly, four of the outcomes, namely Outcomes 2, 3, 4 and 5 emphasises prevention, long term condition, mental health and people with dementia.

(2) It is notable that the JSNA priority of "Shifting care closer to home and out of the hospital (including dementia and end of life care) and improving quality of care are all essential fabric of the commissioning work that Adult Social Care is mounting.

8. Stakeholder Engagement

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

(2) Adult Social Care has undertaken a survey with service users on their current experiences of integrated care and support. The outcomes of this survey will be used to inform further development within integration and can help inform implementation of the BCF plan.

9. Summary

(1) This report has provided a summary position of the commissioning plans being taking forward by Adult Social Care. The story of the success of the commissioning changes whether by KCC alone or in partnership will be demonstrated by fewer people needing long term help but people still having their needs met in a timely and appropriate manner.

10. Recommendation

(1)	The Health and Wellbeing Board is asked to: A) **COMMENT** on the Adult Social Care Commissioning Executive Summary

Background documents

Adults Transformation Portfolio, 2014 (draft)

Kent Better Care Fund Submission, 2014 (draft)

'Facing the Challenge: Whole Council Transformation, the Adult Services Transformational Programme, 2013

Adult Social Care Transformation Programme Blueprint and Preparation Plan, 2012

Social Care, Health and Wellbeing Directorate Strategic Priorities Statement 2014/15 (draft)

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NHS England (Kent and Medway)

Commissioning Plan 2014/15 and 2015/16

Introduction

1. This paper is a summary of NHS England (Kent and Medway)'s commissioning plans for 2014/15 and 2015/16.

Context

2. NHS England (known legally as the NHS Commissioning Board) is an independent organisation which operates across England, at arms-length from government. Through its 27 local area teams, NHS England is responsible for directly commissioning:
    - Primary care services (including GP services, dental services and pharmacy services)
    - Secondary care dental services
    - Specialised healthcare services
    - Healthcare services for offenders and those within the justice system
    - A range of public health service on behalf of Public Health England (e.g. covering pregnancy to age five public health programmes, screening and immunisation programmes, sexual assault referral centres)
    - Some healthcare services for the armed forces.
3. NHS England (Kent and Medway) is the local arm of NHS England (also known as the Kent and Medway Area Team).
4. In regards to its direct commissioning functions, NHS England's focus is on improving health outcomes for patients and ensuring equity and consistency in the provision of health services, but with services tailored to meet local need. This includes establishing national service specifications and commissioning intentions, which are then tailored locally.
5. NHS England also works closely with local clinical commissioning groups (CCGs) to support them to use their local knowledge and understanding of the needs of local patients to commission a wide range of other community and hospital services.
6. Each year the Government publishes the NHS mandate setting out ambitions for the National Health Service. This can be viewed at https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015. The mandate details the outcomes that the Government wants the NHS to achieve for patients but gives clinical commissioning groups (CCGs) and NHS England (through its direct commissioning role) flexibility on how these are delivered.
7. Much of the basis for the Government's mandate originates in the NHS Outcomes Framework which describes the five main categories of better outcomes we want to see within the health service:

a. We want to **prevent people from dying prematurely**, with an increase in life expectancy for all sections of society.

b. We want to make sure that those people with long-term conditions, including those with mental illnesses, get the **best possible quality of life**.

c. We want to ensure patients are able to **recover quickly and successfully** from episodes of ill-health or following an injury.

d. We want to ensure patients have a **great experience** of all their care.

e. We want to ensure that patients in our care are **kept safe** and protected from all avoidable harm.

8. Delivering these identified long-term ambitions will require transformational change, which will require a change in the way health services are delivered. That is why in July 2013 NHS England (along with our national partners) launched *A Call to Action* which set out the challenges and opportunities faced by the health and care systems across the country over the next five to ten years. We need to find ways to raise the quality of care for all in our communities to the best international standards, while closing a potential funding gap of around £30 billion by 2020/21.

9. On the 20th December NHS England issued planning guidance to CCGs and NHS England direct commissioners titled Everyone Counts: Planning for Patients 2014/15 to 2018/19. This sets out how it is proposed to invest the NHS budget so as to drive continuous improvement and to ***make high quality care for all, now and for future generations*** into a reality. The planning guidance can be viewed at http://www.england.nhs.uk/2013/12/20/planning-guidance/ and will be used to inform the development of local health services in Kent and Medway.

10. Change will need to be achieved through:

- Listening to patient views
- Delivering better care by realising the benefits of the digital revolution
- Transparency and sharing data about local health services
- Transforming primary care services
- Ensuring tailored care for vulnerable and older people
- Delivering care in a way that is integrated around the individual patient
- Ensuring access to the highest quality urgent and emergency care
- A step change in the quality of elective care
- Providing specialised services concentrated in centres of excellence
- Improving access to services (e.g. moving to seven day service provision)
- Supporting research and innovation

11. NHS England is focused on ensuring equity and consistency of provision but with services tailored to meet local need. This includes establishing national service specifications and commissioning intentions, which are then tailored locally. The

following sections provide information on the development of commissioning plans and intentions for those services that NHS England directly commissions for the population of Kent and Medway, taking account of the national planning guidance and commissioning intentions.

Public health services (e.g., national screening and immunisation programmes, public health services 0-5 years)

12. Responsibility for the commissioning of public health services is split between Public Health England (PHE), local authorities and NHS England.
13. An agreement between the Secretary of State for Health and NHS England, made under Section 7a of the National Health Service Act 2006, details the public health commissioning functions that are carried out by NHS England. These functions, which include responsibility for commissioning national screening and immunisation programmes and health visiting services, are characterised by thirty-two national service specifications and nationally mandated programmes of work. These include public health provision in secure estate (prisons), sexual assault services, and public health programmes for under-fives until 2014.
14. Attachment 1 provides details of the local commissioning intentions that relate to these national requirements.

Health and justice healthcare services (e.g. healthcare services provided in secure estate settings such as prisons)

15. NHS England (Kent and Medway) commission health and justice healthcare services across Kent, Surrey and Sussex, which include health care services provided to offenders and others within the criminal justice system.
16. Work is underway to develop national service specifications covering the delivery of healthcare services in secure estate settings, such as prisons. In addition, the NHS and the National Offender Management Service (NOMS) is continuing to progress the transfer of commissioning responsibilities for healthcare from police forces to the NHS. This includes with regards to forensic medical examinations and healthcare services provided within police custody suites). The majority of commissioning of healthcare in prisons has already transferred over to the NHS.
17. Attachment 2 provides details of the local commissioning intentions that relate to health and justice services.

Primary care services (e.g. core services from general practitioners, community pharmacies, dentists and optometrists):

18. The delivery of core primary care services is largely covered through nationally negotiated contracts (e.g. general medical services (GMS) contracts) or nationally determined regulations (e.g. regulations governing the process for reviewing applications to open a new community pharmacy). It is anticipated that further national commissioning intentions for primary care will be released in January 2014.

19. For general practice services a number of changes have been agreed to the national GMS contract, including:

- **Having a named, accountable GP for people aged 75 and over.** As part of a commitment to more personalised care for patients with long-term conditions, all patients aged 75 and over will have a named, accountable GP with overall responsibility for their care.
- **Out-of-hours services.** There will be a new contractual duty for GPs to monitor and report on the quality of out-of-hours services and support more integrated care, e.g. through record sharing.
- **Reducing unplanned admissions.** There will be a new enhanced service to improve services for patients with complex health and care needs and to help reduce avoidable emergency admissions. This will replace the Quality and Outcomes Framework (QOF) quality and productivity domain and the current enhanced service for risk profiling and care management and will be funded from the resources released from these two current schemes. The key features of the scheme will be for GP practices to:
    - improve practice availability, including same-day telephone consultations, for all patients at risk of unplanned hospital admission;
    - ensure that other clinicians and providers (e.g. A&E clinicians, ambulance services) can easily contact the GP practice by telephone to support decisions relating to hospital transfers or admissions;
    - carry out regular risk profiling, with a view to identifying at least two per cent of adult patients – and any children with complex needs – who are at high risk of emergency admissions and who will benefit from more proactive care management;
    - provide proactive care and support for at-risk patients through developing, sharing and regularly reviewing personalised care plans and by ensuring they have a named accountable GP and care coordinator;
    - work with hospitals to review and improve discharge processes; and
    - undertake internal reviews of unplanned admissions/readmissions.
- **Choice of GP practice.** From October 2014, all GP practices will be able to register patients from outside their traditional boundary areas without a duty to provide home visits. This will give members of the public greater freedom to choose the GP practice that best meets their needs. NHS England's area teams will need to arrange in-hours urgent medical care when needed at or near home for patients who register with a practice away from home.
- **Friends and Family Test.** There will be a new contractual requirement from December 2014 for practices to offer all patients the opportunity to complete the Friends and Family Test and to publish the results.
- **Patient online services.** GP practices will be contractually required from April 2014 to promote and offer patients the opportunity to book appointments online, order repeat prescriptions online and gain access to their medical

records online. The current enhanced service for patient online services will cease and the associated funding transfer into global sum payments for local GP practices.

- **Extended opening hours.** The extended hours enhanced service will be adapted to promote greater innovation in how practices offer extended access to services.
- **Patient participation.** The patient participation enhanced service will be adapted to promote greater innovation in how practices seek and act on patient insight and feedback, including the views of patients with mental health needs.
- **Transparency of GP earnings.** The British Medical Association's General Practitioners Committee (GPC) will join a working group with NHS England and NHS Employers to develop proposals on how to publish (from 2015/16 onwards) information on GPs' net earnings relating to the GP contract. The first published data would be based on 2014/15 earnings and publication of this information will be a future contractual requirement.
- **Diagnosis and care for people with dementia.** There will be changes to this enhanced service to promote more personalised care planning and allow greater professional judgement in which patients should be offered assessment to detect possible dementia.
- **Annual health checks for people with learning disabilities.** There will be changes to this enhanced service to extend its scope to young people aged 14-17 to support transition to adulthood and to introduce health action planning.
- **Alcohol abuse.** There will be changes to this enhanced service to incorporate additional assessment for depression and anxiety.

20. Locally, NHS England (Kent and Medway) is committed to ensuring patients can access high quality GP services that meet the needs of our local communities. We will work with CCGs and other stakeholders to review and either extend (where there is flexibility to do so), reprocure or decommission those existing Alternative Provider of Medical Services (APMS) contracts and services which are scheduled to end at various points during the next two years (up to 31st March 2016). The following APMS contracts are scheduled to end during the next two years are:

Practice Name	CCG Area
DMC Sheppey Healthcare Centre	Swale
DMC Walderslade Surgery	Medway
College Health-Boots	Medway
College Health –Sterling House	Medway
DMC Medway Healthcare Centre	Medway
The Broadway Practice	Thanet

White Horse Surgery and Walk-In Centre	Dartford, Gravesham and Swanley
Minster Medical Centre	Swale
The Sunlight Centre	Medway

21. NHS England (Kent and Medway) has a relatively high percentage of general practices on General Medical Services (GMS) contracts. In this respect 82% of GP contractors across Kent and Medway hold GMS contracts with only 13% of practices holding Personal Medical Services (PMS) contracts and a further 5% holding APMS contracts. GMS contracts are nationally negotiated contracts in which price and service requirements are determined through discussions between NHS Employers (on behalf of the Department of Health) and the General Practitioners Committee (on behalf of the BMA).
22. NHS England is committed to a comprehensive review of PMS contracts to ensure these offer value for money and deliver services that are aligned to patient need, as well as CCG and NHS England strategies. A local review of PMS contracts was undertaken throughout 2012/13 by the former Cluster PCT through which the vast majority of PMS contracts were successfully reviewed. A further review of PMS contracts across Kent and Medway will be undertaken in three phases:
    - Phase 1 will be to facilitate any transfer back to a GMS contract that PMS contractors wish to make.
    - Phase 2 will be to comprehensively review those contracts where the previous review was not concluded to the satisfactions of the NHS England.
    - Phase 3, which will be undertaken in 2015/16, will be to review the objectives of other PMS contracts to ensure they reflect the needs of their population, are delivering value for money and are aligned to CCG and NHS England priorities.
23. Other local priorities for 2014/15 include:

- Reviewing the minor surgery Directed Enhanced Service, which covers specific types of procedures carried out by GPs.
- Reviewing and, if appropriate, reprocuring the occupational health service for GPs and other primary care contractors.
- Rolling-out healthy living pharmacies to provide local people with health and wellbeing advice, thus helping to promote healthy lifestyles and to reduce health inequalities.
- Extending the delivery of flu vaccinations in community pharmacies in order to help boost take up of the vaccine amongst at risk patients.
- Reviewing access to NHS dentistry and improving this for local patients where necessary.

NHS England

- Reviewing and where appropriate reprocuring interpreting services to support patients in accessing primary care contractor services.

Prescribed specialised services

24. NHS England (Surrey and Sussex) is responsible for commissioning prescribed specialised services on behalf of the populations of Kent and Medway and Surrey and Sussex. Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of more than one million. These services tend to be located in specialist hospital trusts that can recruit staff with the appropriate expertise and enable them to develop their skills.

25. NHS England is committed to ensuring that such services are commissioned on behalf of patients in a nationally coherent and equitable way. Commissioning intentions for specialised services have therefore been developed nationally and can be viewed at: http://www.england.nhs.uk/wp-content/uploads/2013/10/comm-intent.pdf.

26. Six key strategic strands are identified as part of these commissioning intentions:

    a. Ensuring consistent access to effective treatments for patients in line with evidence based clinical policies, underpinned by clinical practice audit.

    b. A Clinical Sustainability Programme with all providers, focused on quality (this includes the need to achieve and maintain compliance with full service specifications and to keep these specifications under review in order to deliver a continuous improvement in health outcomes for patients).

    c. An associated Financial Sustainability programme with all providers, focussed on achieving better value in the use of NHS resources.

    d. A systematic market review for all services to ensure the right capacity is available, consolidating services where appropriate to address clinical or financial sustainability issues.

    e. Adopting new approaches to commissioning care where it promotes integrated care and clinical oversight for patients in particular services and care pathways.

    f. A systematic rules-based approach to in-year management of contractual service delivery.

27. NHS England (Surrey and Sussex) have been asked to provide details of the implications of the national intentions for specialised services for Kent and Medway patients and services. These will be circulated to Health and Wellbeing Board members when available.

Armed forces health

28. NHS England (Bath, Gloucestershire, Swindon and Wiltshire) commission armed forces health services (for serving personnel and their families) on behalf of all areas in the South of England, including in Kent and Medway.

29. NHS England has agreed capacity plans, detailing anticipated demand for services, for armed forces healthcare activity for 2013/14. NHS England (Bath, Gloucestershire, Swindon and Wiltshire) has agreed a further six capacity plans with providers in the south of England and more contracts will be placed in 2014/15 in order to increase the availability of services for armed forces and their families.
30. There are some challenges in terms of the availability and accuracy of data to support commissioning decisions. This is partly due to providers not always identifying patients as serving armed forces personnel or their families NHS England (Bath, Gloucestershire, Swindon and Wiltshire) is working with national NHS England leads for information and finance to resolve these issues.
31. A first draft of commissioning intentions for armed forces health for 2014/15 is being prepared and will be shared shortly.
32. A review of current commissioning for quality and innovation payments (CQUINs) across existing contracts is identifying the CQUINs which most support the armed forces population. These will be adapted and promoted as part of contract negotiations.

Summary

33. This paper provides a summary of NHS England's commissioning plans. Comments from stakeholders and partners are welcomed.

Attachment 1: Public Health

Work Programme	Brief description of Commissioning Intention 2014 / 15	Service Change - Service Specification, redesign, decommission, etc.	Provider affected	Financial Implications	Comments
School based immunisations	To commission a school immunisation team for Kent and Medway to provide school based immunisation programmes. Current provision is through Medway NHS Foundation Trust (MFT) and Kent Community Health NHS Trust (KCHT) who provide a mixed model of school based immunisation programmes, i.e. via school nursing service in the east of the county and a standalone immunisation team in the west.	Review the need to decommission the current programme and procure a single school based Kent and Medway immunisation service in order to ensure consistency in delivery of vaccinations across the county.	KCHT and MFT	Costs are not identified at present. Reference costs are being sought from providers to inform service redesign.	School based immunisations are part of a block contract at present. Both providers have been extracting costs of current provision. This commissioning intention has implications for school nursing services which are currently commissioned by Medway Council and Kent County Council. An immunisation team is already in place for West Kent.
Meningitis C (MenC) immunisation programme MenC adolescent booster school year 9 - starting January 2014	Current school nursing team to be commissioned to provide MenC at 14-15 years, with GP's immunising children that did not receive vaccine via school nursing.	Commission KCHT and Medway NHS Foundation Trust (MFT) school nursing team to deliver Men C adolescent booster. Issue Local Enhanced Service for MenC to GP's for those that did not receive vaccine via school nursing.	KCHT & MFT school nursing and GPs	National guidance proposes that funding to deliver the adolescent Men C programme will be transferred from primary care where the second dose (now ceased) has been funded within GP contract/global sum.	To enable Men C to be commissioned from current providers we are currently seeking reference costs from Medway providers and will benchmark against KCHT and other areas to ensure VfM in the commission.

MenC catch up for first time university entrants under the age of 25	From mid-August 2014 there will be a catch up programme of limited duration (possibly up to 5 years) to offer the vaccine to first time university entrants under the age of 25.	Likely to be commissioned via a GP Local Enhanced Scheme (LES); further national guidance awaited	GPs - this programme will be mainly delivered through primary care.	Further information will follow relating to funding and vaccine supply arrangements for the catch-up.	Awaiting further information relating to the funding and vaccine supply.
Men C Removing 2nd 4 month dose	Childhood immunisations are classified as additional services in the GP contract and the infrastructure costs of delivering these are covered by the GP practices global sum payment or baseline PMS funding. GPs are also eligible for target payments if they have vaccinated 70% to 90% of their 2 year cohort.	Decommission 2nd MenC dose in line with national policy around clinical effectiveness	GPs (with a need to inform other providers who provide patients with advice and information)	NHS England plans an adjustment to those target payments to reflect the change from 2 doses to 1 dose, however this adjustment will not be made until 2015/16, reflecting that vaccination status is not assessed until children reach 2 years.	

Human papillomavirus (HPV) - Local Enhanced Service contract ended in August 2013. This service is for children who were not vaccinated under the school programme	Area Team to issue an HPV local enhanced scheme (LES) for general practice to reflect new commissioning arrangements for Jan 2014	Specification to be written	GPs	£9.00 per item	
HPV - School Nursing Team	School nursing team to be commissioned to provide HPV at 14-15 years (with GPs immunising children that did not receive vaccine via school nursing - see the row above).	Revised contract in year	KCHT and MFT school nursing teams		

Additional childhood flu vaccination	The national Joint Committee on Vaccination and Immunisation (JCVI) has recommended that the seasonal influenza programme be extended to all children from aged two up to the age of 17. This programme has been rolled out to all healthy two and three year olds in the 2013/14 flu season as part of a gradual step to full implementation. This programme is in addition to the existing routine seasonal influenza programme.	Service redesign and service specification. Make provision for 4 year olds. Commence delivery of childhood flu vaccination to as many children of secondary school age as reasonably possible.	Best vaccination uptake among 5-16 year olds is likely to be achieved through a school based programme – involving school nursing teams and GPs.	Awaiting further information and funding from NHS England.	

Health visiting	NHS England (Kent and Medway) and Health Education England Kent, will work together to increase the number of health visitors as required by the national programme, monitored by the Department of Health. In Kent and Medway the increase in the number of health visitors is planned to be in line with the nationally agreed trajectory of 421 whole time equivalent (wte) health visitors by April 2015. This represents 342.2 wte employed within Kent Community Health NHS Trust (KCHT) and 78.8 wte for Medway Community Healthcare (MCH). This equates to an increase of 68.2 wtes for KCHT and 7.7.wte for MCH in 2014-15.	A national service specification is in place with local trajectories in term of delivery of the new model aligned to the Healthy Child Programme (HCP 0-5 years)	KCHT and Medway Community Health (Social Enterprise)	Additional costs of £1,544,190 for 2014/15.	Mandated programme in line with Department of Health
Family Nurse Partnership (FNP)	Expansion of FNP by one team in both Kent and Medway, thus increasing the number of places by 100 for each area. Kent and Medway are both on the national expansion plan and will therefore contribute to the Department of Health planned increase to 16,000 places nationally. Linked to Public Health Outcomes Framework.	Nationally driven programme aligned to the Health Visitors Programme using a sub license. There is therefore no service change, but just an increase in the number of FNP places	KCHT and MCH	Awaiting costs	Awaiting confirmation of funding

Child Health Information System (CHIS)	The current Careplus CHIS will be replaced by the new SystmOne system during 2014. This system is being deployed across the entire South of England region. This will provide an integrated IT system across Kent and Medway. Work is needed to integrate the Medway Child Health Record Department (CHRD) with the Kent team under a single management structure. This will provide: • a strengthened governance arrangements for CHRD with improved performance monitoring process; • the potential to increase opportunities for learning and development within the team; • efficiency and streamlining as a result of having one single, larger team; and • support robust project plan for implementation of SystmOne.	The service charge relates to the integration of the CHRDs in Kent and Medway.	KCHT and MFT	Costs to be confirmed	

Diabetic Eye Screening service re-procurement.	Continue with and complete the diabetic eye screening re-procurement. The service is being reprocured as the existing contract for the local diabetic eye screening service is nearing the end of its period of operation and under procurement rules, NHS England's Kent and Medway Team is required to re-tender. The objective is to ensure that appropriate services are in place to support the prompt identification and effective treatment of sight threatening diabetic retinopathy. The priorities are to: - ensure effective contract transition processes are in place; - identify transition risks and ensure mitigating actions are implemented; - ensure services are delivered in line with national service specifications; and - any gaps in service provision are addressed in order	Re-commissioning	Pending outcome of tendering process	Costs to be confirmed subject to the procurement	TBC

Attachment II: Health and Justice Commissioning Intentions

Work Programme	Brief description of Commissioning Intention 2014 / 15	Service Change - Service Specification, redesign, decommission, etc.	Provider affected	Financial Implications	Comments
Paediatric Sexual Assault Referral Service (SARC) Kent, Surrey and Sussex	To commission fit for purpose Paediatric SARC Services in Kent and Sussex and seek reassure of quality of care pathway and service in Surrey	The key stages of the work are service design, development of an options paper, consultation and procurement of Paediatric SARC services	Services delivered on a cost per case basis, anticipate there will be a limited impact on current providers due to low volume	Funding has been identified for the health element of the paediatric SARC from budget uplift received	National funding arrangements, roles and responsibilities across Partners to be clarified
Sussex Sexual Assault referral Centre (SARC)	Re-procure Sussex SARC Phase 1 (health element) by June 2014, Part 2 (social care element) by April 2015	Re procure service	Tascor	Sussex Police and local authorities transfer their budgets to NHS England	Further development of Forensic Medical Examiner (FME) service necessary
Kent Sexual Assault Referral Centre (SARC)	Re procure Kent SARC Forensic Medical Examiner (FME) and Forensic Nurse Practitioner (FNP) element by June 2014 and deliver FME and FNP training programmes . Extend service to be able to receive self-referrals by Autumn 2014.	Re procure FME / FNP element Review Kent SARC care pathway	FMEs paid on a retainer, no contracts in place	Kent Police confirmed financial envelope available, NHS England anticipating contributing to uplift	Partners, with NHS England need to commission a fit for purpose SARC that reflects national best practice and excellence.
Kent Sexual Assault Referral Centre (SARC)	Agree development plan for the new Kent and Medway SARC, including the move to self-referral	Review service specification and review care pathway	Kent and Medway Partnership Trust, Family Matters, East Kent Rape Line and	Uplift received will ease any cost pressures that the review and further development of an excellent Kent SARC may require.	Partners, with NHS England need to commission a fit for purpose SARC that reflects national best practice and excellence.

			Kent Police		
Surrey Police Custody Healthcare Commissioning Transfer	Prepare for transfer of commissioning responsibility of FME and FNP service to NHS England (Kent and Medway) for 1st April 2015	Transfer of commissioning responsibility anticipate novation of contract to NHSE	Tascor	None known	Preparing Statement of Readiness
Kent Police Custody Healthcare Commissioning Transfer	Re procure FME provision into Kent and Medway police custody suites and prepare for transfer of commissioning responsibility of FNP service to NHS England (Kent and Medway) for 1st April 2015	Implement a re procured FME service into police custody by Summer 2014	FMEs paid on a retainer, no contracts in place	None known	Market testing underway
Sussex Police Custody Healthcare Commissioning Transfer	Support Sussex Police to uncouple FME and FNP element of block custody contract	Activity on-going to extrapolate health element of contract in order to re-procure	Tascor	None known	Preparing Statement of Readiness
Surrey Prisons - Virgin Healthcare	Review and redraft service specifications, key performance indicators (KPIs) and service delivery improvement plans (SDIPs) for healthcare provision for each of the four Surrey prisons. Incorporating a formal review of in-patient services at HMP Highdown.	Service specification, KPI's , Quality Dashboard and SDIP	Virgin	None anticipated	NHS England (Kent and Medway) working to embed partnership working with the provider
Surrey Prisons - Surrey and Borders NHS Foundation Trust	Review and redesign of mental health Service and contractual supporting documents	Service specification, KPI's , Quality Dashboard and SDIP	Surrey and Borders Partnership Foundation Trust	Commissioner may seek uplift in funding if identified as necessary for a comprehensive mental health service i.e. improving access	Provider aiming to being a Phased implementation from 1st April 2014

				to psychological therapies (IAPT) service	
Surrey Prisons - Virgin Healthcare	Re procure clinical and psycho-social elements of substance misuse services across Surrey Prisons fro implementation by 1st May 2014.	Re procurement completed, contract awarded and announced	Virgin	A saving of no more than 3100,000.00 per annum is anticipated	Contract transition and mobilisation planning underway.
Review of Discipline Officers enabling healthcare functions across all Kent, Surrey and Sussex prisons	Review the role and function of Discipline Officers who enable healthcare functions across all Kent, Surrey and Sussex prisons and plan with Governors for the transfer of funding responsibility from 1st April 2014	Novate commissioning responsibility from NHS England to Prison Service	Prison Service / National Offender Management Services (NOMS)	Cost pressure for NOMS, release of funds for NHS England to reinvest in clinical services	National programme of work but adopting a local delivery plan
HM Prison Lewes and Ford health services re procurement	Re procurement of healthcare services for 1st April 2015	Re procurement	Sussex Partnership NHS Foundation Trust	Unknown until procurement complete	Current Provider and NOMS advised of intention.
HM Prison/ Young Offenders' Institute (YOI) Rochester and HMYOI Cookham Wood reprocurement	Re-procurement of primary healthcare, pharmacy and child and adolescent mental health services (CAMHS) (Cookham only) for 1st April 2014	Re procurement	Prison Service	Anticipated this will be cost neutral	New ways of working fully implemented at Rochester, Cookham operational capacity increase and Rochester re-roll to 70% adults. Procurement completed and contract awarded and announced.
Telemedicine	Develop a business case and feasibility test regarding the introduction of telemedicine in the Kent, Surrey and Sussex prison estate. Report expected Autumn 2014.	Service innovation	Miscellaneous	Anticipate it will be cost neutral	NHS England (Kent and Medway) need to progress development work with key stakeholders

HM Prison Bronzefield - primary healthcare and psycho-social substance misuse services	Close partnership working with NOMS to support the prison to review its existing service specifications and associated contract document suite i.e. key performance indicators (KPIs), service deliver improvement plans (SDIP), quality dashboard, adopt serious incident reporting framework, complaints process and Prison Health Performance and Quality Indicators (PHPQI) framework	Review and refresh of Service specs, KPIs, SDIP, Quality Dashboard, intro of use of PHPQI's, serious incident reporting framework, NHS complaints process	Sodexo	None	NOMS retain the budget, commissioning and contract management responsibility for the delivery of primary healthcare and psycho-social services at HMP Bronzefield. NHS England is working to support Sodexo and NOMS to prepare to transfer commissioning responsibility to the NHS when negotiations with Sodexo regarding uncoupling of healthcare element of main budget is completed.
Mental health services across Kent and Medway prison estate	Re-procurement of mental health services across all Kent, Surrey and Sussex adult prisons for 1st July 2014	Re procurement	Oxleas	Anticipated this will be cost neutral	Re-procurement well advanced
Gatwick Immigration and Removal sites (3 sites)	Transfer commissioning responsibility from UK Border Forces (UKBF) to NHS England and re procure health services by Sept 2014	Transfer commissioning responsibility and re procure	G4S	Anticipate will be cost neutral for NHS England	NHS England's London Area Team are taking the lead on a multi-site procurement, Kent and Medway actively supporting

Secure Children's Homes (SCH) – welfare only	Formalise East Sussex and West Sussex local authorities retaining commissioning responsibility for SCH whilst NHS England (Kent and Medway) take accountability through a formal memorandum of understanding (MOU). Contractually implement service uplift.	Service uplift due to increase in residents and in response to refreshed health needs assessment (HNA). Area Team commissioners to confirm budget transfer value for commissioning transfer to Area Team from 1st April 2014.	Local authorities and local healthcare providers to SCH in East and West Sussex	Increase in available resources for comprehensive health services. NHS England (Kent and Medway) may need to incorporate local authority commissioning service costs into service baseline (if required by local authorities).	Local authority commissioners keen and content to carry on their local commissioning function of these bespoke placements and services for individualised packages of care
Medway Secure Training Centre (STC)	Provide on-going support in preparation for transfer of commissioning responsibility to NHS England from 1st April 2015 anticipating a re procurement of health services by 1st April 2015	Re procurement by April 2015, transfer of commissioning responsibility December 2014	G4S	Anticipate no cost pressures to NHS England	Position regarding transfer of commissioning responsibility to NHS England still fluid as is reprocurement timetable
Surrey Police Court Liaison and Diversion Service (PCLDS)	Commission Phase 2 of Surrey PCLDS to include some court coverage and enhance existing police custody coverage	Commission	Surrey and Borders Partnership NHS Foundation Trust	Planned for service uplift	Surrey is the last PCLDS to become established across Kent, Surrey and Sussex

By: Roger Gough, Cabinet Member for Education and Health Reform

Jenny Whittle, Cabinet Member, Specialist Children's Services

Andrew Ireland, Corporate Director Families and Social Care

To: Health and Wellbeing Board – 26 March 2014

Subject: **CHILDREN'S HEALTH AND WELLBEING BOARD**

Classification: Unrestricted

Summary: A report which invites the Health and Wellbeing Board to consider a proposal by the Children's Health and Wellbeing Board (formerly Children and Young People's Joint Commissioning Board), to be considered as an informal Working Group of the Health and Wellbeing Board that focuses on children's services.

Recommendations

The Health and Wellbeing Board is asked to:

1. NOTE the contents of this report
2. ENDORSE the proposal that Children's Health and Wellbeing Board should operate as an informal Working Group to the Board as outlined in paragraph 3.4

1. Introduction

(1) Children's Health and Wellbeing Board (formerly Children and Young People's Joint Commissioning Board) discussed and agreed in principle to forge a more direct working relationship with the Health and Wellbeing Board (HWB) at its meeting on 5 February 2014.

(2) The expressed view of the Children's Health and Wellbeing Board (CHWB) is consistent with the direction of travel of the previous report to the HWB, titled "Working Arrangements Between Boards" on 17 July 2013. More recently, the HWB had endorsed the establishment of an informal Working Group focused on adult services. This group is better known as the Pioneer Steering Group, which is instrumental in helping to drive forward with the renewed focus on the health and social care integration agenda.

(3) The purpose of this report is to set out the proposed intention of and the in-principle decision of the CHWB, subject to the discussion and endorsement by the HWB.

2. Policy Context

(1) Working Together to Safeguard Children, (March 2013), sets out the latest children's services guidance that governs the work of all the relevant partnership organisations, in exercising their functions to contribute to keeping children and young people safe. It is noted that, Working Together references that fact that the Children Act 2004, **'**places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children'. The guidance also reiterates requirements to promote cooperation between the relevant partners.

(2) The CHWB recognises that the integration agenda, of which the HWB is the chief promoter, is also relevant to children's services, as it to adult services. Without an exception, all the key partners are considering or embarking on furthering service integration in order to improve outcomes for children and young people.

(3) One of the objectives of the Kent Joint Health and Well Being Strategy is to "transform services to improve health and care outcomes, the experience for patients/service users, and value for money and quality, for example better community care, moving services closer to home and improving access for patients and carers". This objective is consistent with the Every Day Matters, the strategic plan for children and young people endorsed by the CHWB and HWB.

3. Proposal for the Children's Health and Wellbeing Board to report to the Health and Wellbeing Board

(1) In the light of the assessment of the role, and how the Children and Young People's Joint Commissioning Board had operated, the CHWB formed the view that it would be beneficial to change its relationship with the HWB.

(2) The CHWB recognises the important place of the Joint Strategic Needs Assessment and its role in identifying needs, gaps in provisions and shaping commissioning (jointly where necessary) and integration of services where these would add value and improved outcomes.

(3) The CHWB acknowledges that one of its principal roles is to provide strategic leadership concerning children's services issues, and where necessary, encourage commissioners that sit across the spectrum of relevant partner organisations to pool resources, if not going for true integration.

(4) The CHWB is of the view that its intention to be re-established as the informal Working Group of the HWB, with a remit for children's services, logically provides a balancing effect, alongside the informal Working Group (the Pioneer Steering Group) concerned with adult services.

(5) There are compelling reasons for the agencies with responsibilities for children's services to mount a programme, similar in nature, to the Pioneer initiative that is driving the work of the Better Care Fund (previously Integration and Transformation Fund).

(6) The acceptance of the CHWB proposal put before the HWB would also cement the agreement to locate local children's arrangements under the umbrella of the local Health and Wellbeing Boards. It would simplify the reporting arrangements and provide a more visible reporting line from the local Children's Operational Group to the local Health and Wellbeing Board and to the Kent HWB.

(7) The proposed arrangements would also have the effect of streamlining the relationship between the HWB and the Kent Safeguarding Children Board. The Protocol between the Kent Safeguarding Children Board and the Joint Commissioning Board would be revised accordingly.

4. Conclusion

(1) This report has put forward the positive intention of the CHWB to report to the HWB for the reasons set out in the preceding paragraphs. It has identified the need as well as some of the benefits that could come out of the proposals.

(2) The decision to move the function of local children's arrangements under the sphere of the local Health and Wellbeing Board would be further strengthened.

5. Recommendations

The Health and Wellbeing Board is asked to:

5.1 **NOTE** the contents of this report

5.2 **ENDORSE** the proposal that Children's Health and Wellbeing Board should operate as an informal Working Group to the Board as outlined in paragraph 3.4 above.

Background Documents

Kent Joint Health and Well Being Strategy, 2013

Every Day Matters, 2013

Working Together, 2013

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