AGENDA

HEALTH AND WELLBEING BOARD

Wednesday, 12th February, 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, 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, Ms M Peachey, Mr S Perks, Dr R Stewart, Cllr P Watkins, and Mrs J Whittle

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 20 November 2013 (Pages 3 - 10)

5 The Better Care Fund (Pages 11 - 186)

6 Assurance Framework (Pages 187 - 210)

7 Children and Young People's Mental Health and Wellbeing Services (Pages 211 - 218)

8 Joint Strategic Needs Assessment - 2013/14 Exception Report (Pages 219 - 240)

9 Date of Next Meeting 26 March 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, 4 February 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, 20 November 2013.

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

IN ATTENDANCE: Dr A George (Consultant in Public Health), Mr M Lemon (Strategic Business Adviser), Ms J Mookherjee (Consultant in Public Health), Ms S Scamell (Commissioning Manager Mental Health), Ms P Southern (Director of Learning Disability and Mental Health), Mrs A Tidmarsh (Director of Older People and Physical Disability), Ms M Varshney (Consultant in Public Health) and Mrs A Hunter (Principal Democratic Services Officer)

UNRESTRICTED ITEMS

45. Chairman's Welcome

(Item 1)

(1) Mr Gough opened the meeting by reminding members of the board to complete declarations of pecuniary interest.

(2) He then welcomed Steve Inett, who will be the new chief executive of Healthwatch with effect from December 2013, and who was representing Healthwatch at the meeting.

(3) Mr Gough said he would write to all members of the HWB with more details about the Big Lottery Resilience Fund which was seeking to invest in programmes to develop the mental health resilience of young people.

(4) Mr Gough drew members' attention to the Public Health Annual Report which had been circulated to the HWB.

(5) He concluded by saying he had received a letter from an organisation called Escaping Victimhood that provided residential programmes for those bereaved by manslaughter or murder and offered to share the information with partners.

46. Apologies and Substitutes

(Item 2)

(1) Apologies for absence were received from Dr F Armstrong, Ms F Cox and Ms M Peachey.

(2) Dr M Cantor, Mr M Ridgwell and Mr Scott-Clark attended as substitutes for Dr F Armstrong, Ms F Cox and Ms M Peachey respectively.

(3) It was noted that Dr Lunt had replaced Dr Bora as a Dartford, Gravesham and Swanley CCG representative on the HWB.

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

There were no declarations of interest.

48. Minutes of the Meeting held on 18 September 2013
(Item 4)

RESOLVED that the minutes of the meeting of the Health and Wellbeing Board held on 18 September 2013 are correctly recorded and that they be signed by the chairman.

49. Joint Health and Social Care Learning Disability Self-Assessment Framework
(Item 5)

(1) Penny Southern (Director of Learning Disability and Mental Health) introduced the report which said that the Joint Health and Social Care Learning Disability Self-Assessment was a single delivery and monitoring tool that supported clinical commissioning groups and local authorities to assure NHS England, the Department of Health and the Association of Directors of Adult Social Services about progress against key priorities in the Winterbourne View final report (Annex B), Adult Social Care Outcomes Framework (2013-14), Public Health Outcomes Framework 2013-14 and the Health Equalities Framework.

(2) The report also asked the HWB to support and agree the submission to IHaL website which would allow the Public Health Observatory to analyse Kent against the nationally agreed benchmark and would enable Kent to assess its own progress.

(3) Tina Walker and Dawn Johnson (Co-chairs, Kent Learning Disability Partnership Board), Penny Southern, Sue Gratton (Associate partner, KMCS) and Malti Varshney (Public Health Consultant) gave a short presentation highlighting the key issues for Kent.

(4) **RESOLVED:**

(a) That the content of the report be noted.

(b) That Kent's Joint Health and Social Care Learning Disability Self-Assessment Framework be agreed and supported for submission and publication.

(c) That KCMS, Public Health and NHS England consider issues relating to nationally agreed screening programmes for people with learning difficulties.

(d) That the outcomes form part of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy for Kent.

(e) That a progress report sharing results and monitoring progress against the Kent Implementation Plan be received by the Health and Wellbeing Board in 2014.

50. Health and Wellbeing Strategy Outcome 4 - People with Mental Health are Supported to Live Well
(Item 6)

(1) The Health and Wellbeing Board considered a suite of papers that provided information about the range of services currently commissioned by clinical commissioning groups, Families and Social Care and Public Health. The Board also received an overview of current investment and performance of Adult Social Services and the clinical commissioning groups against Outcome 4 of the Kent Joint Health and Wellbeing Strategy- People with Mental Health Issues are supported to Live Well.

(2) Jill Roberts (Chief Executive of Sevenoaks Area Mind) gave a presentation about the Time to Change programme which aimed to end the stigma of mental health. This was followed by a presentation from Penny Southern, Jess Mookherjee, Hazel Carpenter and Dr Liz Lunt outlining the key headlines from the reports.

(3) At the end of the presentation the HWB considered how it might address the challenges outlined in the presentation, possible changes to the primary care system to stop people falling through the net and the barriers to delivering mental health services in Kent.

(4) During discussion the following issues were raised:
- Encouraging veterans to access health services in general;
- The transition of young people from child and adolescent mental health services to adult mental health services;
- Responding to people in crisis and the development of urgent care pathways;
- The numbers of children and adults with mental health issues being held in Police cells overnight because of a lack of suitable secure accommodation;
- Transition and continuing support for those who had participated in talking therapies; and
- The further development of relationships between primary care and other providers to ensure better care

(5) **RESOLVED:**

(a) That the continuing progress towards the Health and Wellbeing Strategy and the development of local resources to support it be noted.

(b) That a report on the specific issues raised be considered at a future meeting of the Board with a view to using it to inform the development of the next Kent Health and Wellbeing Strategy.

51. The Integration Transformation Fund

(Item 7)

(1) Mr Gough invited Dr Robert Stewart (Clinical Design Director) to join the meeting.

(2) Mr Gough proposed and the HWB agreed that:
- (a) Most of the meeting scheduled for 29 January 2014 be devoted to the Integration Transformation Fund especially as a submission to the Department of Health was due by 15 February 2014,
- (b) The meeting scheduled for 26 March 2014 be used to hear from a range of commissioners and look forward to the year ahead and beyond;
- (c) Dementia (one of the outcomes identified in the Health and Wellbeing Strategy) be considered in May 2014.

(3) Mark Lemon (Strategic Business Advisor) introduced a report called **The Integration Transformation Fund** (ITF) which gave an update on developments since August 2013 and in particular on the timescales and details issued by government and progress made in Kent.

(4) He drew particular attention to: the need to create a shared plan for the totality of health and social care activity and expenditure; the announcement of funding allocations to councils; the indicator set currently being considered by ministers; and the timetable for completion of the planning templates. He also said the Pioneer Integration Group had already met.

(5) Anne Tidmarsh (Director of Older People and Physical Disabilities) introduced a report called the **Department of Health Integrated Care and Support and Pioneer Programme** which provided an update on the governance arrangements for the delivery within the Integrated Care and Support Pioneer programme, the links with the Integration Transformation Fund and the terms of reference for the Kent Integration Pioneer Steering Group.

(6) She said there had been a meeting with the NHS Improvement and Delivery Programme Liaison Manager who clarified the outcomes anticipated from the Pioneer Programme and gave feedback on the reasons Kent had been chosen as a pioneer.

(7) During the discussion the following points were made:
- There was a need to articulate a clear and radical vision to bring services together and how they would be different by 2015;
- Emphasis should be on the Integration Pioneer and the need to guard against the ITF becoming an industry;

- Integration Pioneer status created the opportunity to draw best practice and innovation into Kent as well as providing access to those who could help overcome barriers to integration;
- Localism was extremely important and there needed to be coherence rather than absolute consistency across Kent.

(8) **RESOLVED:**

(a) That the delivery mechanisms for the ITF plan be noted and the Integration Pioneer Steering Group be mandated to begin co-ordination of the plan;

(b) That a programme support group be established from across the Board's member organisations to work on the Integration Pioneer Programme and the Integration Transformation Fund planning process;

(c) That the final draft of the ITF plan for Kent be received at the next meeting of the HWB on 29 January 2014.

(d) That the creation of the Integrated Pioneer Steering Group be noted subject to an amendment to the terms of reference from "Provide a strategic direction and oversee successful delivery of health and social care Integration in Kent" to "Provide advice on the strategic activity of the Health and Wellbeing Board in relation to health and social care integration in Kent."

(9) The HWB agreed to deviate from the order of the agenda and considered System Leadership next. The chairman invited John Deffenbaugh from Frontline and Laurie McMahon from Loop2 to join the meeting. The chairman said that the System Leadership project offer had been made to the HWB over a year ago and it was important to progress this to develop the approach to integrated commissioning.

(10) There was a discussion about the order in which the stages of the project should be conducted. The complexity and interlocking nature of the health economies in Kent; and the importance of localism and action at the health economy level was acknowledged; as was the need to involve local partners, providers, patients and carers and the urgency of developing a shared vision.

(11) **RESOLVED:**

(a) That John Deffenbaugh and Laurie McMahon be asked to establish a pattern of meetings at the whole system level both before and after the HWB meeting scheduled for 29 January 2014.

(b) That an event be arranged to clarify thinking prior to the meeting of the HWB on 29 January 2014.

(12) Abraham George (Consultant in Public Health) introduced a report called **Integrated Intelligence: how it will support integrated commissioning?** It made a case for whole systems intelligence and the need for a shift away from

analysing data at an organisational level to analysing information across the complete patient pathway.

(13) Dr George also said that integrated or whole systems intelligence was increasingly seen as the game changer for integrated commissioning and transformation to meet the future challenges faced in the health and social care economy. Much work had already been done in Kent to move towards developing a framework to understand how the use of health and social care services varied across the whole population, how and what services needed to be transformed and improved, to build local evidence for whole system change and to move towards an integrated model of care.

(14) **RESOLVED:**

(a) That the importance of this area of work and its links with the wider integration agenda be noted.

(b) That the establishment of a task and finish group, reporting to the HWB to support the Integration Pioneer Steering Group to establish the processes and mechanisms to construct the plan and deliver aims and objectives across Kent, be endorsed.

52. Assurance Framework
(Item 8)

Consideration of this item was deferred to another meeting.

53. Pharmaceutical Needs Assessment
(Item 9)

(1) Andrew Scott-Clark (Director of Public Health Improvement) introduced the report which: set out the statutory requirement for producing and publishing a pharmaceutical needs assessment (PNA); and sought agreement on the joint management of the process for undertaking the PNA and publishing the results in a Kent PNA and a Medway PNA).

(2) **RESOLVED:**

(a) That the requirements for producing and publishing a Pharmaceutical Needs Assessment be noted.

(b) That the establishment of a Joint Kent and Medway Steering Group to oversee the production, consultation and publication of the Kent Pharmaceutical Needs Assessment and the Medway Pharmaceutical Needs Assessment be agreed.

54. Co-option of members to the Health and Wellbeing Board
(Item 11)

(1) The report invited the Health and Wellbeing Board to consider a change to its terms of reference to enable it to co-opt members.

(2) **RESOLVED:**

(a) That the Selection and Member Services Committee be asked to agree an amendment to the terms of reference for the Health and Wellbeing Board to enable the co-option of non-voting members.

(b) That authority be delegated to the Head of Democratic Services, in consultation with the chairman of the Health and Wellbeing Board, to invite Dr Robert Stewart, Clinical Design Director, White Gate Design to become a non-voting, co-opted member of the Health and Wellbeing Board subject to an amendment to its terms of reference being agreed by the Selection and Member Services Committee.

55. Revisions to terms of reference for CCG level health and wellbeing boards
(Item 10)

(1) Mark Lemon (Strategic Business Advisor) introduced the report which set out a number of issues in the terms of reference for local health and wellbeing boards that needed clarification.

(2) Concerns were raised about the status of officers who are statutory members of the HWB at local health and wellbeing boards; the difficulties of having elected members of the local health and wellbeing boards who were subject to the Kent Code of Conduct for Members and advisory members who were not. Views were also expressed that proposals in the report were a pragmatic and right way to go forward.

(3) **RESOLVED** that a decision on this matter be deferred and officers be asked to consider further the issues raised.

56. Meetings for 2014
(Item 12)

RESOLVED that the dates of meetings of the Health and Wellbeing Board in 2014 be noted.

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By: Dr Robert Stewart, Chair Integration Pioneer Steering Group

To: Kent Health and Wellbeing Board, 12 February 2014

Subject: **The Better Care Fund**

Classification: Unrestricted

Summary: This paper presents the first draft of the Kent Better Care Fund Plan and outlines the further steps required in advance of final submission.

Recommendation(s)
The Kent Health and Wellbeing Board is asked to:
1. Agree the first draft of the BCF plan and endorse submission to NHS England;
2. Note the progress required to achieve a final submission and endorse the plan for continued activity.

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.

1.2 Kent is an Integrated Care and Support Pioneer supported to deliver integration at pace and scale. As Pioneers Kent has been challenged to ensure that our Better Care Fund is ambitious and helps deliver the transitional steps required to achieve true transformation within health and social care.

1.3 It was agreed by the Health and Wellbeing Board in November that the Integration Pioneer Steering Group would coordinate producing Kent's plan. A cross-partner working group is coordinating the development of the plan.

2. Ambitions of Kent's Better Care Fund

2.1 Within the Pioneer bid Kent identified the bold ambitions required to create whole system change and improve outcomes for citizens. The key ambition is to create an easily accessible health and social care system that is wrapped around the citizen with the GP as coordinator of their care.

2.3 The Better Care Fund will be used to:
- 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.
- Support people to stay well in their own homes and communities, wherever possible.
- Support people to take more responsibility for their own health and wellbeing.
- Reduce the pressure on the acute hospitals by ensuring the right services are available and accessible for people when they are required.

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

2.3 A key principle of Kent's Pioneer programme is the importance of valuing localism with objectives being developed and delivered within CCG areas. To facilitate this, the Kent plan is made up of CCG area plans, which provide the detail to inform the Kent picture and vision.

2.4 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.

3. Timetable

3.1 The first draft is presented to the Health and Wellbeing Board for consideration. This will then be submitted to NHS England on 14 February for ratification as part of the CCGs Strategic and Operational Plans. Feedback from this process will be received from NHS England to inform the submission of the final version on 4 April.

3.2 The HWB are asked to recognise that further work will be required prior to considering the final submission on 26 March. Based on initial feedback from NHS England this work includes the following:

- Evidence of engagement with providers – the context of the CCG plans needs to have been discussed with providers at a local level.
- Evidence of impact on providers and market readiness of potential providers.
- Further evidence of public engagement.
- Further development of detailed financial plans, with the aim of including more of the Kent £ within the Better Care Fund.
- Risks and identified mitigations based on risk of the schemes, risk of delivery and risk of non-delivery.
- Agreed metrics – linked to the wider context of the outcomes required by the schemes within the Better Care Fund.

3.3 The current draft of the plan identifies some of the steps required during February and March to achieve these outcomes.

4. Conclusion

4.1 Kent as an Integration Pioneer will deliver integrated care and support at pace and scale. The Better Care Fund underpins this and provides the mechanism to achieve key outcomes across the next two years and achieve the level of transformation required to make sustainable change.

4.2 Although the current first draft submission sets out the required level of ambition for how Kent will use the Better Care Fund it is recognised that further work is required on the Kent plan and the CCG level plans during February and March to ensure that they meet the required standards prior to final submission.

5. Recommendation(s)

The Kent Health and Wellbeing Board is asked to:

5.1 Agree the first draft of the BCF plan and endorse submission to NHS England.

5.2 Note the progress required to achieve a final submission and endorse the plan for continued activity.

6. Contact details

Report author:
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Contents:

Owner: The Kent Health and Wellbeing Board

Date: 12 February 2014

Version No: 1.0 First Draft Submission

1. Introduction

Health and social care integration in Kent is about improving outcomes for our 1.5million population through supporting independent living, empowering people and placing 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. The Kent approach has been to look at whole system integration; rather than working in one area and then moving on to others we have developed a comprehensive programme which supports integration across the entire health and social care economy.

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.

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. It will drive forward our integration programme, developing more community based services alongside the re-design and commissioning of new systems-wide models of care that ensure the financial sustainability of health and social care services; a proactive, rather than a reactive model that improves outcomes for people and means the reduction of hospital and care home admissions.

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

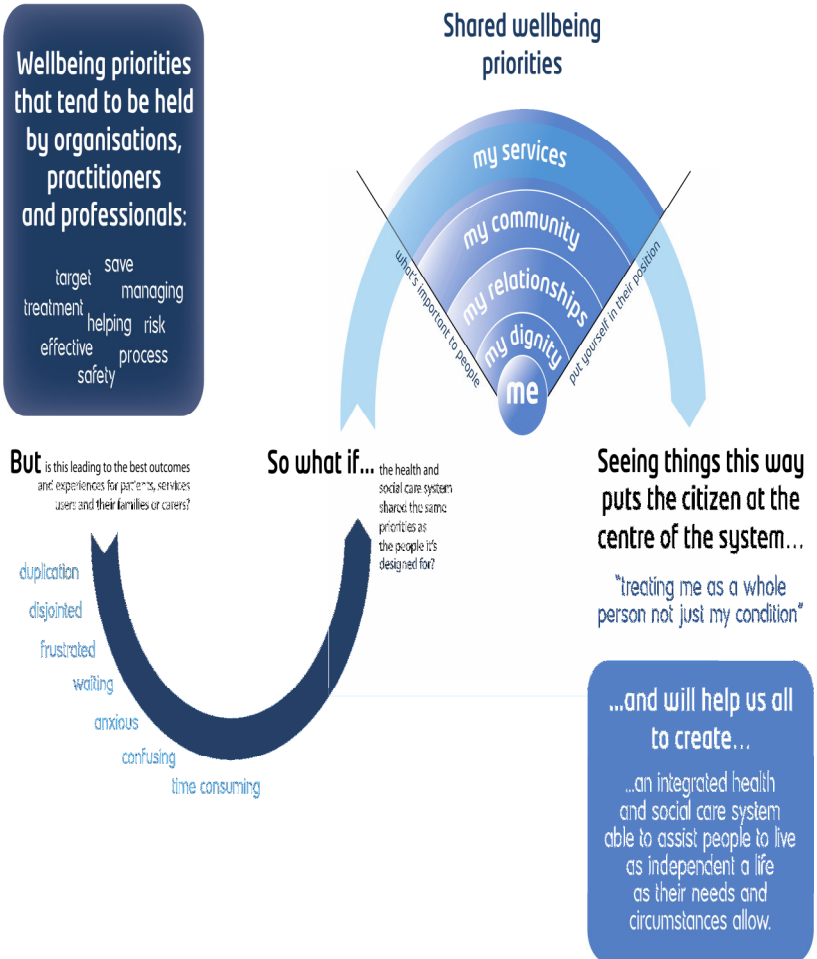
2. Our Vision

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 with improved outcomes for Kent's 1.5 million population and includes the Kent £ across the entire health and social care economy.

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 Kent Vision



We will use the Better Care Fund to:

- 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.
- 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".
- Support people to take more responsibility for their own health and wellbeing.
- Reduce the pressure on the acute hospitals by ensuring the right services are available and accessible for people when they are required.
- Get the best possible outcomes within the resources we have available.

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. They also have access to some really great You Tube videos which help them to understand supporting someone with diabetes.

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.

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

Integrated Commissioning:

- Together we will review current models of integrated care, and re-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.
- 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.

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.

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.

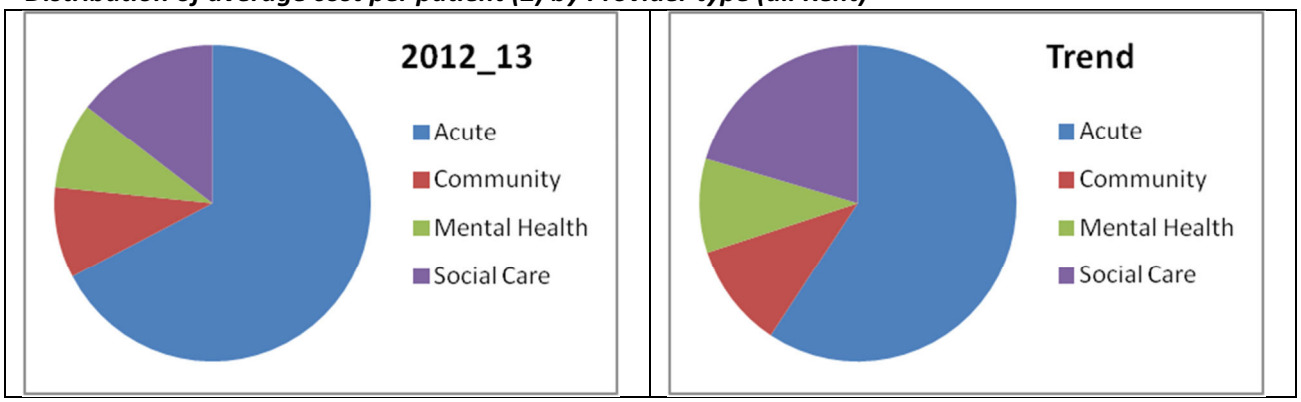
The value of the Better Care Fund across Kent is £27m in 2014/15 and £101m in 2015/16, however Kent as a Pioneer wants to go further than this and by 2018 be considering the Kent £ across the entire health and social care economy.

Year of Care

Kent is an early implementer of the Year of Care tariff which will help establish improved funding streams going forward. 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.

YOC is currently forecasting the need for a shift in trend of spend across the health and social care system to deliver whole system transformation:

Distribution of average cost per patient (£) by Provider type (all Kent)



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. We will work together to ensure we are reviewing the current commitments to ensure they are achieving what we was agreed in the original business case. 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. The tables below captures our current plans on a thematic Kent wide level, full detail of local implementation is provided in the appendices.

The Kent Better Care Fund
Our Model of Integrated Services

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

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

"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 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

(12 February 2014 v1.0)

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	Description	Investment	
		Min £000	Max £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.	16153	17000
Ease of Access to Services	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.	1610	2000
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.	3228	3603
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 join accommodation strategy to support the needs of Kent.	531	970
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.	649	649
Falls Car Service	An appropriately equipped and staffed vehicle that can respond to emergency falls requests and install measures designed to enable someone to remain in their own home.	759	759
Access to health and social care information	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.	759	1334
Supporting implementation of Integration	Support the coordination of delivery of integration through the HASCIP / Pioneer Programme Team.	310	685
	Total		**£27m**

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Note: **further detailed analysis on the amounts of finance allocated to schemes is taking place within local areas; this includes a commitment to providing additional funding to the baseline BCF.**

2015/16 Schemes	Description	Finance		
		Baseline BCF £000	New Investment £000	Total £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.			
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.			
Integrated personal health and social care budgets	Extend the use of personal health budgets, social care budgets and implementation of integrated budgets, including the use of the Kent Card.			
Pro-active care	Support the principle of unequal investment to close			

2015/16 Schemes	Description	Finance		
	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.	27000		
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.	7,208		
ASC Capital Grants	Home support fund and equipment.	3,432		
Implementation of the Care Bill	Carers assessments and support services; Safeguarding Adults Boards; and national eligibility.			
Carers support	Continue to develop carer specific support – including carers breaks.			
	Total	**£101m**		

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:

- 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.

Year of Care is providing additional metric information to inform final submission.

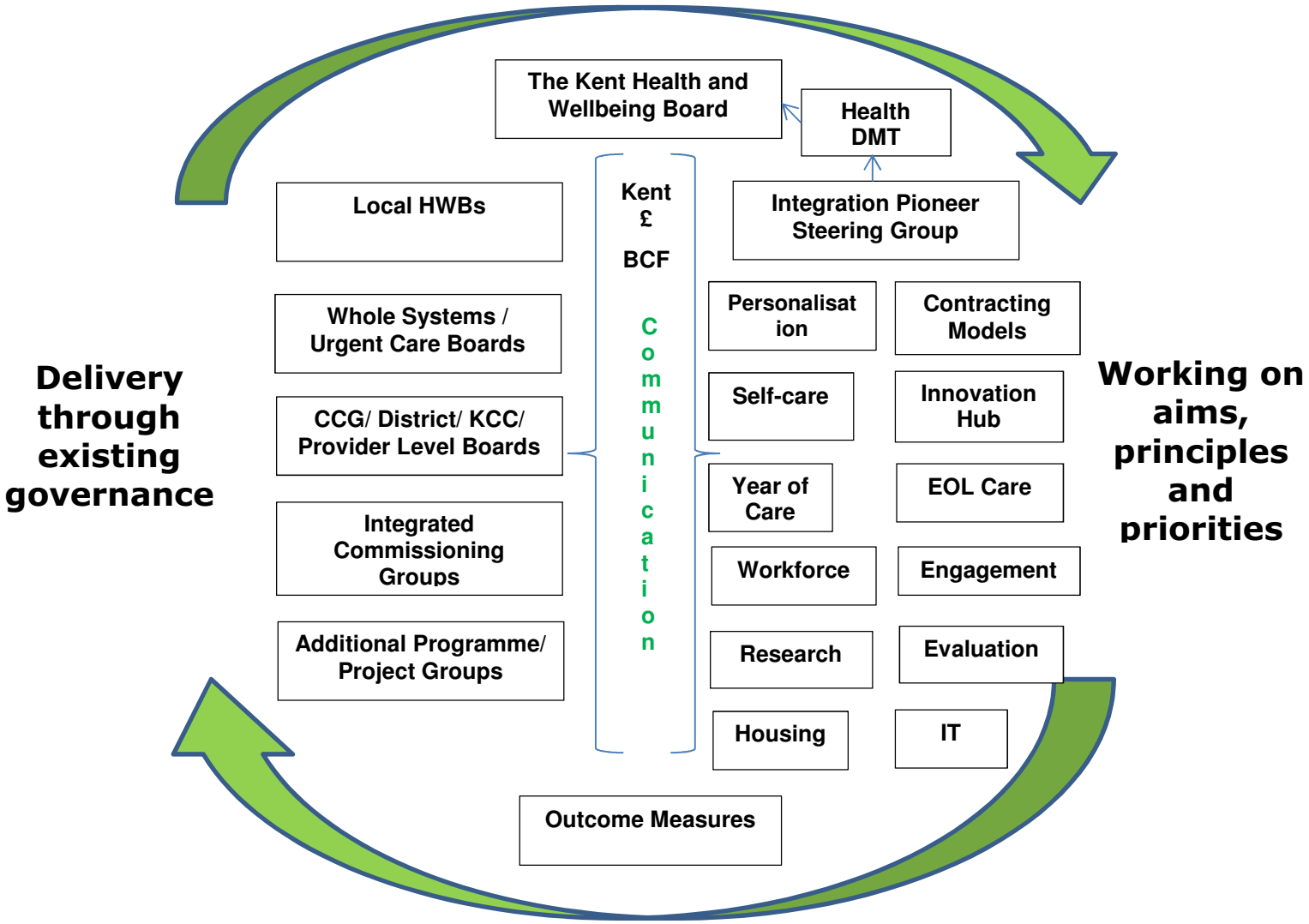
Metric	Current Sept 2013	Baseline Sept 2014	Progress April 2015	Target Sept 2015
Permanent admissions to residential and care homes				
Effectiveness of reablement – those 65+ still at home 91 days after discharge.				
Delayed transfers of care				
Avoidable emergency admissions				
Patient / service user experience	Kent will use the national metric provided			
Local metric to be confirmed based on area plans				

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.

Any additional local governance for delivery of area plans is 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 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

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:	**To be agreed 12 February 2014**
Date submitted:	**First draft 14 February 2014**
Minimum required value of BCF pooled budget: 2014/15	**£27m (provisional)**
2015/16	**£101m (provisional)**
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	**Dartford Gravesham and Swanley**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>
Signed on behalf of the Clinical Commissioning Group	**Swale**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

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Signed on behalf of the Clinical Commissioning Group	<Name of ccg>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>
Signed on behalf of the Clinical Commissioning Group	**West Kent**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>
Signed on behalf of the Clinical Commissioning Group	**Ashford**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>
Signed on behalf of the Clinical Commissioning Group	**Canterbury and Coastal**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>
Signed on behalf of the Clinical Commissioning Group	**South Kent Coast**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>
Signed on behalf of the Clinical Commissioning Group	**Thanet**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>
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>

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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 will be finalising the development of the Kent plan and is mixed group of commissioners and lead providers. They will be meeting 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 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 and Integrated Commissioning Groups across Kent.

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 is required to ensure that providers have been engaged in discussing the outcomes of the plan and the risk and impact of required changes to the system.

During February and March further engagement activities are scheduled on a local area basis to ensure all providers are aware and engaged with the contents of the plan. This includes discussions at local HWBs, Integrated Commissioning Groups, Whole System Boards and Health and Social Care Integration Programme area steering groups.

Facilitated discussions on a care economy level will be arranged to finalise the detail of local BCF plans. The first of these discussions has already taken place for North Kent on 29 January.

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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.

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

Further engagement activity has been undertaken as part of Call to Action. **Further evidence of this will be provided prior to submission in April.**

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 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.

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.

Kent will seek to further engage the public on the contents of the plan throughout February and March via local networks and a public communication campaign via Twitter.

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	**Pioneer Draft Delivery Plan currently included –**

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Support Programme Plan	**full version to be available via link April 2014**  1401 delivery plan v01 .xlsx
HWB Assurance Framework	**To be included – link to HWB paper**
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.

Kent's geographical size and range of stakeholders presents opportunities and challenges in rolling out integrated services across the whole area but there is a determination across the whole system to demonstrate that it can be done. While 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.

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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:

- 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.
- 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".
- Support people to take more responsibility for their own health and wellbeing.
- Reduce the pressure on the acute hospitals by ensuring the right services are available and accessible for people when they are required.
- Get the best possible outcomes within the resources we have available.

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

<u>Integrated Commissioning:</u>

- Together we will design and commission new systems-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.

<u>Integrated Provision:</u>

- A proactive model of 24/7 community based care, with fully integrated multi-disciplinary teams across acute and community services with primary care playing a key co-ordination role. The community / primary / secondary care interfaces will become integrated.
- We will have a workforce fit for purpose to deliver integrated health and social care services. To have this, we need to start planning now and deliver training right

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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.

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 5 outcomes identified within the Health and Wellbeing Strategy:

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

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.

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.

Further measures and the health gain for population will be identified prior to final submission in April.

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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 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). They are aligned with the objectives of the Kent Health and Wellbeing Strategy as detailed above, form part of CCG Commissioning Plans and the Kent Families and Social Care Adult Transformation Plan.

Further work is required prior to April submission to outline the direct impact on existing providers of the implementation of the schemes and the consideration of market readiness of other potential providers. Work will take place within care economy groups convened to further develop detailed plans. Examples include work in North Kent with partner agencies The Kings Fund and Newton Europe.

2014/15 Schemes	Description	HWB outcomes and national conditions supported by scheme
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.	• 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	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.	• 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
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.	• Effective prevention of ill health by people taking greater responsibility for their health and wellbeing. • Protection of social care services.

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2014/15 Schemes	Description	HWB outcomes and national conditions supported by scheme
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 join 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.	• 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.
Falls Car Service – as part of an integrated falls pathway	An appropriately equipped and staffed vehicle that can respond to emergency falls requests and install measures designed to enable someone to remain in their own home.	• 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.
Access to health and social care information	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.	• Effective prevention of ill health by people taking greater responsibility for their health and wellbeing. • Better data sharing between health and social care. • Joint approach and coordinated care planning.
Supporting implementation of Integration	Support the coordination of delivery of integration through the HASCIP / Pioneer Programme Team.	• 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. • Plans jointly agreed.

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2015/16 Schemes	Description	HWB outcomes and national conditions supported by scheme
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.	• 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	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.	• 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.
Integrated personal health and social care budgets	Extend the use of personal health budgets, social care budgets and implementation of integrated budgets, including the use of the Kent Card.	• Effective prevention of ill health by people taking greater responsibility for their health and wellbeing. • Better data sharing between health and social care. • Joint approach and coordinated care planning.
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.	• Joint approach and coordinated care planning. • Plans jointly agreed.
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	• Effective prevention of ill health by people taking greater responsibility for their health and wellbeing. • The quality of life for people with

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2015/16 Schemes	Description	HWB outcomes and national conditions supported by scheme
	technology, patient held records and the development of Dementia Friendly Communities.	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 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 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

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.

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 between 10 – 33%.

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

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

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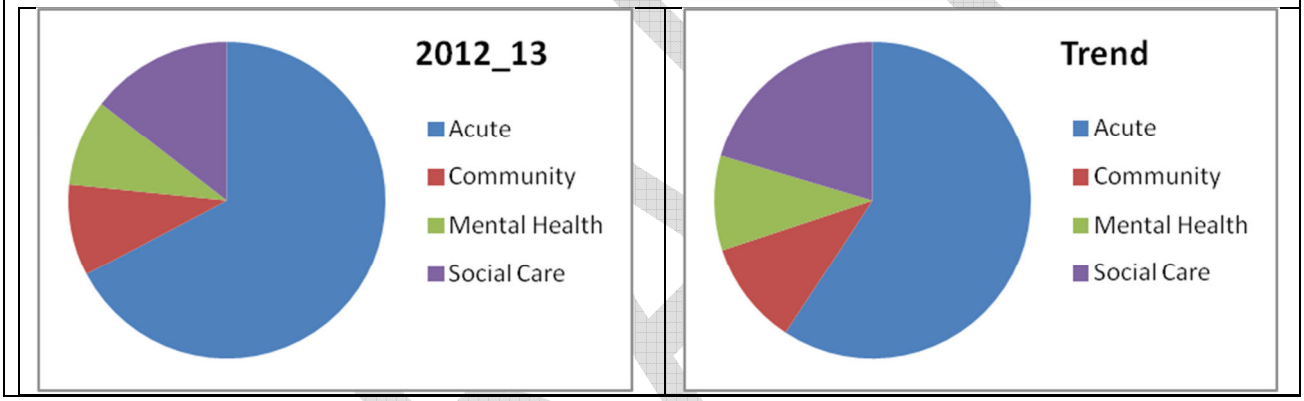
Detailed investment and benefit management plans will be designed throughout 2014/15 in line with CCG and Social Care commissioning plans. **Further work will take place prior to submission in April to quantify the impact on the acute sector and contingency if savings are not achieved. This will take place at the care economy groups to be convened.**

A summary of the local plans **(to date)** 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.

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:



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.

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

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Appendix A Kent Submission – First Draft v1.0

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

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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.

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. 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.

Further work required with data to be inserted from Year of Care/Risk Stratification/MDT report on % of adult population at high risk, % with a joint care plan and accountable professional

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

Further work is required to provide detail of risks and mitigations – with a particular focus on risk of schemes, risk of delivery and risk of non-delivery.

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. • **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.
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**	• **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.**

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		• 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**	• **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.
Protection of social care is 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.

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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)
Kent County Council				
Dartford Gravesham and Swanley		3278	**14947**	
Swale		1440	**6556**	
West Kent		6760	**26394**	
Ashford		1736	**7321**	
Canterbury and Coastal		3050	**12564**	
South Kent Coast		3532	**13283**	
Thanet		2265	**9699**	
BCF Total		**27000**	**101404**	

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.

To be completed - contingency

Contingency plan:		2015/16	Ongoing
Admissions to residential and care homes	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Effectiveness of reablement	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Delayed transfers of care	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Avoidable emergency admissions	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Patient / service user experience	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Local Metric to be agreed	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
Enabling people to return to/or remain in the community									
Ease of Access to Services									
Enabling Prevention and Self Care									
Expand integrated commissioning of schemes that produce joint outcomes.									
Falls prevention exercise classes									
Falls Car Service									
Access to Health and Social Care Information									
Supporting Implementation of Integration									
Section 256 Social Care to benefit health									
Disabled Facilities Grant									
ASC Capital Grants									
Implementation of the Care Bill									
Integrated working through local models that deliver 7 day access									
Residential and Nursing Homes									
Integrated personal health and social care budgets									
Self Care / Self Management									
Tackling Health Inequalities									
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.

To be completed -

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 Metric to be completed

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

Contingency

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 Kent will be using the national metric (under development)			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

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:	**3 February (1st Draft for 12 Feb Kent HWB)**
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 - £4,543,143**
2015/16	**£13,283,000 – 18,862,575**

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>

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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 local South Kent Coast Integrated Commissioning Group who is overseeing the development of the Better Care Plan has included representation from local providers to help shape the plan and the schemes within it. 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.

Elements of the Better Care Plan include 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

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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?

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 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

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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).

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.

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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

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:

(1) <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 and coordinate post-discharge support into the community linking with the community based Neighbourhood Care Teams, primary care and the voluntary sector.

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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.

(2) <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

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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 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;
- 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;
- 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 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.

(3) <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.

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SCHEME REQUIREMENTS:

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 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.

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;
- 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.

(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 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

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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.

(5) 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 disability in a safe home environment.

SCHEME REQUIREMENTS:

An integrated approach to local housing and accommodation provision to enable more people to live safely in a home and other environments

- 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 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.

(6) 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

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- 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. A detailed programme plan is under development to set out timeframes for delivering each of the schemes. 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.

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.

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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.

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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 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.

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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

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

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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 (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.

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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 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

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		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)
Kent County Council				
South Kent Coast		3,884,000 - 4,543,143	13,283,000	13,283,000 - 18,862,575
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
Admissions to residential and care homes	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Effectiveness of reablement	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Delayed Transfers of care	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Avoidable emergency admissions	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Patient and service user experience	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
Integrated Teams and reablement		2,692,336		-129,506		6,313,704 - 8,921,504		-129,506	
Enhanced Neighbourhood Care Teams and care coordination		441,210		-88,828		5,633,624 - 7,946,256		-88,828	
Enhance primary care		544,957 - 1,204,100		-87,464		720,718 - 1,379,861		-87,464	
Enhance support to care homes		0		-168,498		259,457		-168,498	
Integrated health and social housing approach		179,435		-42,042		179,435		-42,042	
Falls prevention		26,062		-77,135		176,062		-77,135	
Total		3,884,000 - 4,543,143	0	-593,473	0	13,283,000 - 18,862,575	0	-593,473	0

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*	1774.9	N/A	1759.7
	Numerator			
	Denominator			
		(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		72.4	N/A	72.25
		(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*	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.

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>

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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 heakth 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

A number of Thanet commissioning schemes included in its operational plans for 2014

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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

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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)
- 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

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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
- 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*

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- *% patients with long term conditions known to the team*
- *% of admissions avoided from A&E*

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

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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.

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

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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 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*

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- *GP practice and patient satisfaction*
- *% of admissions of patients seen by the team*
- *% 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

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wider health and well-being needs supported by primary care. This will 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*
- *Numbers of:*
    - *hospital admissions from care homes*

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- *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:

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,

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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.

e) Governance

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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 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

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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 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

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		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)
Kent County Council				
Thanet CCG		3,045,000	9,699,000	9,699,000
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
Scheme 1									
Scheme 2									
Scheme 3									
Scheme 4									
Scheme 5									
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.

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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Appendix A Kent Submission – Draft v0.2

Better Care Fund planning template – Part 1

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Kent County Council**
Clinical Commissioning Groups	**Canterbury & Coastal**
Boundary Differences	**There are some boundary differences between CCGs and District authorities. Swale CCG also connects with Medway. 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	**Canterbury & Coastal CCG**
By	Bill Millar
Position	Chief Operating Officer
Date	30/1/14
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>

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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

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 is based upon. The Integration Pioneer Working Group who have 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.
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 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.
Kent will seek to further engage the public on the contents of the plan throughout February and March via local networks.
The CCG has existing forums for engagement with patients, care homes and volunteer agencies which will support the projects
Canterbury HWB

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	
Kent Health and Wellbeing Strategy	
Kent Integrated Care and Support Programme Plan	**To be inserted**

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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?

The vision for 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

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?

- 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.
- Support people to stay well in their own homes and communities, wherever possible – avoiding unnecessary A&E attendance and avoidable admissions to hospital.
- Support people to take more responsibility for their own health and wellbeing.
- 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.

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.

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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

Continued development of Integrated Teams

The CCG and KCC will continue to develop the role of the Health & Social Care Co-ordinator and Neighbourhood Care Teams to support 7 day working to deliver services, across all providers in line with outcome of local Community Services Review and East Kent Integrated Urgent Care Strategy, to;

- Support a reduction in A&E attendance and admission avoidance
- Timely discharge from all providers
- Support patients to remain in own homes for treatment and care
- Support carers in time of crisis
- Support patients and carers to play active role in delivery of health care
- Support self management through education, technology, provision of information and advice and guidance
- Provision of signposting linking in with urgent care and primary care

Continued development of care home project

- 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.
- Access to integrated community teams to support ability to care for patients within their own home
- 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

Projects to reduce urgent care activity

- In addition to above we will develop an integrated urgent care system incorporating the following:
- Primary (including Out of Hours provider) and community focused front end at Kent & Canterbury Hospital linking in with the community Neighbourhood Care Teams and Health & Social Care Co-ordinators.
- The model will support all age ranges and will include mental health
- Integrated discharge teams working across secondary and community teams. This will include rapid response
- Integrated loan store service which can be accessed by health and social care
- Community based ambulatory care pathways

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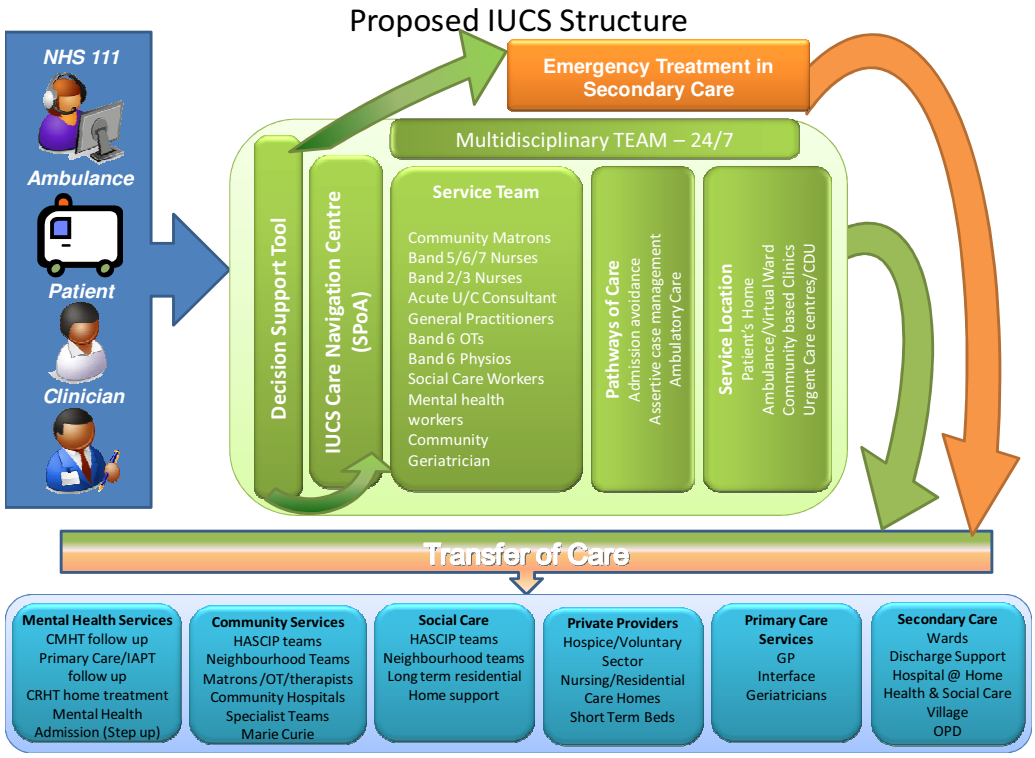

Mental Health Services

The CCG and KCC will work with all partners to deliver improved mental health services for all ranges to support:

- Increased schemes to support health minds and early interventions
- Crisis support for all care pathways
- Integrated models for all pathways to support patients within range of pathway

Support to patients to manage own condition

The CCG will work with all partners to ensure that patients and carers and fully informed and supported at all stages of their condition to allow them to make informed choices to support:

- Education at all stages of disease pathway
- Access to peer support
- Increase in number of patients using Personnel Health Budgets
- Links to technology to support patients ability to manage condition
- Self 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. An integrated telecare / telehealth solution, where necessary backed up 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

Key Success Factors

These will include:

- Reduction in secondary care activity and associated spend
- Increased patient satisfaction
- Reduction in patient reliance on medical intervention, including medicines management, through increase in patients self management at start of pathway
- Reduction in patient handovers and duplication of services through increased

efficiencies
- Increased skill development across all professionals

To support the above 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

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.

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 will ensure delivery and the Integration Pioneer Steering Group provide advice and guidance.

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

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

c) Data sharing

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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.

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. As a Pioneer Kent is a participant in a number of national schemes reviewing information governance – including the 3 Million Lives IG workstream. 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.

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 introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, 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.		
Workforce Education establishments will be required to review current training schemes to support ability to transfer care		
Destabilisation of providers		
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.		

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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	**Ashford**
Boundary Differences	**There are some boundary differences between CCGs and District authorities. And Swale CCG also connects with Medway. 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	**Ashford**
By	Bill Millar
Position	Chief Operating Officer
Date	
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>

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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

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 is based upon. The Integration Pioneer Working Group who have produced the Kent plan is 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.
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 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.
Kent will seek to further engage the public on the contents of the plan throughout February and March via local networks.
The CCG has existing forums for engagement with patients, care homes and volunteer agencies which will support the projects
Ashford HWB

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	
Kent Health and Wellbeing Strategy	
Kent Integrated Care and Support Programme Plan	**To be inserted**

Appendix A Kent Submission – Draft v0.2

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?

The vision within Ashford locality s that through working with partners we can deliver services which are fully integrated and supports the following:

- Reduction of duplication process and delivery
- Supports parity of esteem across the population
- Reduces identified inequalities
- Reduces unnecessary activity within secondary care
- Reduces unnecessary social care activity
- Has patient safety at heart of all we commission
- Improves the patients journey
- Delivers 7 day working 24 hours a day across health and social care
- Incorporates innovation across service delivery
- Demonstrates value for money

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?

- 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.
- Support people to stay well in their own homes and communities
- Support people to take more responsibility for their own health and wellbeing.
- Reduce unnecessary activity within secondary care by ensuring the right services are available and accessible for people when it is required.
- Get the best possible outcomes within the resources we have available.

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

<u>Integrated Commissioning:</u>

- Together we will design and commission new systems and models of care that ensures the financial sustainability of health and social care services in Kent. These services will give people every opportunity to receive personalised care at, or closer to home to avoid hospital and care home admissions.
- We will use an integrated commissioning approach to buy integrated health and social care services where this makes sense.
- The Health and Wellbeing Board will be an established systems leader, supported by clinical co-design and strong links to innovation, evaluation and research

networks. Integrated Commissioning will be achieving the shift from spend and activity in acute and residential care to community services, underpinned by JSNA, Year of Care financial model and risk stratification. We will have a locally agreed tariff system across health and social care commissioning.

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.

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.

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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

Continued development of Integrated Teams

The CCG and KCC will continue to develop the cluster integrated teams with recognised community hubs which will deliver 7 day services to deliver:

- Services to support admission avoidance
- Timely discharge from all providers
- Supports patients to remain in own homes for treatment
- Supports carers in time of crisis
- Supports patients and carers to play active role in delivery of health care
- Supports self-management through education, technology, provision of information and access to advice and guidance
- Provision of signposting linking in with urgent care and primary care

Continued development of care home project

- The CCG and KCC will continue to support care homes and will extend this project to residential care to provide the following:
- Access to community matrons and integrated teams to support ability to care for patients within their own home
- Increased community geriatrician support linking in with the recognised GP for the care setting
- Medicines management support
- Joined up approach to quality overview and timely interaction where issues are identified
- Development of Westview facility to support ethos of community hub

Projects to reduce urgent care activity

- In addition to above we will develop integrated urgent care system incorporating the following:
- Primary and community focused front end within William Harvey Hospital linking in with the community based cluster teams and community hubs
- The model will support all age ranges and will include mental health
- Integrated discharge teams working across secondary and cluster teams. This will include rapid response
- Integrated loan store service across health and social care
- Community based ambulatory care pathways

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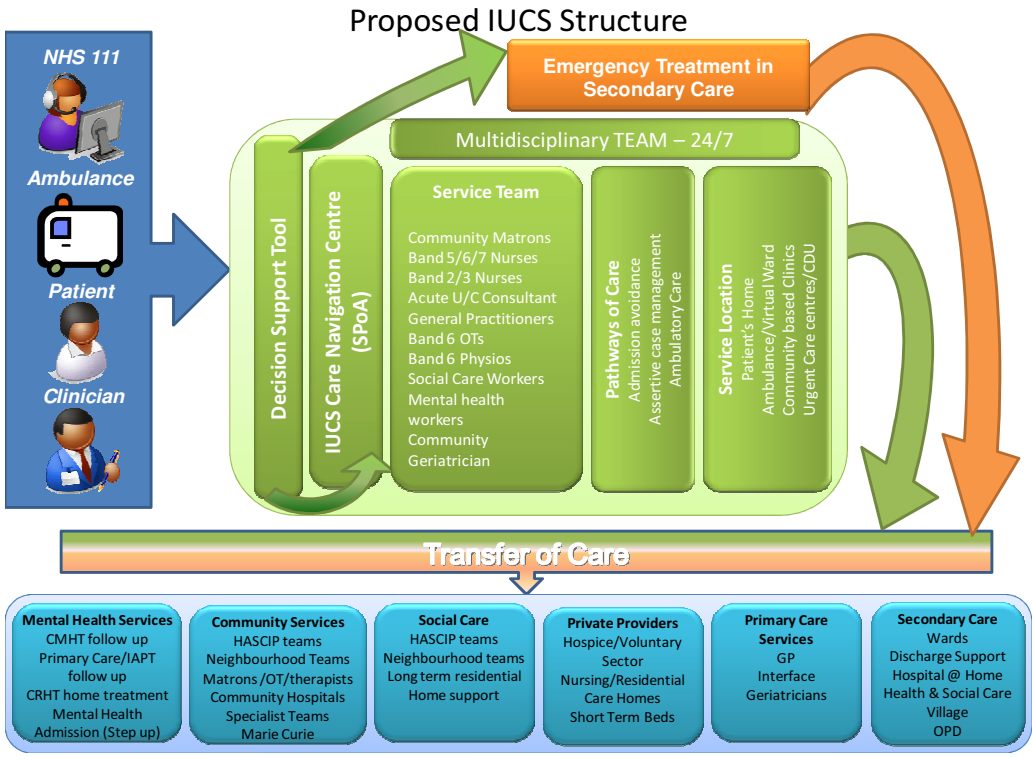

Mental Health Services

The CCG will work with all partners to deliver improved mental health services for all 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

Support to patients to manage own condition

The CCG will work with all partners to ensure that patients and carers and fully informed and supported at all stages of their condition to allow them to make informed chicest to support:

- Education at all stages of disease pathway
- Access to peer support
- Increase in number of patients using Personnel Health Budgets
- Links to technology to support patients ability to manage condition
- Self 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. An integrated telecare / telehealth solution, where necessary backed up 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

Key Success Factors

These will include:

- Reduction in secondary care activity and associated spend
- Increased patient satisfaction
- Reduction in patient reliance on medical intervention through support of patient at start of pathway and there increase in self-management

- Reduction in patient handovers and duplication of services and through increased efficiencies
- Increased skill development across all professionals

To support the above 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

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.

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 will ensure delivery and the Integration Pioneer Steering Group provide advice and guidance.

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

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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.
, community resilience, safeguarding, support for carers and dementia services

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.
In addition the above schemes will 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.

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. As a Pioneer Kent is a participant in a number of national schemes reviewing information governance – including the 3 Million Lives IG workstream. 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.
- 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.

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 introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, 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.		
Workforce Education establishments will be required to review current training schemes to support ability to transfer care		
Destabilisation of providers		
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.		

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		1,378	*4,878*	*2,443*	
Canterbury CCG		2,481	*8,837*	*2,481*	
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
Scheme 1									
Scheme 2									
Scheme 3									
Scheme 4									
Scheme 5									
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.

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

Vision Document

North Kent CCGs

Swale, and Dartford, Gravesham and Swanley CCGs

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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, 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.

2. Our Vision for 2018/19 – what this will mean for the people we service

2.1 Our vision for whole system integrated care is based on what people have told us is most important to them (see appendix X). 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 who 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

[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

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 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 needs and ensuring that there is clinical evidence behind every decision.
- Get the best possible outcomes within the resources we have available; delivering integrate services wherever possible to avoid duplication

3.0 Our vision - What this will mean for our health and social care services

3.1 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 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 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.

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.

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.

3.2 Measuring success

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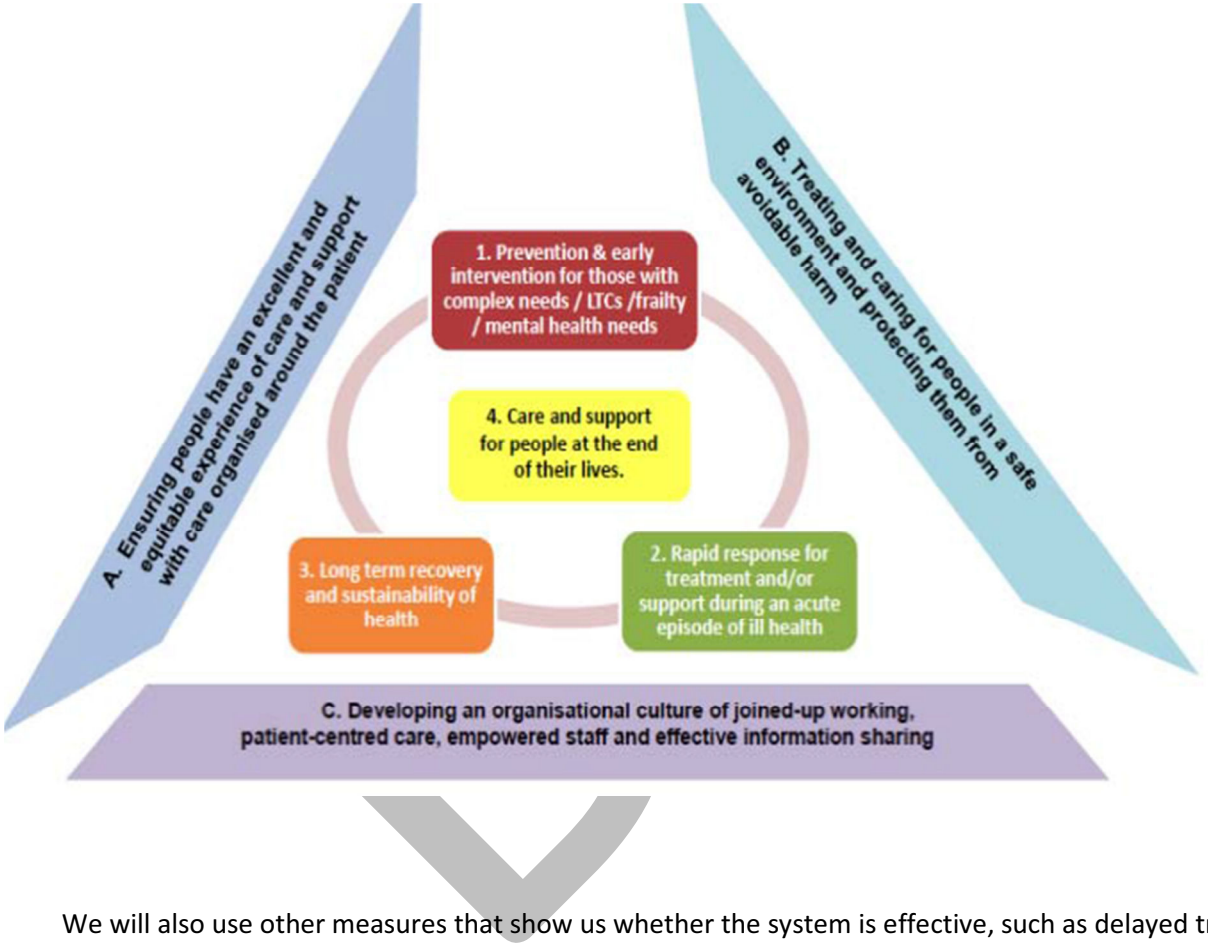
We will measure our success primarily by analysis of demand for acute health services (such as emergency bed days) and formal social care services (such as a paid agency carer supporting someone at home, or someone moving into residential or nursing care home), using current levels of demand as a baseline (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

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.

3.3 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.

3.4 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.

3.5 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, 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-centered.

3.6 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.

4.0 A Proposed Model

4.1 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;

- **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.

- **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 15,000 and 30,000 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 needs.

  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 (inclusive of enablement and re-ablement)
  - 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 and Health prevention workers
  - We would expect District Nurses would 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 third sector providers such as the voluntary sector and District Councils to ensure full packages of care 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.

- **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 care 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 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 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.

Rapid Response services 24/7

Local Referral Unit / 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 work, that the number of patients unknown will be reduced. However, it is accepted that patients ill 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 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 domiciliary care to provide 24/7 support as required
- Crisis Mental Health Teams (including functional and Dementia)
- Clinical assessment utilizing specialist nurses, paramedic practitioners and roving GPs

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- **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)

- **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 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.

  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.

- **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.

5.0 The Financial Implications

5.1 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 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.

Our estimate of the mandated value of the BCF across North Kent is £9.25m in 2014/15, which will grow to £21.5m in 2015/16; however, our ambition is to go much further than this.

5.2 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.

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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

Better Care Fund must detail how they 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.

5.3 What are the key areas for investment through the BCF?

5.3.1 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 Kent County Council in this way are identified in the table below.

Table: Analysis of Better Care Fund Plan Funding Streams

Funding Stream	National 'Pot'	DGS CCG Allocation 13/14	Swale CCG Allocation 13/14
NHS Funding	**£1.9billion**		
Carers Breaks Funding	£130m	£205k	£204k
CCG Reablement Funding	£300m	£730k	£464k
Adult Social Care Capital Grant	£129m	£483k	£208k
Disabled Facilities Grant (Capital)	£225m	£1014k + £200.34k* = £1214.34k	£437 -£97k* = £340k
Current transfer from NHS to Social Care (Non recurrent)	£900m	£3.269m	£1.1m
Additional transfer from NHS (2014/15)	£200m	£723k	£311k

*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

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	£1.214	Disabled Facilities Grant – Swale CCG	£0.340
Total Better Care Fund DGSCCG	**£16.644**	**Total Better Care Fund Swale CCG**	**£7.104**

CCG revenue funding potentially subject to pay-for-performance measures

- DGS CCG - £4320m
- Swale CCG - £1895m

In 2014/15 we will be investing between £Xm and £Xm of additional health funding into 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.

We will use the BCF to:

No.	Schemes 2014/15	Description	Investment		
			Recurrent / Non-recurrent North Kent CCGs	Min £000	Max £000
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) Includes CCG's re-ablement funding	Recurrent	£10.35	£11.5m
			Non Recurrent	£1.35m	£1.5m
BCF02	Primary Care Investment	Local reconfiguration of Locally Enhanced Services budget – including the Visiting Medical Officer (VMO) and % of the cost reduction relating to admission avoidance. This will include the £5/ head allocation under the GMS revised contract. There is an expectation that NHS England will provide support to re-configure the estate around confederation of practices.	Recurrent	TBC	TBC
			Non Recurrent	TBC	TBC
BCF03	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.	Recurrent	£8.6m	£9.576m
			Non Recurrent		N/A
BCF04	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	Recurrent		
			Non Recurrent		
BCF05	Integrated Discharge	7 day per week provision 8am – 10pm. In line with	Recurrent		N/A

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No.	Schemes 2014/15	Description	Investment		
			Recurrent / Non-recurrent North Kent CCGs	Min £000	Max £000
	Teams (DVH and MFT) Strengthen 7 day social care provision in hospitals within IDT	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.	Non Recurrent	£3.78m	£4.2m
BCF06	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	Recurrent	£7.65m	£8.5m
			Non Recurrent		N/A
BCF07	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	Recurrent	TBC	TBC
			Non Recurrent		
BCF09	Developing self-management and peer support	Working with individuals and through 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	Recurrent	TBC	TBC
			Non Recurrent		
BCF10	Primary Prevention	Delivery of agreed health inequality reduction strategy and implementation plan	Recurrent	£0.135	£0.150
			Non Recurrent		
BCF11	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)	Recurrent	£1.4m	£1.554m
			Non Recurrent		
BCF12	Accommodation Strategy	A joint accommodation strategy and implementation plan is required, with appropriate range of accommodation available.	Recurrent		TBC
			Non Recurrent		
BCF13	Adult Social Care Capital Grant			£0.622	£0.691

NB: Need to check AQP contracts / KMPT contract / SECAMB – Hear and Treat and See and Treat activity / Crisis Support contracts / COPD rehab contracts and include in next iteration

The minimum is a 10% reduction on maximum budget

First stage draft. Currently working through the overall funding arrangements with KCC . During 14/15 a number of the schemes have commenced and will be accelerated in 14/15 through the use of section 256 health re-ablement funds and health commissioning intention investments aligned to non-elective reductions

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and achievement of the 10% reduction in conversion to admission expected this year. This will be progressed to 15% in 15/16.

6.0 How will we know if we have achieved our vision?

6.1 GPs, 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.

6.2 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.

6.3 Primary and community care services will be working closer together, along with voluntary organisations and other independent sector organisations.

6.4 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.

6.5 Pressure on the acute hospitals will reduced, we will see fewer acute emergency / non elective admissions and reduced length of stay.

6.6 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
- 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

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- 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.

6.7 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.

6.8 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.

6.9 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.

6.10We 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.

7.0 Suggested Metrics for development?

- **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 condtion.

- **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 (funding for practices plans of £5/head for each practice. 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.

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- **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, 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.

8.0 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

8.1 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

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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.

9.0 Next Steps

This document is a draft, designed to share current progress and thinking around the development of the BCF in North Kent. The proposals within this document will be 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

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.

These were:

- **IDT 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.
- **Delivery of Dementia specialist care** 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 15-30,000 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 final approval) for a specific funding pot to pump prime the above initiatives in 14/15. 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 14/15 year.

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 1014/15 as a prelude and move towards delivery of the BCF from 2015.
Feb	Strategic Commissioning Meeting - Detailed agreement of the implementation planning and outcome measures for 2014/15
Feb	Kings Fund workshops to confirm commitment to delivery within the draft by all provider and Commissioner Executive CEO
Feb	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.

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Appendicies

1. **DGS Health Economy Integrated Discharge Team SLA**

DGS Health Economy Integrated Discharge

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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	**<Name of Local Authority>**
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:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£0.00**

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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	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>

<Insert extra rows for additional CCGs as required>

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

<Insert extra rows for additional Councils as required>

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

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

c) 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 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 are planned for the 6th and 18th February. In addition workshops to review these proposals have been held on a kent wide basis

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(16th January) and North Kent (29th January) basis, which included health and social care commissioners and health providers.

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

These plans are i) aligned with the CCG commissioning plans; which are informed by stakeholder engagement – this is in the form of workshops which are open to members of the public, voluntary groups, local authority representatives, and health providers. Details of workshops held by each CCG can be provided. ii) Informed by patient engagement on a review of community services that took place in 2013. Information on the results of this engagement can be provided *Details re whole plan stakeholder engagement to be added.*

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 Strategies 2014 to 2019	
Draft CCG Operating Plans 2014-2016	
Better Care Fund Vision document	

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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?

2.1 Our vision for whole system integrated care is based on what people have told us is most important to them (see appendix X). 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 who 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 will:

1. Keep people at the heart of everything we do, ensuring they are involved and listened to in the development of our plans
2. 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
3. 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
4. Safeguard vital services, prioritising people with the greatest health needs and ensuring that there is clinical evidence behind every decision.
5. Get the best possible outcomes within the resources we have available; delivering integrate services wherever possible to avoid duplication

3.0 <u>Our vision - What this will mean for our health and social care services</u>

3.1 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 early intervention, and by managing demand in this way, a decrease in the need for more

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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 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.

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.

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.

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?

3.2 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. 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

NHS Outcomes Framework Domains

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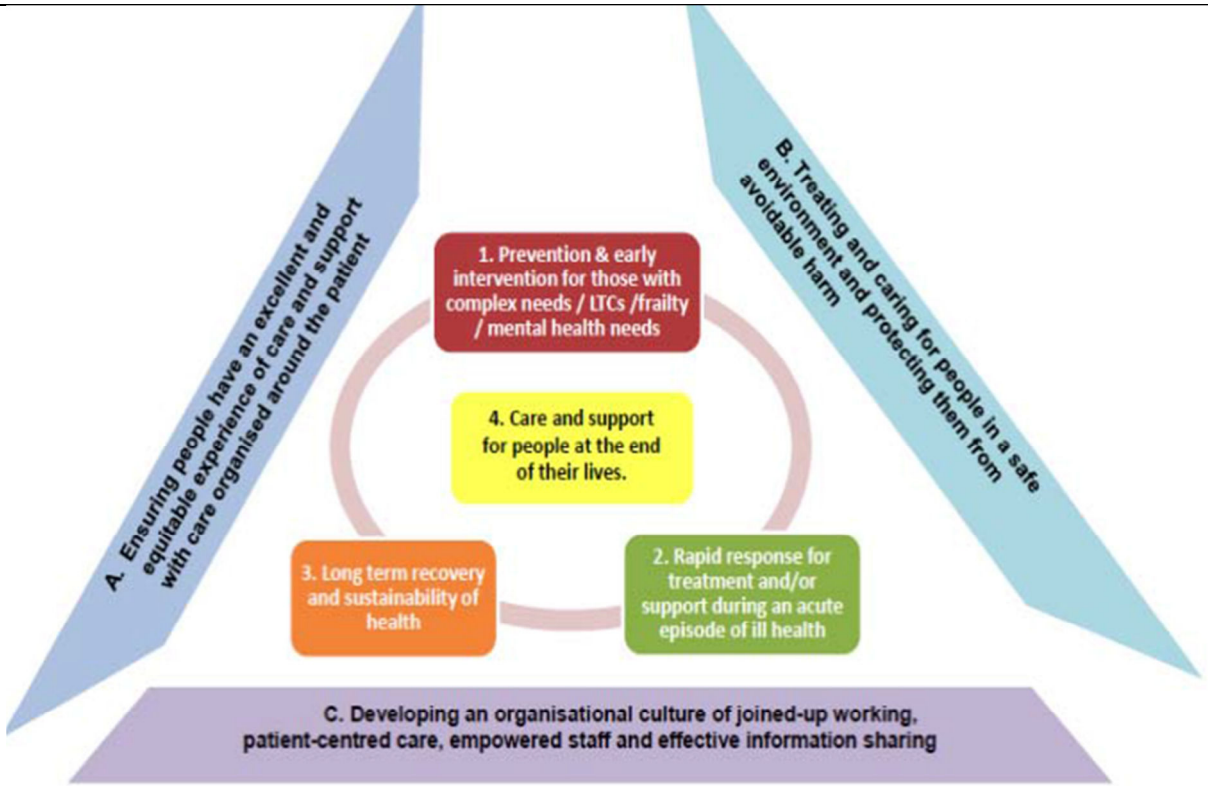

We will also use other measures that show us whether the system is effective, such as delayed transfers of care, the effectiveness of short-term recovery-focused services like reablement, and patient and user experience of services. We will therefore seek to deliver services that have a positive impact as measured by these measures.

3.3 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.

3.4 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.

3.5 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, 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.

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

4.0 A Proposed Model

4.1 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;

f) **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.

- **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 10,000 and 20,000 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 needs.

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 (inclusive of enablement and re-ablement)
- 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 and Health prevention workers
- We would expect District Nurses would 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 third sector providers such as the voluntary sector and District Councils to ensure full packages of care 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.

g) **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 and social care 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 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 and social care support to return back to independent living. Assistive technology, telecare and telemedicine 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.

Rapid Response services 24/7

Local Referral Unit / 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 work, that the number of patients unknown will be reduced. However, it is accepted that patients ill 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 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 domiciliary care to provide 24/7 support as required
- Crisis Mental Health Teams (including functional and Dementia)
- Clinical assessment utilizing specialist nurses, paramedic practitioners and roving GPs

- **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)
-
- **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 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.

  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.

h) 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.

6.0 How will we know if we have achieved our vision?

6.1 GPs, 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.

6.2 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.

6.3 Primary and community care services will be working closer together, along with voluntary organisations and other independent sector organisations.

6.4 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.

6.5 Pressure on the acute hospitals will reduced, we will see fewer acute emergency / non elective admissions and reduced length of stay.

6.6 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;

3) People and particularly those patients with long term conditions accessing support and information to manage their own health and social care to proactively prevent

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deterioration of their condition

4) Carers supported and they will have access to services that enable them to manage their own health.
5) Feedback from people with long term conditions demonstrating that they feel more enabled to manage their health
6) Ill Patients having improved experience and feeling supported to manage their health and social care.
7) Easier access to information, advice and guidance will be available.
8) 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.

6.7 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.

6.8 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.

6.9 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.

6.10 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.

7.0 Suggested Metrics for development?

- **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 condtion.

- **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 (funding for practices plans of £5/head for each practice. 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.

- **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, 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.

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).

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

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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. We have established regular meetings to discuss and agree strategic commissioning priorities.

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9) 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.

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.

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.

As part of the existing governance structure between CCGs, social care, local authorities and KCC (through a number of routes but predominantly through local and County level health and well being boards), a joint Executive Level Strategic Commissioning Group has been established across North Kent, including KCC, CCG, health provider and Health and Wellbeing Board representation has been established, to set the strategy for the BCF plans, and review development and implementation.

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.

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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

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).

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 will be working towards 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.

Joint plans will be implemented through the integrated neighbourhood 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		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 impact on NHS Providers		To be considered through contract negotiations.
Failure to deliver the reduction in acute emergency admissions		Detailed BCF plan and project management approach to implement n System changes and monitor impact

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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 (k)	Minimum contribution (15/16) (k)	Actual contribution (15/16) (k)
Local Authority #1				
Swale CCG	N	14991	£ *6,393.60*	£ *7,104.00*
Dartford, Gravesham and Swanley CCG	N	*20199*	£ *14,979.60*	£ *16,644.00*
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.

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

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)	TBC	
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
Integrated Discharge Team	DVH / MFT	*0*	*4156.318*	*5621400*		*TBC*	*TBC*		
Integrated Primary Care Team	KCHT	*11458.6*	*1500.6*	*as above*		*TBC*	*TBC*	*as above*	
Accomodation Strategy	KCC	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*
Community Strategy	KCHT	*8499.0*	*0*	*as above*		*TBC*	*TBC*	*as above*	
IT Integration	KCC / CCG	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*
Rapid Response and LRU	KCHT	*9576.0*	*0*	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*
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.

Currently in development as part of the preparation of submission for CCG operational plans

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.

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*			
	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)*
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 highest areas of health inequalities.	*Metric Value*	TBC		
	Numerator			
	Denominator			
		April 2013 to December 2013	*(insert time period)*	*(insert time period)*

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Appendix E West Kent BCF Plan

Owner: The West Kent Health and Wellbeing Board

Date: 31 January 2014

Version No: 0.6 draft

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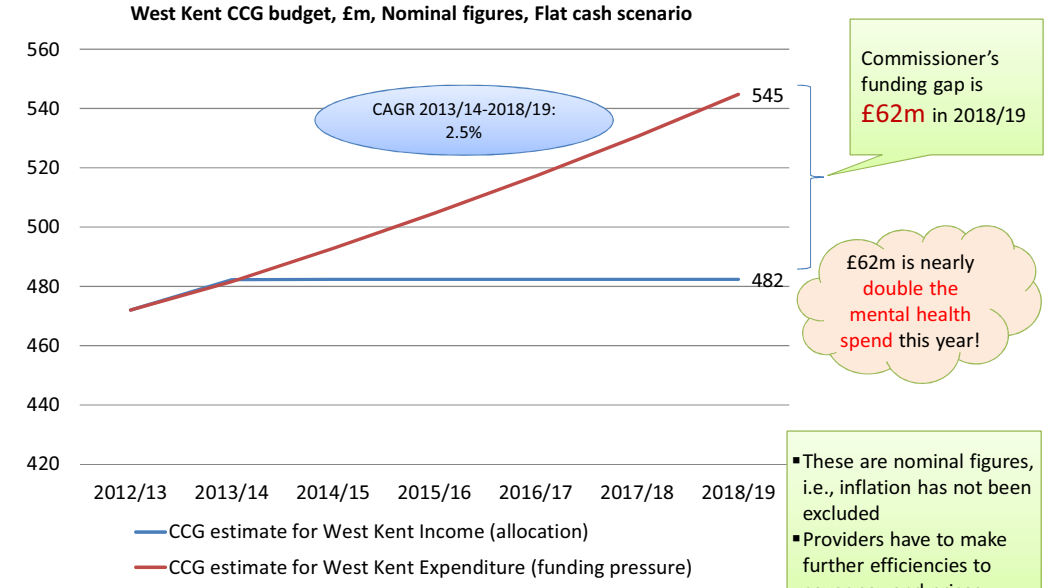
1. Introduction

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

If we do not change our health services there will be a widening gap between our income and spend



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

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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 intial 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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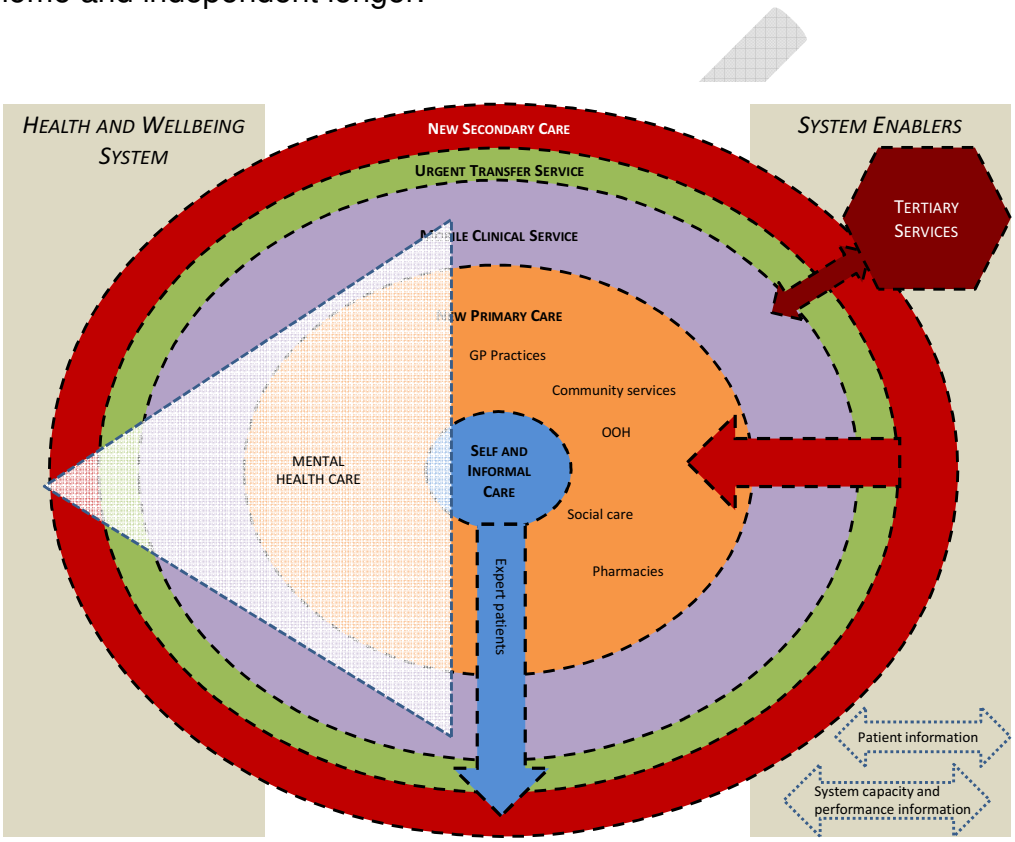
2. West Kent's Vision

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.

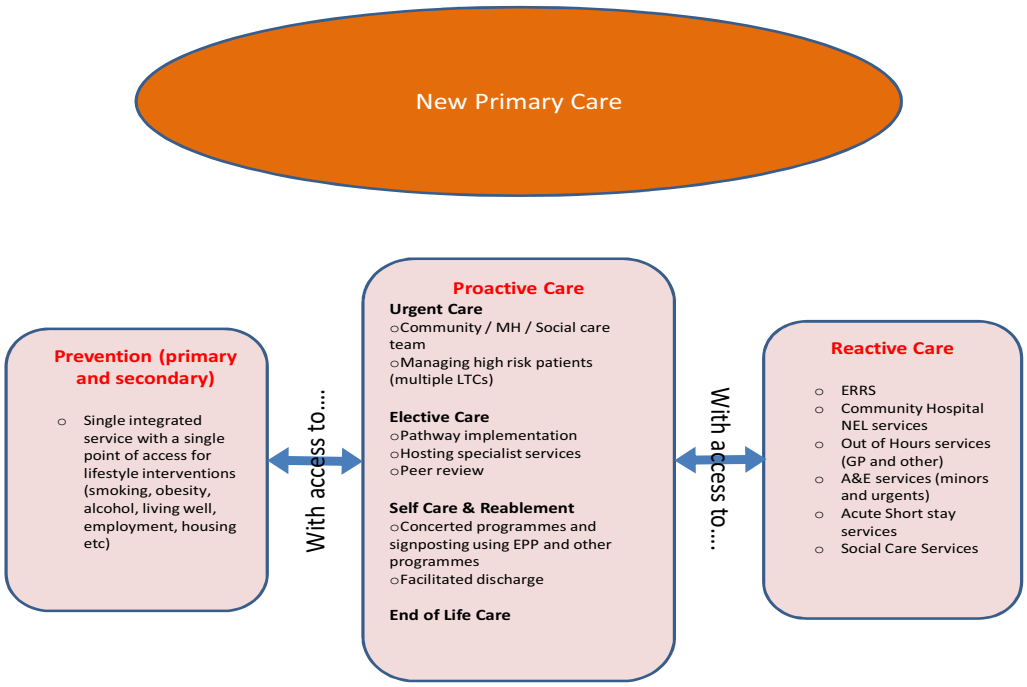


It introduces a new model of Primary Care focussing on three distinct but interlinked areas of care (prevention, proactive and reactive) creating larger scale GP led multi-disciplinary teams which are wrapped around a suitably sized group of practices.

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, 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

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)
- Reduced occupied number of bed days (draft local measure)
- Social Care related quality of life (draft local measure)
- Health related quality of life for people with long term conditions (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)	New Investment (£000)	Total (£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	2111*		
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	1379*		
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	3001*		
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	KCC to add WK Kent share		
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	8156*		

DRAFT

2015/16 Scheme Proposed	Description	Investment		
		Baseline BCF (£000)	New Investment (£000)	Total (£000)
	• Ensure provision of mental health and dementia is within all 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	2050i		
Total		Add total amount		

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

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.

DRAFT

Metrics

Admissions to residential and care homes	Tba
Effectiveness of reablement	Tba
Delayed transfers of care	Tba
Avoidable emergency admissions	Tba
Patient / service user experience	Tba
Draft local metrics: • Reduced occupied number of bed days • Social Care related quality of life (from ASCOF 1A, linked to NHSOF 2) • Health related quality of life for people with long term conditions (from NHSOF2 linked to ASCOF 1A)	Tba

5. Governance and management of Better Care Fund

Need to add diagram to illustrate relationship across the system in West Kent of these groups

Integrated Commissioning POG
Urgent care POG
Planned Care POG
Mental Health POG
Clinical Strategy Group
Governing Body
West Kent Health and Wellbeing Board
Kent Health and Well Being Board

DRAFT

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.

WORKING DRAFT

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:	12 February 2014
Date submitted:	14 February 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

b) Authorisation and signoff

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

Signed on behalf of the High Weald Lewes Havens Clinical Commissioning Group	
By	Frank Sims
Position	Accountable Officer
Date	X March 2014

Signed on behalf of Maidstone Borough Council	
By	Alison Broom
Position	Chief Executive
Date	X March 2014

Signed on behalf of Sevenoaks District Couoncil	
By	Pav Ramewal
Position	Chief Executive
Date	X March 2014

Signed on behalf of Tonbridge & Malling Council	
By	Julie Beilby
Position	Chief Executive
Date	X March 2014

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

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

Signed on behalf of the Kent Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Roger Gough
Date	X 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.

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 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 are scheduled on a local area basis to ensure all providers are aware and engaged with the contents of the plan. This includes commissioning intention letters issued in September 2013 and will include discussions at the West Kent Health and Well-Being Board as well as contract monitoring and negotiation meetings.

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 groups.

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 plan throughout February and March 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	**To be inserted**
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

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 focussing on three distinct but interlinked areas of care (prevention, proactive and reactive) creating larger scale GP led multi-disciplinary teams which are

WORKING DRAFT

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.

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

WORKING DRAFT

to ensure that financial and contractual levers are aligned and promote access to shared information management systems

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

What success will look like

- buy more provision of reablement and 7 day access to services 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 ie hospital buildings and maximise use of human resources ie 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

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.

Could be useful to set out other dimensions including impact on bed capacity and workforce of current acute configuration

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.

WORKING DRAFT

e) Governance

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

Need to add diagram to illustrate relationship across the system in West Kent of these groups
Integrated Commissioning POG
Urgent care POG
Planned Care POG
Mental Health POG
Clinical Strategy Group
Governing Body
West Kent Health and Wellbeing Board
Kent Health and Well Being Board.

WORKING DRAFT

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.

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.

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 .

WORKING DRAFT

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.

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.

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.

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 – including the 3 Million Lives IG workstream. 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 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.

WORKING DRAFT

Data to be inserted from Year of Care/Risk Stratification/MDT report on % of adult population at high risk, % with a joint care plan and accountable professional

WORKING DRAFT

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
Cost reductions arising from a reduction in urgent care admission do not materialise	To be added	To be added
Cost reductions arising from a reduction in occupied bed days do not materialise	To be added	To be added
Cost reductions arising from a reduction in residential and care homes do not materialise	To be added	To be added
Reductions in delayed transfer of care are not achieved	To be added	To be added
The introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, 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.	To be added	To be added
Workforce	To be added	To be added
Destabilisation of providers–	To be added	To be added
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.	To be added	To be added

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*	

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.

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)*
draft local measure - Reduction in number of occupied bed days	*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, linked to NHSOF 2)	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	*(insert time period)*	*(insert time period)*
draft local measure - Health related quality of life for people with long term conditions (from NHSOF2 linked to ASCOF 1A)	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	*(insert time period)*	*(insert time period)*

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By:	Roger Gough Cabinet Member for Education and Health Reform
To:	Kent Health and Wellbeing Board
Date:	12th February 2014
Subject:	Assurance Framework
Classification:	Unrestricted

For Decision:

The Health and Wellbeing Board is asked to:

- Note the contents of the report
- Agree the amendments and additional indicators proposed following discussions with stakeholders.
- Consider and recommend reporting requirements at Local Health and Wellbeing Boards

1. Introduction

This report aims to provide the Kent Health and Wellbeing Board with performance figures on a suite of indicators based on Kent's Health and Wellbeing Strategy; it is arranged on the 5 Outcomes with additional stress indicators. This report outlines details of Outcome 2: Effective prevention of ill health by people taking greater responsibility for their health and wellbeing.

As agreed at the Health and Wellbeing Board meeting in September 2013, the indicators were drawn from a number of existing frameworks and responsible agencies across Kent and England:

- Kent Public Health and the Public Health Outcomes Framework (PHOF)
- NHS Outcome Framework
- Families and Social Care and the Adult Social Care Outcome Framework
- NHS England South Escalation Framework

Previously it was proposed that each report would have an overview of every indicator, however each Outcome domain would be focused on in turn per report, allowing for a manageable approach to monitoring the indicators. Stress indicators will be presented in more detail in every report.

2. Progress since the last report

Since the last Health and Wellbeing Board meeting held in Nov.2013, a number of discussions and developments have taken place, the Board are asked to note and agree the proposals.

- The report to contain the national metrics stated in the Better Care fund; in most cases these metrics were already present in the framework. Metrics on avoidable emergency admissions and patient/service user experience are to be defined and developed in future reporting.

- Additional indicators have been added to reflect the evolution of local and national data sets. These are highlighted within the report.

- Following discussions with the Area Team (NHS England), changes have been made to the section previously titled System Stress Indicators to now reflect stress indicators across the different components of the system – Public Health, Acute/Urgent, GP and Social Care. Work is on-going to ensure the most appropriate indicators have been identified.

- Discussions have taken place with Healthwatch Kent on the inclusion of indicators reflective of their service; Healthwatch Indicators will be added to future reports following on-going discussions.

The Board is also asked to consider future reporting on the Assurance Framework to local Health and Wellbeing Boards.

Key to KPI Ratings used

GREEN	Target has been achieved or exceeded
AMBER	Performance at acceptable level, below target but within 10%
RED	Performance is below 10% of the target
⇧	Performance has increased relative to previous levels (not related to target)
⇩	Performance has decreased relative to previous levels (not related to target)
⇔	Performance has remained the same relative to previous levels (not related to target)

Data quality note: All data is categorised as management information. All results may be subject to later change.

Geographical Comparisons: Comparisons have been made, in addition to England, to Trafford and Bedford; both are within Kent's Socioeconomic Decile Group – Decile 7 Less Deprived as outlined in the mortality rankings. Trafford and Bedford were the closest to Kent within the group based on the median value for deprivation and adjusted ranking.

Report Prepared by

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3. Indicator executive summary

The following tables provide a visual summary of the indicators within each outcome domain. The recent status refers to the rating for the last reporting period; the direction of travel similarly refers to the movement from the last reporting period. **If an indicator has not been RAG rated that indicates that there is no current specified target at this stage**.

Outcome 1: Every child has the best start in life

Indicator Description - Targeted	Previous status	Recent status	Direction of travel	Recent time period
1.1 Increasing breastfeeding Initiation Rates	Temporary suspension. Recommencement March 2014			
1.2 Increasing breastfeeding continuance 6-8 weeks	Temporary suspension. Recommencement March 2014			
1.3 Improve MMR vaccination uptake – two doses (5 years old). **Target for this indicator is 95%**	87.2%	90.5%	⇧	2011/12
1.4 Reduction in the number of pregnant women who smoke at time of delivery	16.8%	15.2%	⇩	2011/12

Indicator Description - Associated	Previous status	Recent status	Direction of travel	Recent time period
1.5 Unplanned hospitalisation for asthma (primary diagnosis) people aged under 19 years old (rate per 10,000)	19.7	19.6	⇩	2012/13
1.6 Unplanned hospitalisation for diabetes (primary diagnosis) people aged under 19 years old (rate per 10,000)	8.1	9.5	⇧	2012/13
1.7 Unplanned hospitalisation for epilepsy (primary diagnosis) people aged under 19 years old (rate per 10,000)	8.4	6.9	⇩	2012/13
1.8 Decrease CAMHS average waiting times for routine assessment form referral (incl. Medway). **Target for this is 4 weeks**	7 weeks	5 weeks	⇩	October 2013
1.9 Increase proportion of SEN assessments within 26 weeks. **Target for this is 90%**	90.6%	94.3%	⇧	December 2013
1.10 SEN Kent children placed in independent or out of county schools (number)	537	553	⇧	December 2013
1.11 Reduction in conception rates for young women aged under 18 years old (rate per 1,000)	35.3	31.0	⇩	2011

For Outcome 1, indicators on MMR Vaccination uptake, pregnant women who smoke at time of delivery, unplanned hospitalisation for asthma and epilepsy, CAMHS waiting times, SEN assessments within 26 weeks and conception rate for under 18 years old are all

heading in the right direction, either increasing or decreasing appropriately. None have a RAG rating of Red against existing targets.
The rate of unplanned hospitalisation for diabetes (primary diagnosis) for people aged under 19 years old shows a small increase. Although this is more likely to be related to Type 1 diabetes, further local analysis may need to be undertaken to understand what proportion are due to Type 1 and Type 2 diabetes, and if it is increasing over time. This analysis will assist in service improvement action planning at a local level.

The number of SEN Kent children placed in independent or out of county schools has increased overall across the year, however there were decreases in the numbers from June through to September 2013. This indicator is being monitored by Kent County Council and a 3-year plan has been implemented.

Outcome 2: Effective prevention of ill health by people taking greater responsibility for their health and wellbeing

Indicator Description - Targeted	Previous status	Recent status	Direction of travel	Recent time period
2.1 Reduction in the under-75 mortality rate from cancer (rate per 100,000)	-	104.76	▬	2009-11
2.2 Reduction in the under-75 mortality rate from respiratory disease (rate per 100,000)	-	22.4	▬	2009-11
2.3 Increase in the proportion of people receiving NHS Health Checks of the target number to be invited (proxy for under-75 mortality from cardiovascular disease). **Target for this is 50%**	28.3%	38.7%	⇧	Q2 2013/14
2.4 Increase in the number of people quitting smoking via smoking cessation services (number. proxy for under-75 mortality). **Target for this is 9,249**	1,527	1,353	⇩	Q2 2013/14
2.5 Reduction in the number of hip fractures for people aged 65 and over (rate per 100,000)	477.0	469.0	⇩	2011/12
2.6 Reduction in the rates of deaths attributable to smoking persons aged 35+ (rate per 100,000)	207	198	⇩	2009-11

Indicators on mortality rates have been revised since the previous reports and it is expected that these will be amended again in the next PHOF release.

Reductions are occurring in both hip fractures and deaths attributable to smoking; however it will be important that local analysis is taken into consideration to draw firm conclusions. This will ensure that in case of local areas that may be seeing an increase will then have an action plan to address the identified issues.

NHS health checks and smoking cessation services are currently performing below targeted levels. Kent Public Health is monitoring both services and will be using CCG level data to identify areas of under-performance and develop local plans to address these. Addressing underperformance through local plans is important to ensure populations that are at a high risk of a cardiovascular event can be identified at an early

stage, and receive appropriate interventions either through lifestyle changes or through pharmacological treatment.

Outcome 3: The quality of life for people with long term conditions is enhanced and they have access to good quality care and support

Indicator Description - Targeted	Previous status	Recent status	Direction of travel	Recent time period
3.1 The proportion of older people (65 and older) mostly at risk of long term care and hospital admission, who were still at home 91 days after discharge from hospital in reablement/ rehabilitation services. ***This has been moved to Adult Social Care System Stress (6.8) and is also a BCF indicator.***				
3.2 Clients with community based services who receive a personal budget and/or direct budget. **Target for this -77%**	76%	73%	⇩	September 2013
3.3 Increase the number of people using telecare and telehealth technology (number). **Target for this is 1,750**	1,937	2,276	⇧	September 2013

The proportion of clients who receive a personal and/or direct budget has decreased from the previous quarter; however the actual number has increased as have the numbers on the caseload further, thereby producing a lower proportion. The target for the recent status is 77%, rising to 84% for Quarter 3.

There has been an increase in the number of people using a telecare service and has exceeded the target for the full year of 2,200. Telecare is a mechanism to allow people to live independently and to support after a period of enablement.

Outcome 4: People with mental health issues are supported to "live well"

Indicator Description - Targeted	Previous status	Recent status	Direction of travel	Recent time period
4.1 Reduction in the number of suicides (DASR per 100,000)	7.54	7.36	⇩	2010-12
4.2 Increased employment rate among people with mental illness/those in contact with secondary mental health services	-	7.4%	-	2012/13

Indicator Description - Associated	Previous status	Recent status	Direction of travel	Recent time period
4.3 Increased crisis response of A&E liaison within 2 hours – Urgent	85%	77%	⇩	Q2 2013/14
4.4 Increased crisis response of A&E liaison, all urgent referrals to be seen within 24 hours. **Target for this 100%**	100%	100%	⇔	Q2 2013/14
4.5 Number of adults receiving treatment for drug misuse (primary substance) number	3,364	2,931	⇩	2012/13

Indicator Description - Associated	Previous status	Recent status	Direction of travel	Recent time period
4.6 Number of adults receiving treatment for alcohol misuse (primary substance) number	Figures currently Restricted			
4.7 Increase in the successful completion and non-representation of opiate drug users leaving community substance misuse treatment (NEW)	*10.21%*	*10.13%*	⇩	June 2012 – May 2013
4.8 Decrease the number of people entering prison with substance dependence issues who are previously not known to community treatment (NEW)	Awaiting indicator development and reporting from Public Health England			

Two further indicators have been proposed for Outcome 4; these indicators refer to substance misuse treatment services and both feature in the Public Health Outcomes Framework. Indicator 4.7 focusses on increasing the number of client's successfully leaving structured treatment and not returning to the treatment services within a set period of time, due to not relapsing. Indicator 4.8 monitors the number of people entering prison, with a substance misuse problem who have not accessed structured treatment in the community before (treatment naïve). This indicator is still under development but will help assess the reach and accessibility of community services in engaging substance misusers before entering the penal system.

Outcome 5: People with dementia are assessed and treated earlier

Indicator Description - Targeted	Previous status	Recent status	Direction of travel	Recent time period
5.1 Improvements in the rates of diagnosis in Kent	Awaiting information from KMCS			
5.2 Increase in effectiveness of post diagnosis care in sustaining independence and improving quality of life for an increased number of people	Awaiting information from KMCS			
5.3 Reduction in care home placements	Awaiting information from KMCS			
5.4 Reduction in hospital admissions	Awaiting information from KMCS			

Indicator Description - Associated	Previous status	Recent status	Direction of travel	Recent time period
5.5 People waiting longer than 12 weeks to access memory services	Awaiting information from KMCS			

Stress indicators

Public Health	Previous status	Recent status	Direction of travel	Recent time period
6.1 Population vaccination coverage – Flu (aged 65+) (NEW). ***Target for this 75%***	*72.8%*	*73.1%*	⇧	2011/12

Public Health	Previous status	Recent status	Direction of travel	Recent time period
6.2 Population vaccination coverage – Flu (at risk individuals) (NEW). ***Target for this is 75%***	*47.2%*	*46.3%*	⇩	2011/12

Two indicators on flu vaccination of those at risk have been proposed as public health stress indicators; coverage is correlated to levels of diseases, vaccination decreases can be identified as trigger points for further action. Both indicators have a target of 95%, 2012/13 data will need to be analysed to give further information on these indicators.

Acute/Urgent	Previous status	Recent status	Direction of travel	Recent time period
6.3 Bed occupancy rates, overnight				
Dartford and Gravesham NHS Trust	96.1%	93.2%	Refer to section 6.3	Rolling 12 month September 2013
East Kent Hospitals University NHS Foundation Trust	77.1%	80.5%		
Maidstone and Tunbridge Wells NHS Trust	89.4%	89.3%		
Kent and Medway NHS and Social Care Partnership	93.3%	93.3%		
6.4 A&E attendances within 4 hours (all) from arrival to admission, transfer or discharge				
Dartford and Gravesham NHS Trust (all)	93.7%	92.4%	Refer to section 6.4	Four- week rolling to Week 40 (ending 05/01/2014)
East Kent Hospitals University NHS Foundation Trust (all)	92.6%	92.5%		
Maidstone and Tunbridge Wells NHS Trust (all)	95.0%	94.3%		
6.5 Number of emergency admissions	To be further discussed and developed with NHS England			

Across all the trusts there has been a gradual decrease over time in the proportions for A&E attendances being dealt within 4 hours from arrival, however all remain above 90%, and will need on-going monitoring. There is a noticeable difference on bed occupancy rates of East Kent Hospitals University NHS Foundation Trust in comparison to the other three, of which have similar proportions. The high percentage of bed occupancy and delayed days could potentially affect transfer from A&E.

Primary Care	Previous status	Recent status	Direction of travel	Recent time period
6.6 GP attendances	Awaiting information from NHS England and indicator development			
6.7 Out of Hours activity / 111 call volumes	Awaiting information from NHS England and indicator development			

Social care / Community care	Previous status	Recent status	Direction of travel	Recent time period
6.8 (was 3.1) The proportion of older people (65 and older) mostly at risk of long term care and hospital admission, who were still at home 91 days after discharge from hospital in reablement/ rehabilitation services **BCF. Target for this is 85%**	85.7%	84.1%	⇩	2012/13
6.9 Number of delayed days, acute and non-acute for Kent **BCF**	2,118 days	2,297 days	Refer to section 6.8	Rolling 3 month Nov 2013
6.10 Infection control rates	Awaiting Information from NHS England			
6.11 Percentage of people with short term intervention that had no further service (NEW). ***Target for this is 46%***	47.4%	47.6%	⇧	September 2013
6.12 Admissions to permanent residential care for older people (number) (NEW). ***BCF Target for this is 130***	133	120	⇩	September 2013

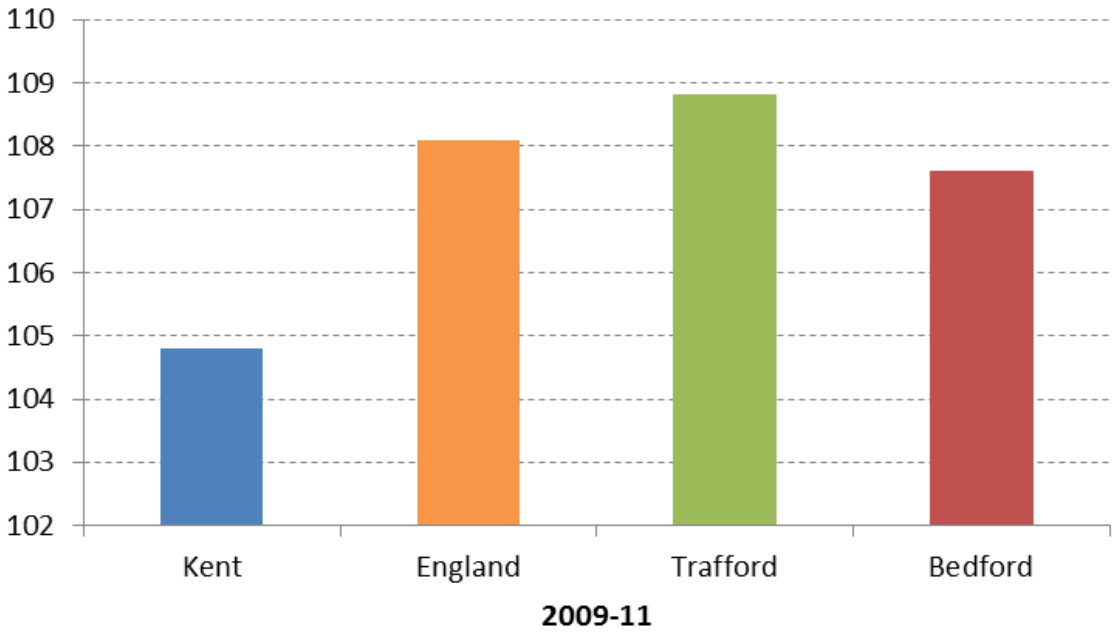
Indicators 6.11 and 6.12 have been proposed as new indicators to take into account the Better Care Fund and stress indicators.

The proportion of people remaining home after discharge has decreased slightly from 2011/12 to 2012/13; however Kent has remained above National levels at 81.4%. Kent County Council has a target of 85%.

4. Assurance Framework

Outcome 2: Effective prevention of ill health by people taking greater responsibility for their health and wellbeing

2.1 Reduction in the under-75 mortality rate from cancer



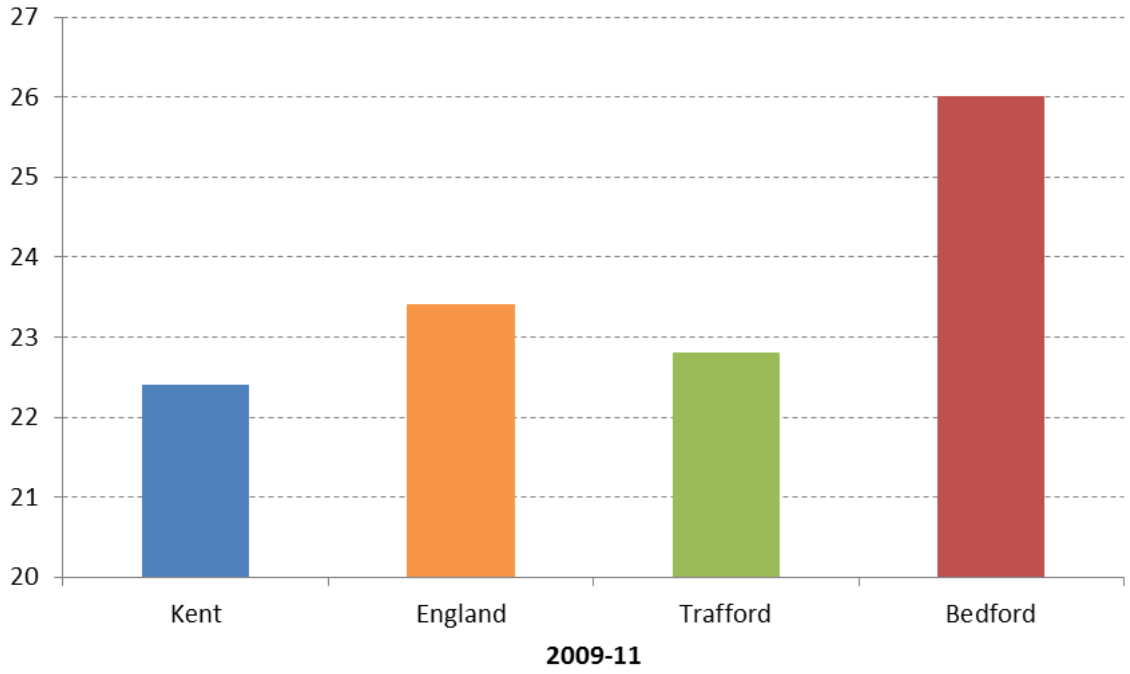
The data highlights that in Kent Directly Standardised death Rate - per 100,000 from cancer for under 75 years is 104.8. This is comparatively lower than England and also with comparative Counties (Trafford and Bedford). Cancer is the highest cause of death in under 75's; prevention and early detection is considered as important as treatment. Consistent increases would need to be analysed alongside other indicators and an evaluation of public health policy and interventions.

The Public Health Outcomes Framework is still in early development with expansion of the indicators still to occur in some cases. The expectation is that this indicator, which was amended, will be backdated. Current provision is two year pooled data with no trend.

Source: Public Health Outcomes Framework: Indicator 4.05i

http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000044/pat/6/ati/102/page/4/par/E12000008/are/E10000016

2.2 Reduction in the under-75 mortality rate from respiratory disease



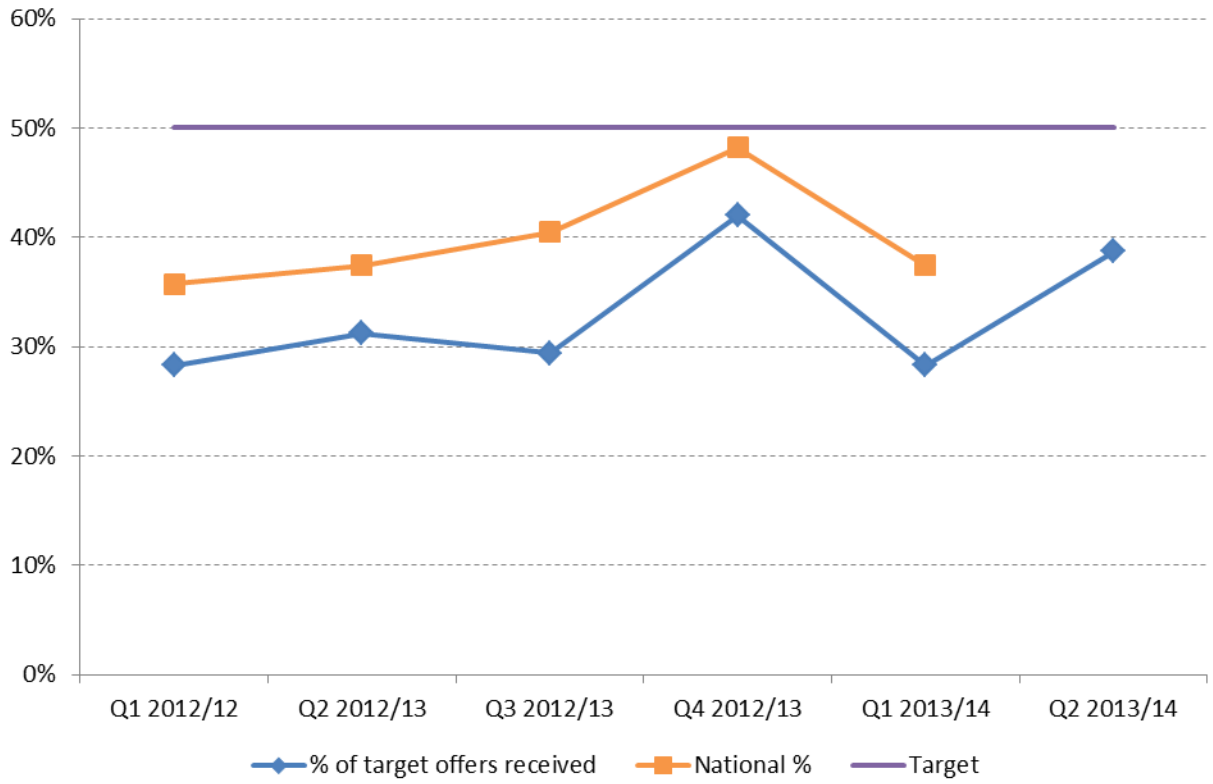
In Kent the Directly Standardised death rate - per 100,000 for respiratory diseases for under 75 years is 22.4 which is again lower than England and two comparative Counties. Respiratory disease is on one the top causes of death in under 75's. Chronic Obstructive Pulmony disease (COPD) is one of the major respiratory diseases of which smoking is the major cause. As with metric 2.1, trend would need to be monitored alongside other indicators and an evaluation of public health policy and interventions.

The Public Health Outcomes Framework is still in early development with expansion of the indicators still to occur in some cases. The expectation is that this indicator, which was amended, will be backdated. Current provision is two year pooled data with no trend.

Source: Public Health Outcomes Framework: Indicator 4.07i (provisional)

http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000044/pat/6/ati/102/page/6/par/E12000006/are/E06000055

2.3 Increase the proportion of people receiving NHS health checks ⇧



It was agreed in previous meetings that the uptake of NHS Health Checks is considered as a proxy indicator for under-75 mortality from all cardiovascular disease. The indicator informs 50% of the target population (40 – 74 years old) to be invited for a NHS health check receiving an actual NHS health check, by quarter.

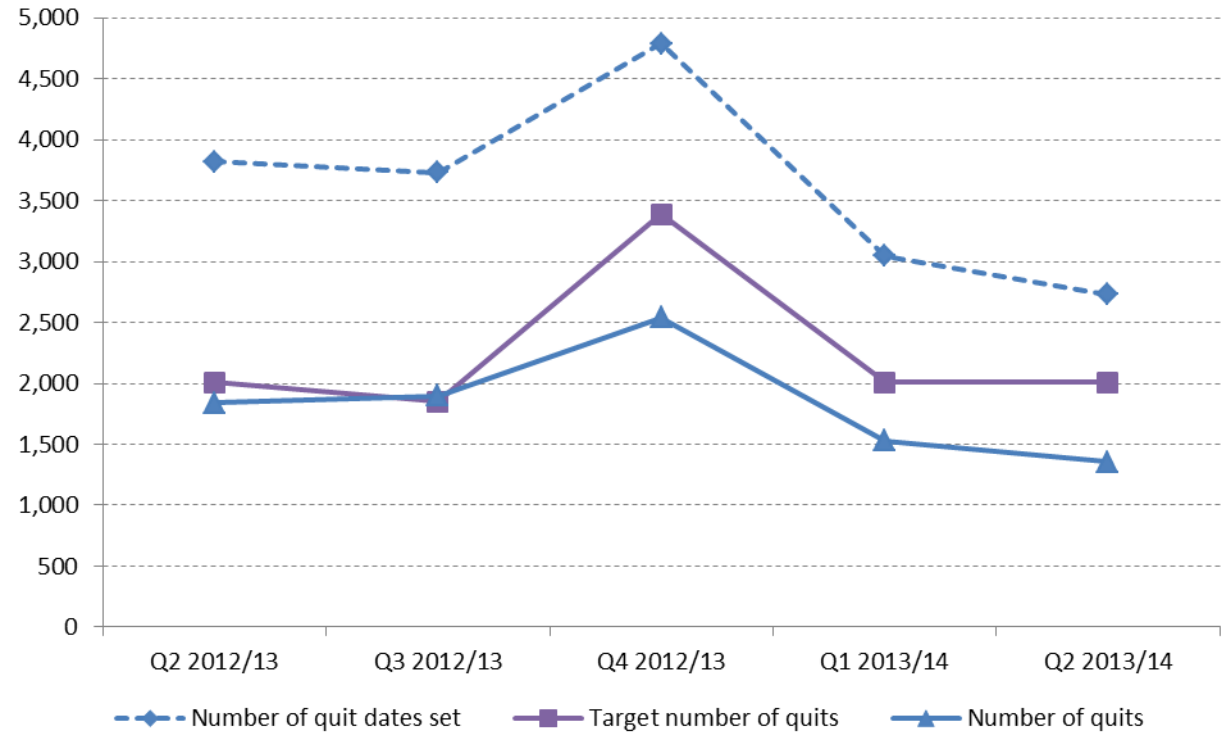
NHS health checks are to identify early signs of poor health and assess the risk of heart disease, stroke, kidney disease and diabetes; the higher the proportion receiving the health checks the better the opportunities for early identification and prevention.

Public Health Kent monitors any variation at CCG and GP level on a monthly basis to ensure the programme is functioning across Kent.

Target: The eligible population in Kent is 91,241for 2013/14; the target for 2013/14 is for all 91,241 to be invited to attend a NHS Health Check with actual take-up of 50% or 45,621.

Source: Public Health Kent

2.4 Increase in the number of people quitting smoking via smoking cessation Services ⇩



Proxy for under-75 mortality from all cardiovascular disease.

From Q2 2012/13 to Q2 in 13/14, the proportion of people quitting following setting a quit date is on average 50% (48% -53%).

Smoking contributes to a range of illnesses – respiratory disease, cancer deaths, circulatory disease and diseases of the digestive system. It is estimated that treating smoking related illness cost £2.7 billion to the NHS in 2006/07. (Healthy Lives, Healthy People: A Tobacco Control Plan for England. 2011). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213757/dh_124960.pdf .

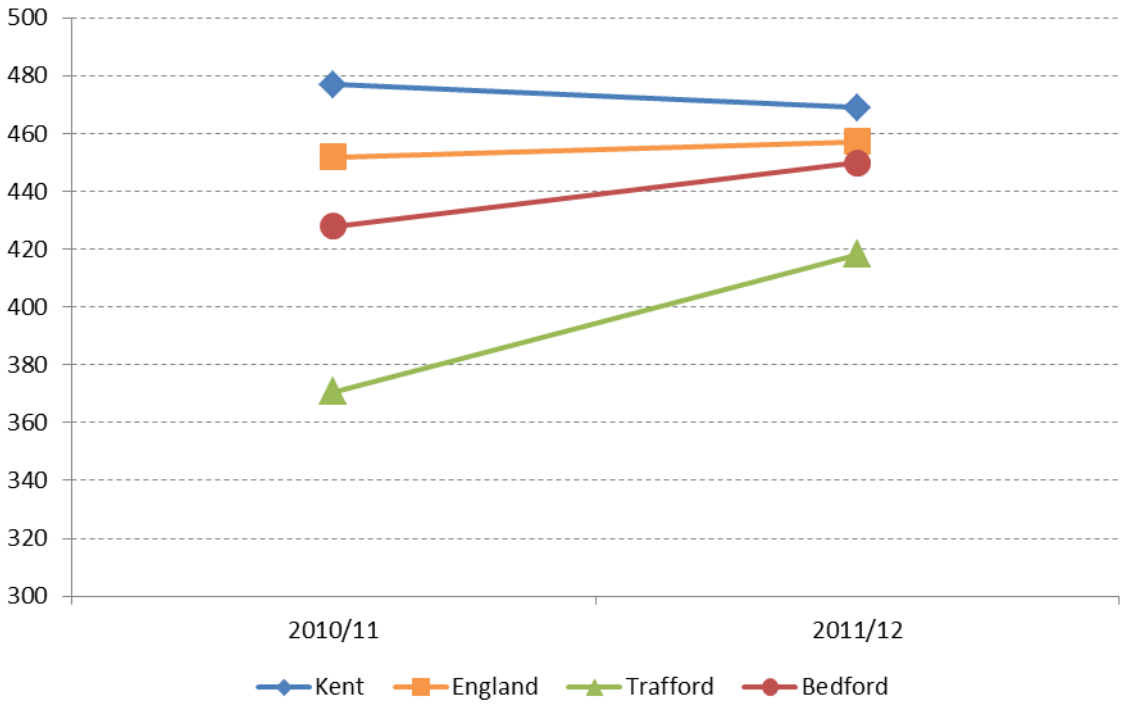
If the numbers of quitters decrease, then the impact on population health and cost to the different components of the health system could escalate.

Kent Public Health is currently working with the commissioned service provider to ensure reporting is available at CCG levels to allow for further analysis and identification of variation across the county.

Target: Historic Department of Health target of 9,249 quits

Source: Public Health Kent

2.5 Reduction in the number of hip fractures for people aged 65 and over	⇩



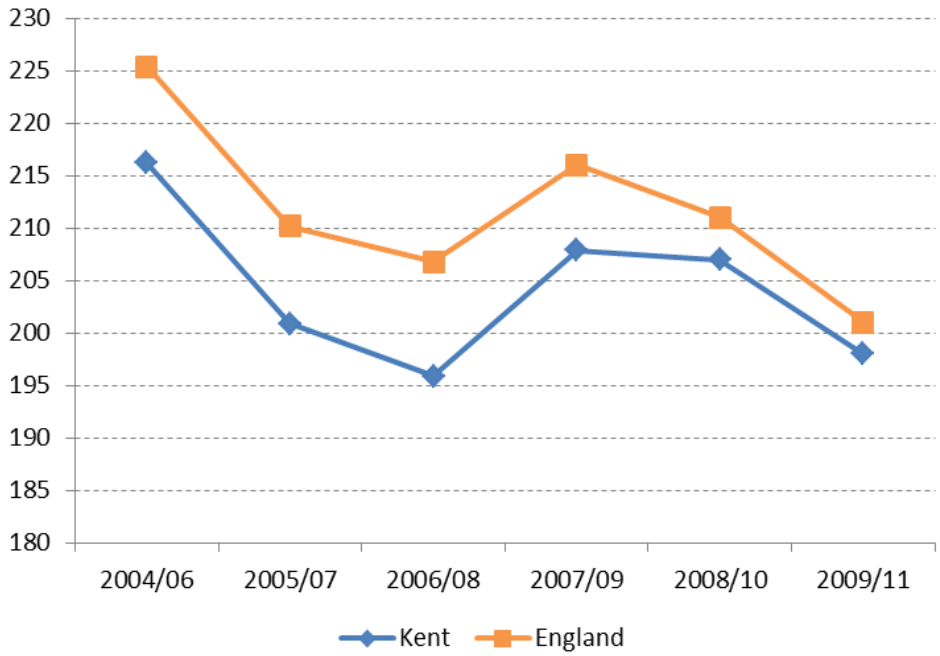
In Kent Directly standardised rate of emergency admissions for fractured neck of femur in those aged 65+ is 469.0 per 100,000. Although showing a downward trend it is still above England rate and that of comparative counties.

Increases in the number of people suffering from a hip fracture have an effect both on urgent care and adult social services, with many potentially needing long-term care. This metric can be considered alongside metric 6.12 admissions to permanent residential care for older people.

Source: Public Health Outcomes Framework: Indicator 4.15i

http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000044/pat/6/ati/102/page/6/par/E12000008/are/E10000016

2.6 Reduction in the rate of deaths attributable to smoking ⇩



Directly age standardised rate per 100,000 population aged 35 and over

The 2013 health profiles for districts highlight the variation across the county; The highest rate was in Thanet at 250 per 100,000. The four districts with the highest rates were all in East Kent. This is mirrored in the three lowest rates which are all in West Kent, the lowest being experienced in Sevenoaks at 136 per 100,000.

Smoking causes more preventable deaths than anything else and contributes significantly towards increasing inequalities within and between communities. Therefore reductions in the rates and numbers of deaths attributable to smoking are essential through concerted effort across the system.

Source: Kent and Medway Public Health Observatory. APHO Health Profiles (2013 most recent)

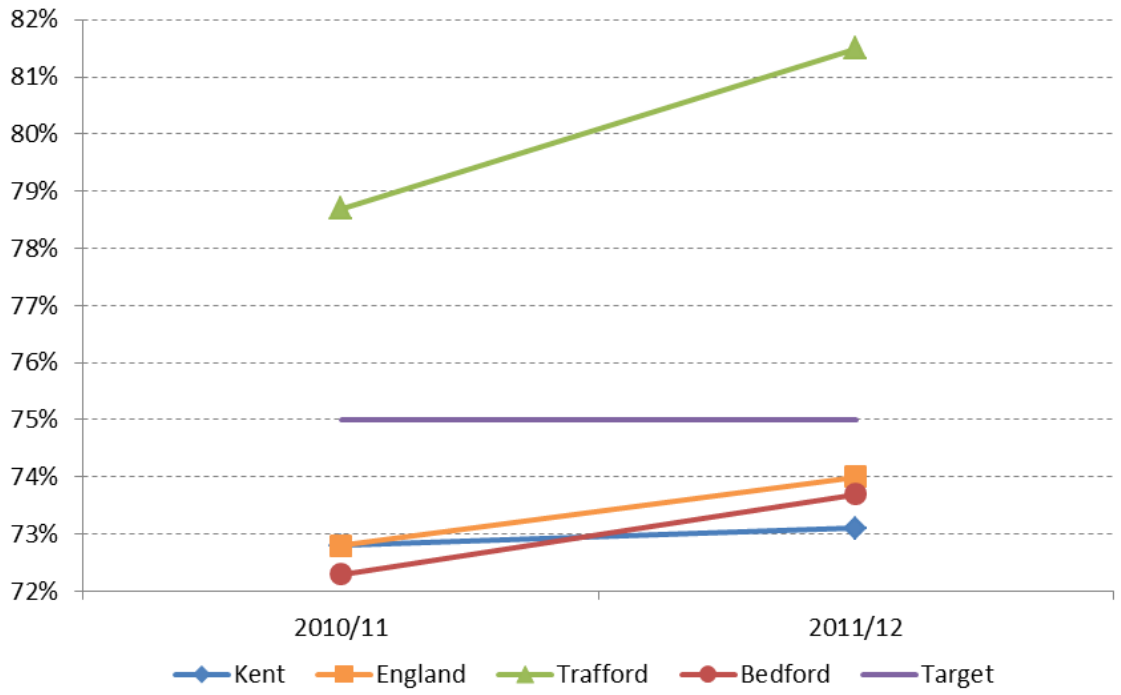
http://www.apho.org.uk/default.aspx?RID=49802

5. Better Care Fund

BCF Indicators	BCF Metric	
6.8 (was 3.1) The proportion of older people (65 and older) mostly at risk of long term care and hospital admission, who were still at home 91 days after discharge from hospital in reablement/ rehabilitation services	Effectiveness of reablement	Refer to Section 6 stress indicators; 6.8
6.9 Number of delayed days, acute and non-acute for Kent	Delayed transfers of care	Refer to Section 6 stress indicators; 6.9
6.12 Admissions to permanent residential care for older people (number) (NEW)	Admissions to residential and care homes	Refer to Section 6 stress indicators; 6.12
For future definition and sourcing		
Avoidable Emergency Admissions		
Patient / Service user experience		

6. Stress indicators

Public Health
6.1 Population vaccination coverage – Flu (aged 65+)



Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely related to levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise (PHOF)*

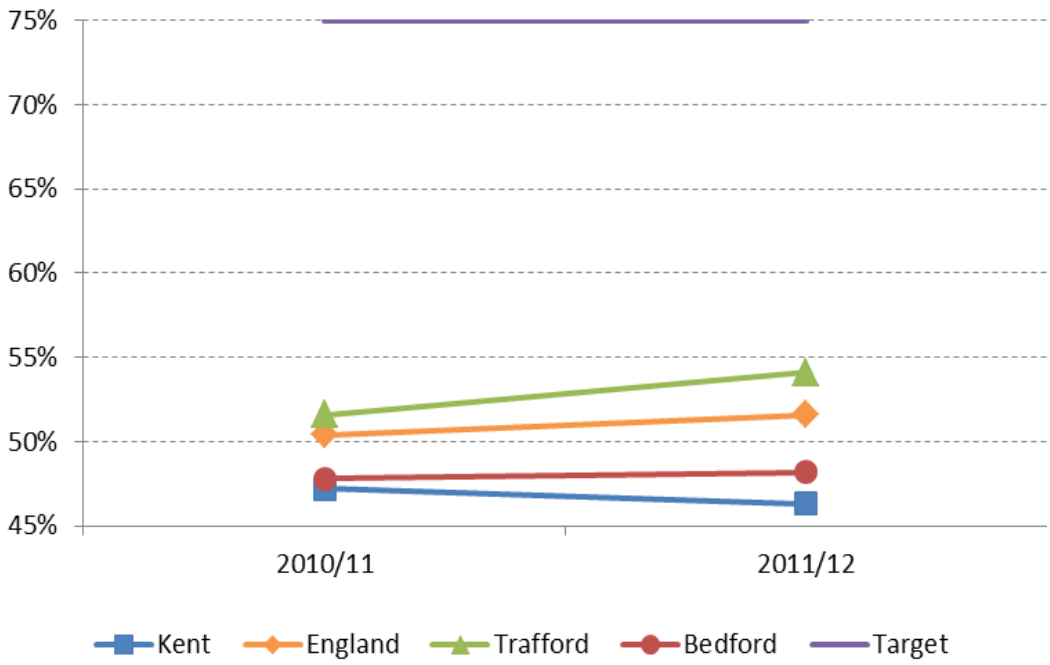
A decrease in the percentage would indicate lower levels of immunity; increasing incidence of Flu can put additional seasonal stress on the health system. Other metrics that could display the effect of this would be GP attendances, out of hours activity/111 call volumes, A&E attendances, emergency admissions and bed occupancy rates.

Target: 75%

Source: Public Health Outcomes Framework: Indicator 3.03xiv

*http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000043/pat/6/ati/102/page/6/par/E12000004/are/E06000015

6.2 Population vaccination coverage – Flu (at risk individuals)



Studies have shown that flu vaccines provide effective protection against the flu. The flu vaccination is offered to people in at-risk groups such as pregnant women and elderly people. These people are at greater risk of developing serious complications, such as bronchitis and pneumonia if they catch flu. (PHOF)*

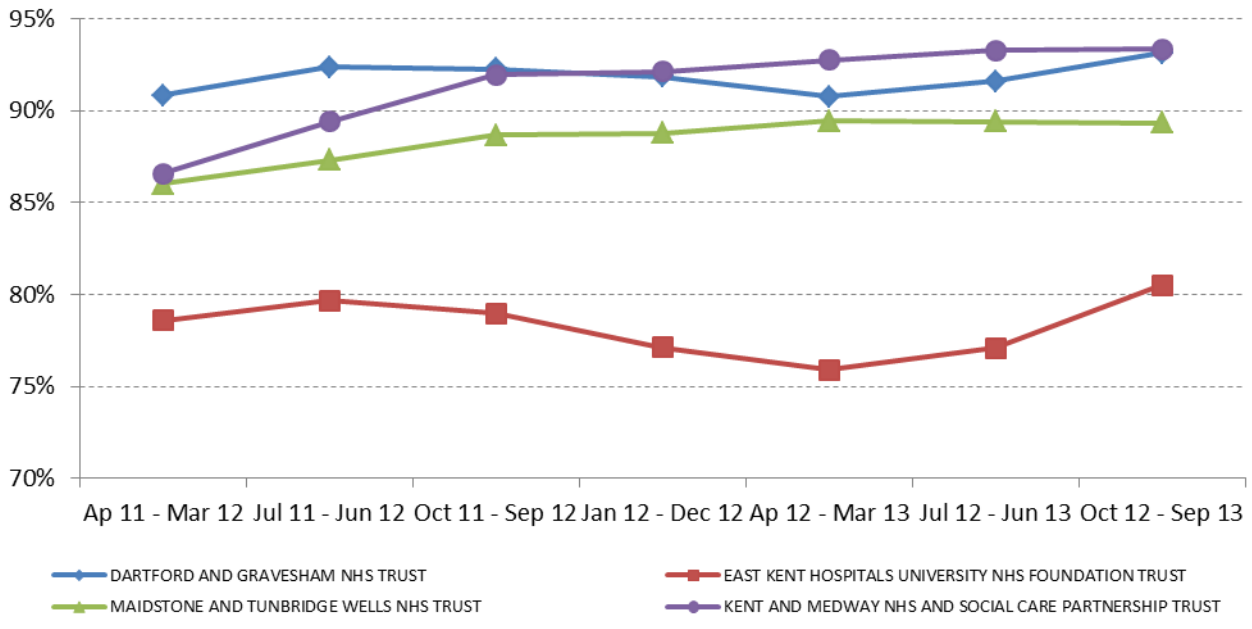
A decrease in the percentage would indicate lower levels of immunity; increasing incidence of Flu can put additional seasonal stress on the health system. Other metrics that could display the effect of this would be GP attendances, out of hours activity/111 call volumes, A&E attendances, emergency admissions and bed occupancy rates.

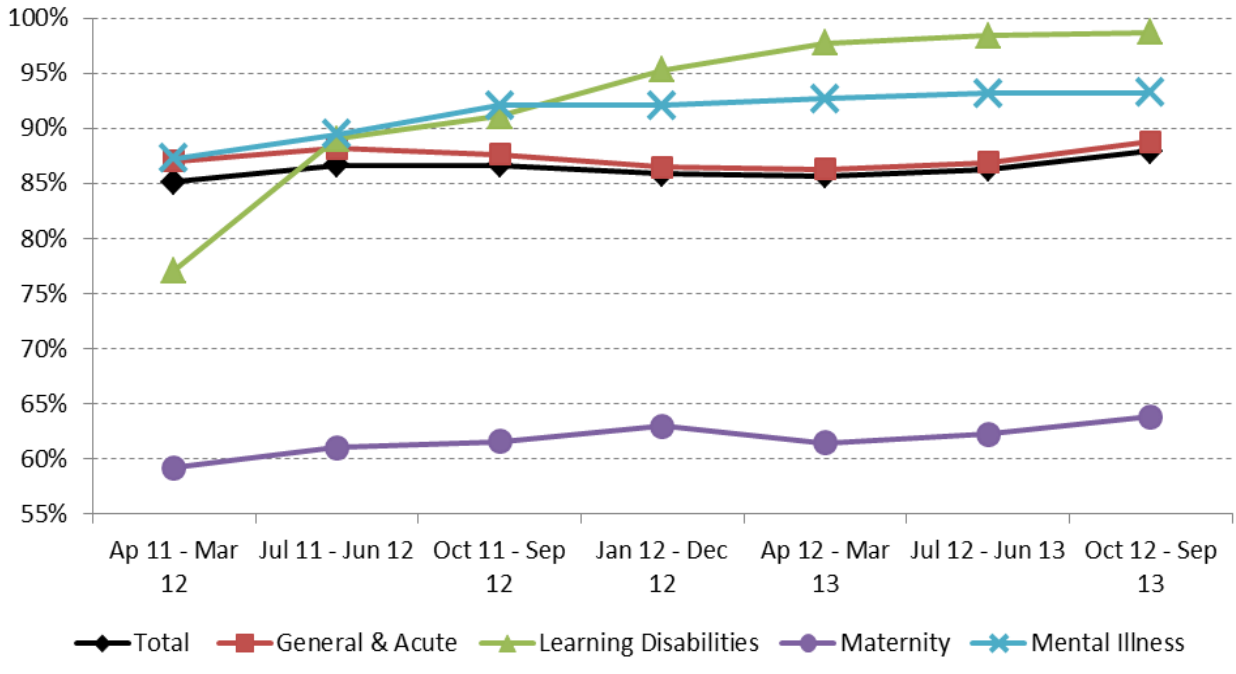
Target: 75%

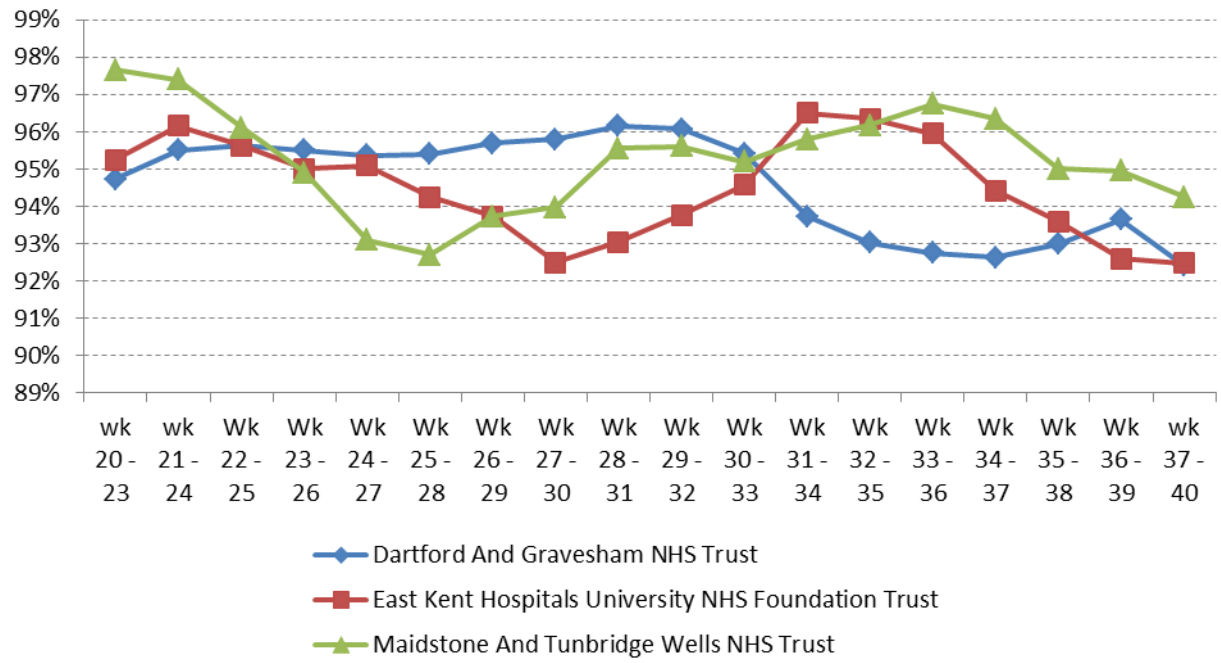
Source: Public Health Outcomes Framework: Indicator 3.03xv
*http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000043/pat/6/ati/102/page/6/par/E12000004/are/E06000015

Acute/Urgent

6.3 Bed occupancy rates



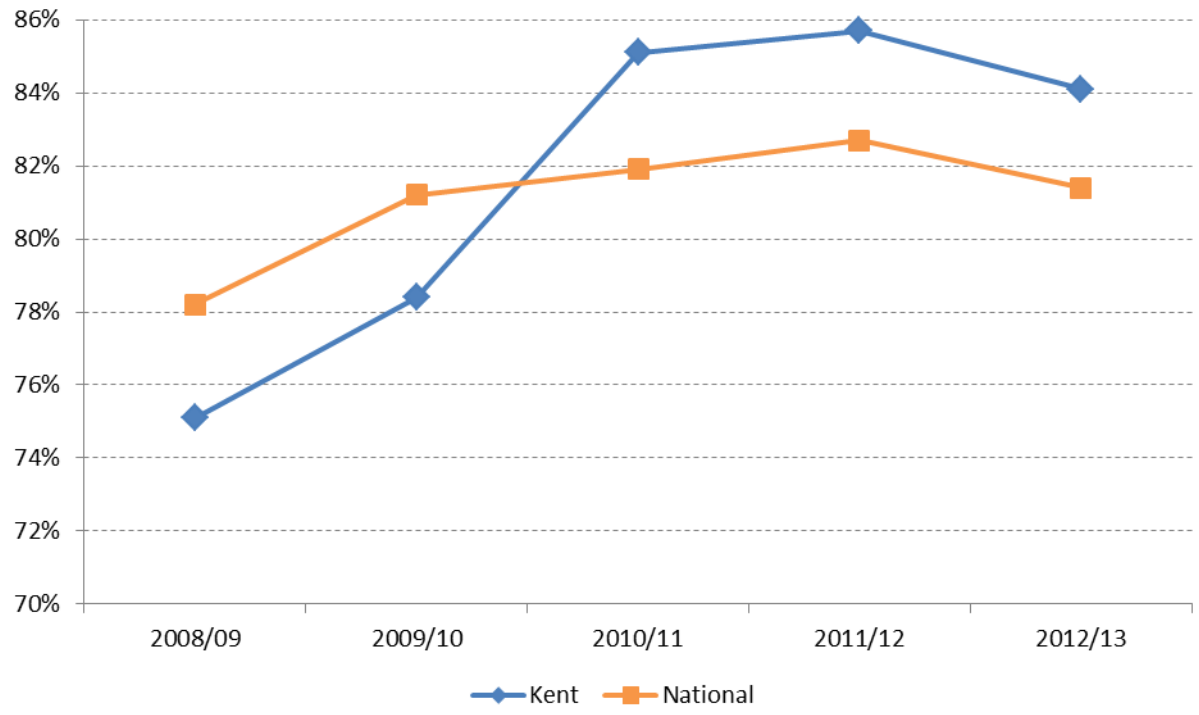


Acute/Urgent
Rolling 12 months data. Percentage of occupied beds open overnight only by consultant main specialty and by Trust. Whilst under-utilisation of beds is not desirable, Occupancy rates at 100% indicate minimal flexibility to respond to an emerging crisis or outbreak. To understand system wide issues this indicator could potentially be seen in conjunction with other indicators such as A&E transfers and delayed days. **Source:** NHS England. January 2014 http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/
6.4 A&E attendances within 4 hours (all) from arrival to admission, transfer or discharge

Percentage within 4 hours. 4-weekly rolling figures (Week 40 is week ending 05/01/2014) Numbers/proportions of people being in A&E more than 4 hours can indicate stressors on A&E and the staff with less flexibility to deal with any influxes/general arrivals and a 'blocking' situation could arise. **Source:** NHS England. AE SitRep January 2014. http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/weekly-ae-sitreps-2013-14/

6.5 Number of emergency admissions
To be further discussed and developed with NHS England

Primary Care
6.6 GP Attendances
Awaiting information from NHS England and indicator development
6.7 Out of Hours activity / 111 call volumes
Awaiting information from NHS England and indicator development

Social Care / Community Care
6.8 Proportion of older people still at home 91 days after discharge



This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services.

It captures the joint work of social services and health staff and services commissioned by joint teams, as well as adult social care reablement. (KCC PID 2013/14)

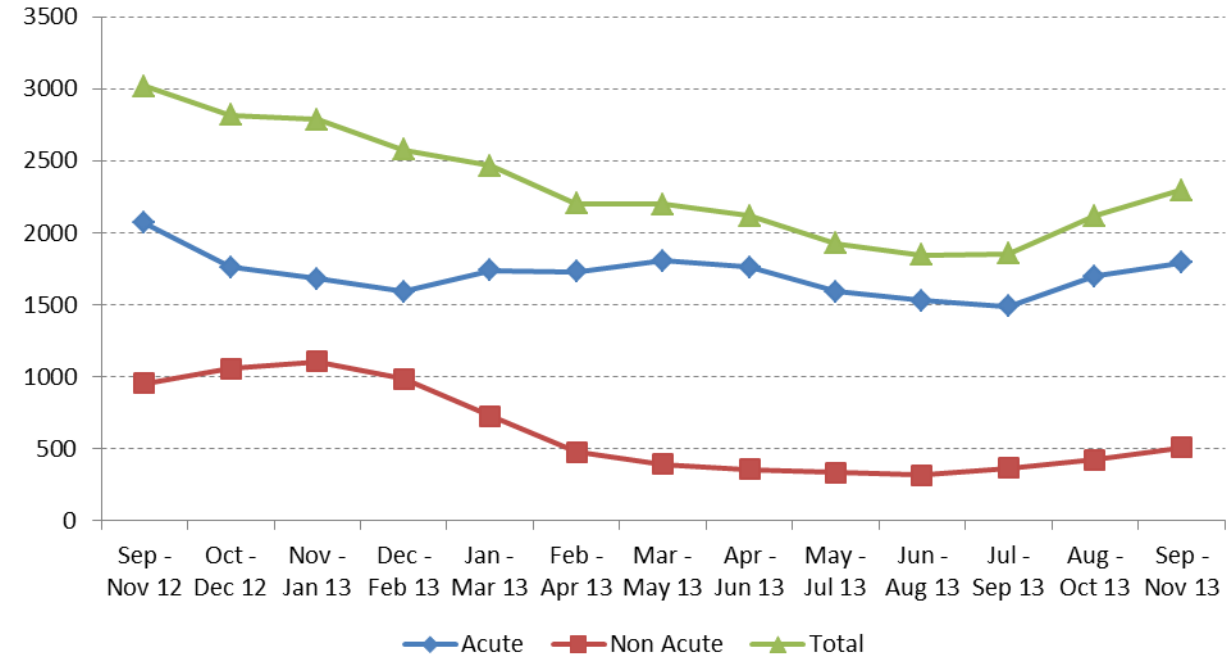
A higher proportion of older people staying at home is desirable, this indicates the quality of reablement services and a reduction in demand on acute/urgent care.

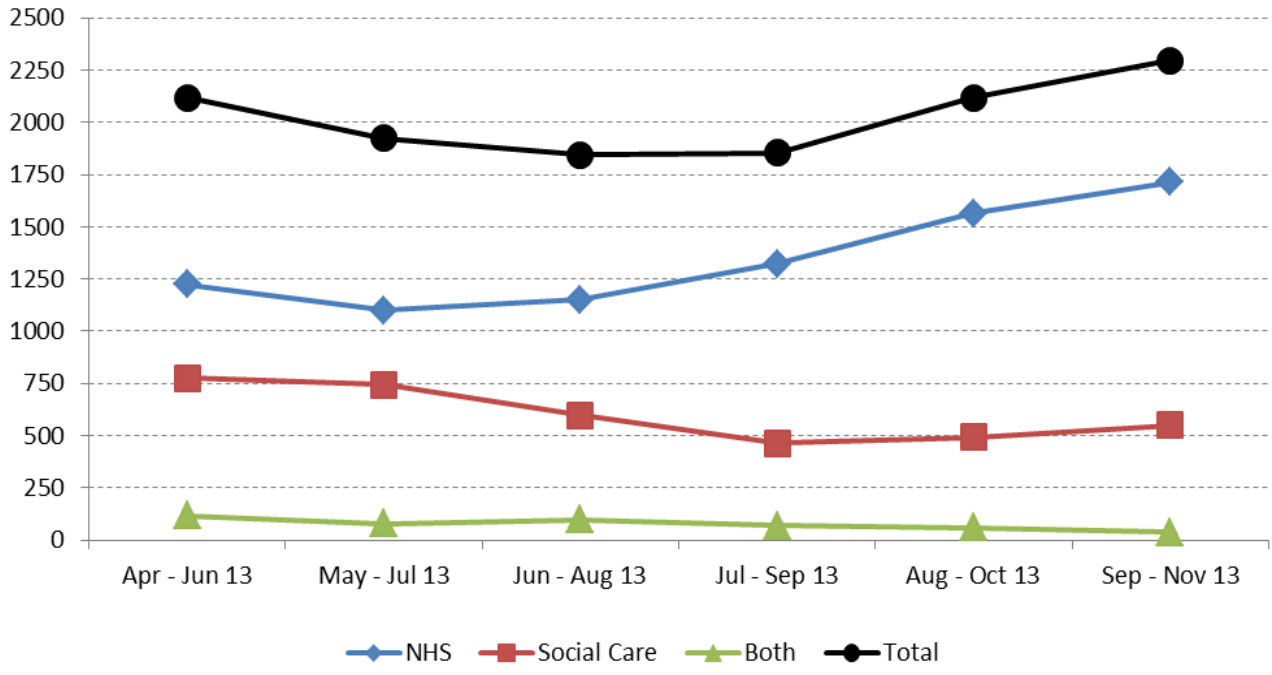
Source: Adult Social Care Corporate Reporting.

Adult Social Care Outcome Framework – Indicator 2B part 1

Better Care fund Metric

6.9 Number of delayed days, acute and non-acute for Kent





Number of delayed days during the reporting period, using three month rolling figures. Acute and non-acute at Local Authority level – Kent. The second chart shows the number of delayed days by the responsible organisation – NHS, Social Care or Both.
Delayed days are when a patient is ready from transfer from a hospital bed but has not been moved, either for delays occurring by the NHS or Social Services. Increases in the number of delayed days could indicate blockages within the hospital/social care and have an impact on other patients receiving the care they need. It is also not desirable and can be stressful to the patient to be in hospital unnecessarily.

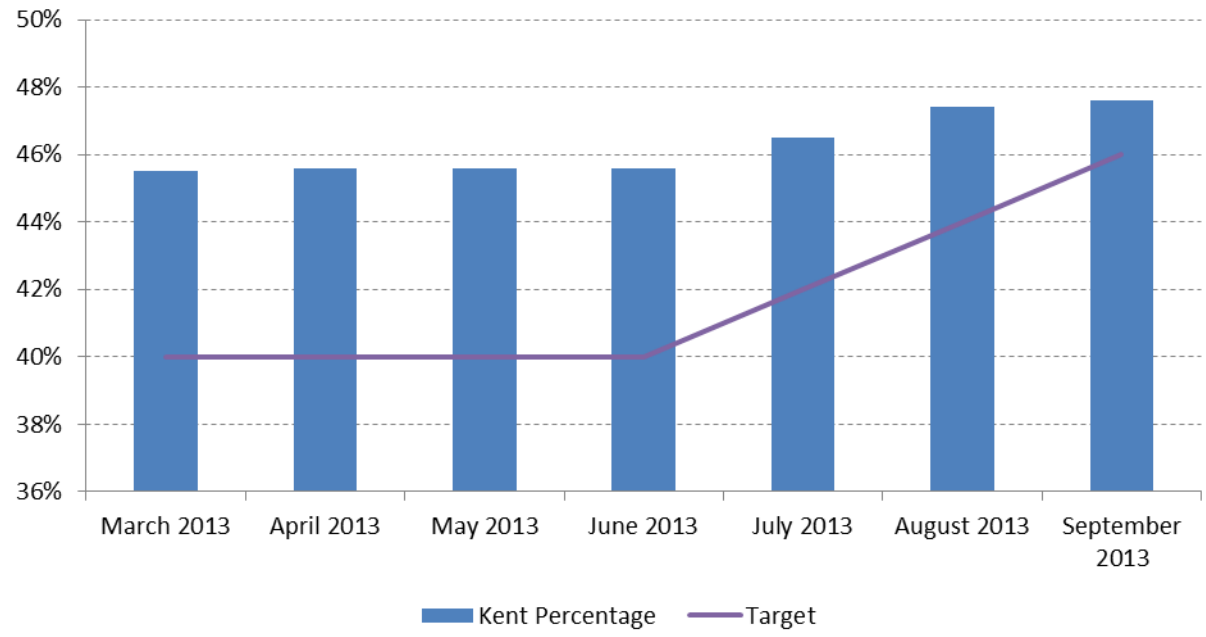
Source: NHS England. January 2014http://www.england.nhs.uk/statistics/statistical-work-

areas/delayed-transfers-of-care/
Better Care fund Metric

6.10 Infection control rates

Awaiting Information from NHS England

6.11 Percentage of people with short term intervention that had no further service



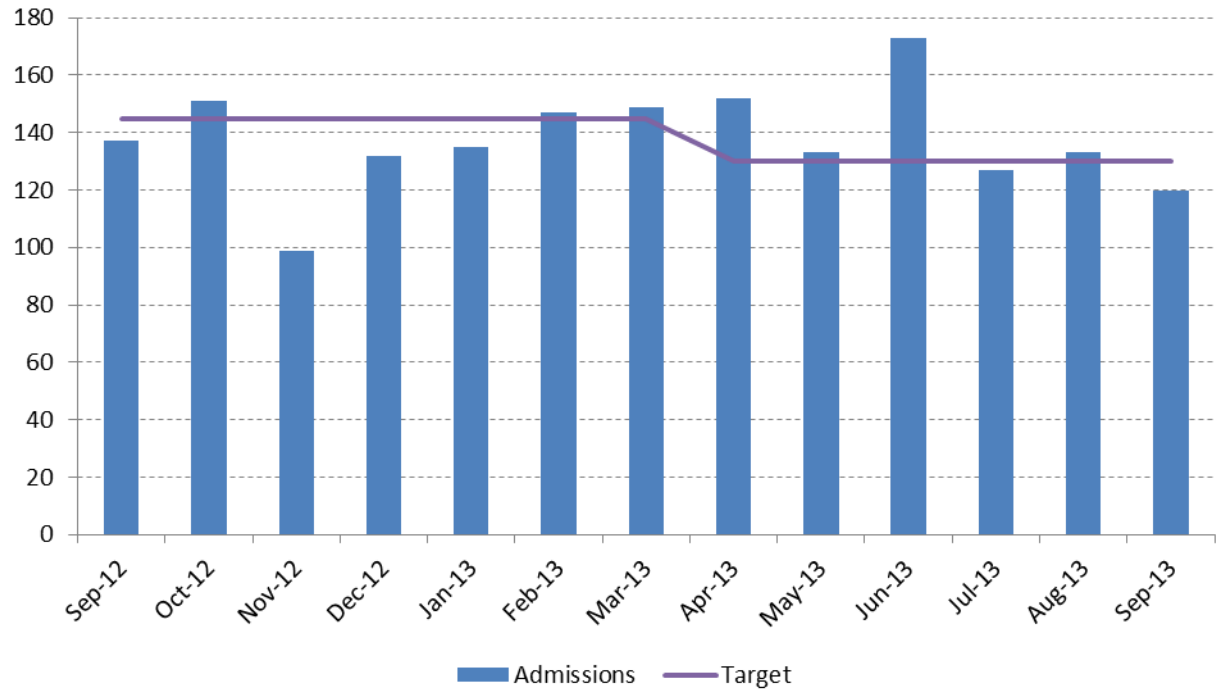
Aims to measure the effectiveness of short term intervention, looking at the percentage of people who are successfully enabled to stay at home with no further support from Social Care. This will include the provision of services such as enablement, immediate care and equipment. (ASC Dashboard September 2013)

An increasing proportion on people needing no further service indicates a good quality of service received and no further demand on services.

Target: The target for the end of the year is 60%; there is an incremental target increase from July 2013.

Source: Adult Social Care Dashboard September 2013. Social Care & Public Health Cabinet Committee.

6.12 Admissions to permanent residential care for older people



Many admissions are linked to hospital discharges, or specific circumstances or health conditions such as breakdown in carer support, falls, incontinence and dementia. (ASC Dashboard September 2013)

A reduction in permanent admissions is desirable and an aim of adult social care; falls prevention support forms part of the analysis into monitoring permanent admissions. Self-management and the ability to stay in their own homes are important for both residents and health services.

Target: 2012/13 Target of 145 with a reduction in 2013/14 to 130.

Source: Adult Social Care Dashboard September 2013. Social Care & Public Health Cabinet Committee.

Better Care fund Metric

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NHS
West Kent
Clinical Commissioning Group

Strategic Commissioning Direction for Children and Young People's Mental Health and Wellbeing Services in Kent

Kent Health and Wellbeing Board

12 February 2014

Patient focused
Providing quality, improving outcomes

KENT HEALTH AND WELLBEING BOARD

WEDNESDAY 12 FEBRUARY 2014

STRATEGIC COMMISSIONING DIRECTION FOR CHILDREN AND YOUNG PEOPLES MENTAL HEALTH AND WELLBEING IN KENT

SUMMARY

This draft report provides an overview of progress in the development of an integrated commissioning approach to children and young people's mental health provision in Kent.

RECOMMENDATIONS

The board is asked to:

Note the report and endorse the integrated commissioning proposal

1. STRATEGIC CONTEXT

The need to improve children and young people's mental health provision is a key challenge for health commissioners and stakeholders. One in ten children aged five to 16 has a clinically significant mental health problem and this burden is rising, Kent mirrors the national picture. Early intervention and a range of high quality services will improve efficiency and patient outcomes. The Kent JSNA 2010 and an updated CAMHS needs assessment 2011, states that at any time in Kent there are approximately 17,000 children aged between five and fifteen who have a diagnosable mental health disorder.

The overarching strategic context for the delivery of children's mental health in Kent is linked to five key strategies

- DoH The NHS Outcomes Framework
- DoH No Health Without Mental Health
- Kent Health and Wellbeing strategy
- KCC Every Day Matters
- Draft Kent and Medway Emotional Wellbeing and CAMHS Strategy 2012

The Kent Health and Wellbeing strategy 2013 outcomes, one and four, set key objectives for children's mental health. The Health and Wellbeing strategy commits to meeting objectives through an integrated commissioning approach and through the delivery of integrated provision and person centred care, essentially the delivery of seamless services for the public. The outcomes are:

Outcome One - Every child has the best start in life

Outcome Four – People with mental health issues are supported to live well

KCC Every Day Matters sets a clear vision for children's services. This is underpinned by 4 broad outcomes and five priorities. The key vision within Every Day Matters is:

"Every child and young person in Kent achieves their full potential in life, whatever their background".

The four outcomes at the heart of Kent County Council's integrated children's services are:

- Keep all children and young people safe
- Promote the health and wellbeing of all children and young people
- Raise the educational achievement of all children and young people
- Equip all young people to take a positive role in their community.

Kent County Council, Kent and Medway NHS and key partners developed the Draft Kent and Medway Emotional Wellbeing and CAMHS Strategy 2012 using a multi-agency approach to improve emotional wellbeing and mental health of children and young people in Kent and Medway. This draft strategy has influenced the aim of improving services by strengthening strategic relationships across the system, provide direction and direct the development of commissioned services.

2. KENT INTEGRATED COMMISSIONING PROPOSAL

Current arrangements

In September 2012 NHS Kent & Medway and Kent County Council agreed to align funding in order to jointly commission new Emotional Well-being and Mental Health Services for children and young people. Sussex Partnership NHS Foundation Trust (SPFT) commenced delivery of Community Children and Young People's Mental Health Services (CAMHS), with Kent and Medway NHS acting as the lead commissioner. The total value of the contract is £15m. KCC contributes £1m for the children in care (CIC) element of the service.

It was agreed that the new services would take the form of an Emotional Well-being Service delivering support within universal settings (Tier 1 - 2), alongside a 'Community CAMHS' model comprising targeted (Tier 2) and specialist (Tier 3) mental health

services. Within this contract is the specialist service for children in care, funded by KCC. Tier 4 CAMHS specialised mental health is commissioned through NHS England. There are currently two years remaining of the contract to April 2016.

The Health and Social Care Act 2012 provided a new structure for commissioning of mental health in England in the main commissioning transferred from the Primary Care Trusts to Clinical Commissioning Groups (CCGs). Since April 2013 following organisational re-structures as part of the Health and Social Care Act reforms, West Kent CCG has been the coordinating commissioner across Kent for the CAMHS (Tier 2 and 3) contract.

At the time of taking over the contract, SPFT inherited significant waiting lists from the previous provider of the service, particularly in West Kent for specialist (Tier 3) and targeted services (Tier 2), which they have been working to reduce. An action plan was put in place to reduce waiting times for first appointment to 4-6 weeks, this was achieved by September 2013, but waits have started to increase in quarter 3.

At present, West Kent CCG is the co-ordinating commissioner on behalf of Kent & Medway CCGs and is taking a robust approach to managing the performance of the provider against the contract requirements. As a consequence of targets that were missed, the CCG initially formally wrote to Sussex Partnership Trust outlining its concerns and seeking re-assurance through an action plan to address the shortfall in service delivery. Board to board discussions to further improve performance monitoring data is now in place in order to provide confidence in the performance regime and quality of service delivery. Contractual levers such as penalties have been considered and if performance does not improve these can be implemented.

Some improvements have been made, the service is prioritising those young people who need urgent support and there have been no breaches in urgent referrals. The introduction of the Choice and Partnership approach is helping caseload management. Care pathways and referral routes have improved. A workforce development plan has been implemented and the service is still recruiting to reach a full complement of staff. Temporary staffing solutions (agency) are being used to support this area particularly the Dartford area, to address this backlog.

The CCG will continue to monitor and work with the provider to ensure that the service is working to full capacity and will continue to use all necessary contract levers to ensure this is adhered to. West Kent CCG will continue to co-ordinate monthly performance meeting with SPFT to review progress.

Strategic Integrated Commissioning Proposal

Since April 2013, through the current coordinating commissioner contract monitoring arrangements, it is becoming apparent that the CAMHS provision is not correctly

imbedded within the wider context of vulnerable children and young people pathways and the wider context of current and future C&YP commissioning plans.

Recent drivers from central government particularly the Children and Families Bill is pushing towards a more integrated and partnership approach in developing children and young people services. Kent CCGs believe this is a good opportunity, during this contract refresh round to consider developing a Section 75 pooled budget agreement with KCC bringing all the appropriate investment into an agreed strategic arrangement.

A Section 75 agreement will provide the structure for integrated commissioning arrangements leading to greater opportunities to create a more seamless patient care pathway journey. This will provide greater opportunity for Health Commissioners to ensure that health financial investment and health outcomes of children and young people pathways is more integrated within the preventative and recovery pathway that currently sits within the remit of KCC.

Through this arrangement, there is the opportunity to develop with KCC joined planning and investment to support the Emotional Well-being and Mental Health Services for children and young people and CAMHS provision through the patient journey. An agreed approach to the integration of the Common Assessment Framework (CAF) coordinators and the KIASS will support CAMHS referral processes ensuring children are correctly assessed by the best service to meet needs. Agreed strategic planning of provision will promote access into the KCC preventative agenda (including Public Health), education services, targeted prevention & early intervention services (which will include young offenders, Healthy Young Minds Provision), Troubled Families Agenda and Aim Higher agenda (disabilities - transition).

Through the establishment of Section 75 pooled budget agreement, there may be a requirement for 3 agreements either sitting underneath an overarching Section 75 or three separate Section 75 agreements to reflect the emerging North Kent, East Kent and West Kent health economies. This arrangement mirrors the agreed NHS adult mental health commissioning arrangements from April 2014.

To prevent any possible dilution of health investment within this arrangement, the Section 75 pooled budget agreements will become the mechanisms for CCGs to monitor KCC in their function as commissioners on health's behalf; and as there could be three arrangements within the overarching Section 75, CCGs and KCC will have greater input, control and flexibility of how their investment is being used to meet local populations needs.

In addition to CAMHS the arrangements for wider children's emotional wellbeing commissioning frameworks can also be considered going forward.

If agreed, the initial milestone is for an 'in principle' agreement with key stakeholders by April 2014. Following agreement, an options analysis will be completed. Once the details of the transfer have been agreed West Kent CCG, on behalf of associate CCG commissioners, will novate the current CAMHS contract as a whole across to KCC for them to act as commissioners for the contract on behalf of health. The proposal has been raised with colleagues across the health economy and with KCC and there is a positive response to this proposal.

3. GOVERNANCE ARRANGEMENTS

A refresh of the JNSA and the draft Kent and Medway Emotional Wellbeing and CAMHS Strategy will be required going forward, to act as the strategic vehicle to deliver service transformation and improve outcomes for children and young people. Clarity regarding governance and the role of the Health and Wellbeing Board, Joint Commissioning Board and health DMT will need to be considered. CCGs reporting mechanisms will need to be defined .Future plans could include an integrated children's mental health and wellbeing board who will oversee the delivery and performance manage the emotional and wellbeing strategy, this board could report into relevant organisations and the Kent Health and Wellbeing Board.

4. FINANCE

The overall expenditure for Kent CCGs, KCC and Medway Council on tier 1,2 and 3 children's mental health provision is circa £15m this is allocated in the following areas:

CCGs/ Local Authorities	**Total (£)**
NHS Ashford CCG	1,203,028.10
NHS Canterbury and Coastal CCG	2,192,839.41
NHS Dartford, Gravesham and Swanley CCG	1,729,550.25
NHS Medway CCG	1,124,075.04
NHS South Kent Coast CCG	2,333,250.47
NHS Swale CCG	1,157,091.15
NHS Thanet CCG	1,781,140.31
NHS West Kent CCG	3,007,645.73
Kent County Council	1,000,000
Medway Council	144,269
Total	**15,672,889.45**

The value of the South London and Maudsley (SLAM) contract for Kent and Medway Tier 4 provision at the point of transfer to NHS England was £4.8m.

5. NEXT STEPS

This paper was shared at the Kent Health and Overview Scrutiny Committee on 31 January as part of a wider item on CAMHS in order to inform the meeting about the future model options. Due to ongoing concerns noted earlier in this paper HOSC will

have a role going forward examining the performance of the current service. The HWWB is the senior stakeholder environment to agree and set the strategic commissioning direction across the children's emotional wellbeing and mental health system.

Kent CCGs will need to work collaboratively with Kent County Council and continue to build the partnership arrangements with the voluntary sector, patients and carers in order to implement the proposal to drive transformational change in the way children's mental health services are commissioned, provided and purchased in line with key guidance. A refresh of the Joint Strategic Needs Assessment (JSNA) and the specific children's element of the Mental Health Assessment (MHA) will provide further evidence based information to support the commissioning intentions and commissioning governance framework.

Kent CCGs will be focusing on key transformational commissioning intentions aimed at driving significant economy and efficiency within the local health and social care environment. Commissioners in West Kent for example will demand a quicker and more responsive service for children and young people that need access to mental health services.

Contractual details linked to agreed baselines, risk, due diligence, performance monitoring in addition to any emerging PbR tariff, further efficiency programs and outcome focused KPIs will need to be clarified. Governance arrangements will need to be confirmed. Where innovation has been successful it will be mainstreamed into the new Section 75 contract arrangements and innovation programs will continue to be a key contractual tool to transform, integrate and redesign services to children and young people with mental health issues.

Once an 'in principle' agreement is reached more detailed work will commence to facilitate a Section 75 arrangement in 2014/15. Further details will need to be examined and an option analysis paper with more detailed thinking will be presented at a future Health and Wellbeing Board.

List of Background Documents

DoH NHS Outcomes Framework

No Health Without Mental Health 2011

Draft Kent and Medway Emotional Wellbeing and CAMHS Strategy 2012

Kent Health and Wellbeing Strategy 2012

Health and Social Care Act. 2012

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From:	Roger Gough, Cabinet Member for Education and Health Reform Meradin Peachey, Director of Public Health
To:	Kent Health and Wellbeing Board – 12 February 2014
Subject:	**2013/14** Exception report for the Kent JSNA
Classification:	Unrestricted

Summary:

The joint strategic needs assessment is a set of reports, chapters and interactive maps and as such is under constant review, update and development. Almost all summary chapters of the JSNA have been reviewed and updated, to reflect the latest policy, guidance and data trends. A list of the new and emerging priorities and highlights are reported in this paper to the Health and Wellbeing Board.

Recommendations:

The Health and Wellbeing Board is asked to note the contents of the report

Update on the Local Development Process

In September 2013 a decision was made to combine the JSNA and JHWS steering groups with Roger Gough as the meeting chair. The first meeting of this group took place on 11th October 2013. This is to ensure that the two documents are linked through the process and to ensure that the JHWS reflects recommendations from the JSNA. Membership currently includes representation from a variety of internal and external organisations as described in the JSNA update to May 2013 HWBB meeting. Since then 2 new organisations have also been invited to this group – Kent Police and Kent Fire & Rescue.

This report and the updates from respective chapters and needs assessments will be fed into a prioritisation process that will be developed by the Public Health team supported by a collaboration of Universities of Kent, Sheffield and Durham. A workshop involving the JSNA / JHWS stakeholder group and other key representatives will be held on 13th March 2014 to determine which priorities will go forward and be included in the JHWS which is expected to be completed by June 2014.

The majority of chapter updates are represented here with the notable exception of Child and Adolescent Mental Health. This is being currently scheduled for a complete needs assessment refresh. An update for the JSNA will be provided later in autumn of 2014 once the assessment has been completed.

Demographic Changes

- The overall resident population in Kent in 2012 was approximately 1.48 million resident (1.55 million registered practice population) indicating a growth of just under 1%, smaller than the previous year on year figure which was 2.7%.
- The fastest growing section of the population is those aged 65 and over. In this age group the population grew by over 5% to over 279,000.
- Part of the population change is due to births and deaths. In 2012 there were approximately 16,000 deaths across Kent & Medway whilst we saw over 21,000 births. This gave an indigenous population growth of 6,200 (approximately half of the total growth)
- General fertility rates (rate of births to mothers aged 15-44) continues to rise across the county with the exception of Canterbury where fertility rates remain low.
- Life Expectancy for Kent continues to rise in both males and females and now stands at 79.1 and 83 years respectively.

Health Inequalities

The table below shows the trends in avoidable deaths (aged under 75) for various causes and for each Clinical Commissioning Group in Kent County Council area, showing the trajectory for the period 2002-2012, contrasted with the rate in the latest year. Also included is the rank for each CCG and disease, where 7 = the highest rates in Kent and 1 = the lowest rates.

	All cause			Cancer			Circulatory disease			Respiratory disease			Liver disease[4]		
CCG	Rank[1]	Period trend[2]	Trend in last year[3]	Rank[1]	Period trend[2]	Trend in last year[3]	Rank[1]	Period trend[2]	Trend in last year[3]	Rank[1]	Period trend[2]	Trend in last year[3]	Rank[1]	Period trend[2]	Trend in last 3 years[4]
Ashford	2	↓	↓	2	↓	↓	2	↓	↑	2	↓	↑	1	↑	↓
Canterbury	3	↓	↓	3	↓	↓	3	↓	↓	3	↓	↓	3	↑	↑
DGS	4	↓	↓	4	↓	↓	4	↓	↑	4	↓	↔	4	↑	↔
SKC	5	↓	↓	5	↓	↓	5	↓	↓	5	↓	↓	6	↑	↑
Swale	6	↓	↓	6	↓	↓	7	↓	↔	6	↓	↓	5	↔	↓
Thanet	7	↓	↓	7	↓	↓	6	↓	↓	7	↓	↓	7	↑	↓
West Kent	1	↓	↑	1	↓	↑	1	↓	↔	1	↔	↓	2	↑	↔
Kent	-	↓	↓	-	↓	↓	-	↓	↑	-	↓	↓	-	↑	↔

Source: PHMF, ONS, KMPHO
[1] - Rank 1 = lowest mortality rates in Kent, through Rank 7 = highest mortality rates
[2] - 2002-2012 death registrations
[3] - 2012 death registrations
4 - Three-year rolling averages, due to small numbers

↑ Rate increasing over period ↓ Rate decreasing over period ↔ No evident period change

In Kent, the period trend for all causes, cancer, circulatory disease and respiratory disease was downward, although in the latest year (2012) a small increase was noted on the previous year for circulatory disease. For liver disease, mortality increased over the period, although in the latest year the mortality rate has not changed from the previous year.

Lifestyles and Behaviour

Smoking

- The latest synthetic estimates for adult smoking prevalence in Kent is 20.1%, equating to approximately 231,753 people.
- Up until 2010/11, there has been a year on year increase in the numbers of people attempting to quit smoking. In 2010/11 19,979 people set quit dates, which then significantly reduced to 16,774 people in 2012/13, through the use of stop smoking services (perhaps due to increased uptake of other nicotine delivery products such as 'e-cigarettes').
- 15.2% of women continue to smoke during pregnancy in Kent (2012/13). The overall trend over time has been downwards locally, regionally and nationally. It is widely believed that self-reported smoking rates during pregnancy represent an underestimate of the true prevalence of smoking during pregnancy due to women's reluctance to disclose their smoking behaviour. A recent audit of pregnant women in Tunbridge Wells revealed significant differences between the self-reported prevalence of smoking and cotinine testing.
- Kent County Council is currently reviewing the delivery of Stop Smoking Services as there is a need to consider how services are currently delivered. NICE (2013) has produced new guidance on 'harm reduction' which needs to be implemented.
- Disadvantaged children, young people and adults are also likely to be exposed to higher levels of second-hand smoke than those from more privileged backgrounds. This is due to lower levels of smoking restrictions in the home. Work with children and young people is still required to ensure that the denormalisation of smoking continues to take place.
- Work on reducing illicit tobacco in Kent is still required. A Problem Profile was also undertaken to identify areas where illegal tobacco is a particular issue. This has also now been undertaken in the South East in 2013. An action plan needs to be developed to take forward activities to reduce the wider societal impacts of illicit tobacco.

Adult Obesity

- The adult rate of obesity in England is 24.2% and Kent is 26.3%, higher than the national average. Nine Kent Districts are also higher than the national average. Sevenoaks (23.9%), Tunbridge Wells (22.9%) and Canterbury (23.4%) are the only districts with rates lower than the national average, although district variation is not statistically significant.
- Key recommendations include:
  - Ensure that all tiers of the adult care pathway can be provided across Kent Currently access to Tier 2 physical activity services is not available in some areas particularly in DGS and WKCCGs.
  - Ensure these services are integrated with other primary prevention services such as Health Trainers.
  - Public Health are reviewing adult weight management and obesity prevention programmes to develop a Kent model including specialist physical activity programmes which are acceptable to people who are very obese for which there is a perceived lack of services available.

Childhood Obesity

- In Kent, rates are not significantly different to last year (and the England average) and could be interpreted as having plateaued. In Reception the rate of children recorded as overweight is 13.0% and recorded as obese is 9.3%. In year six 14.4% of children are overweight, 18.2% are obese. District rates vary, with Dartford, Gravesham and Dover having significantly higher rates than the Kent average.

Key recommendations include:

- Kent Community Health is reviewing interventions and care pathways to develop a model of care for family/child and young people for obesity prevention and treatment.
- KCC and schools should focus on early years and school settings that foster a healthy environment, including School Food Plans and include cooking skills as part of the commissioned programmes for families.
- The provision of appropriate workforce training, including the NHS and the development of a targeted evidence of what works specifically as regards children and young people including an action-learning approach.
- Advice to colleagues and the Kent Planners forum on planning permissions for licensing of take-away outlets near schools.

Alcohol

- Latest synthetic estimates suggest that 209,260 adults in Kent are drinking at 'increasing risk' levels (22-50 units a week for men and 15-35 units for women). 49,843 drink at 'high risk' levels, showing evidence of harm to their own physical and mental health, and 30,423 people have a level of alcohol addiction (dependency).
- (Under 18yrs) hospital admissions specific to alcohol use have more than halved since 2006, although there is variation across the county. Thanet has the highest rate in Kent and is around four times higher than that of Sevenoaks District.
- Since 2011 there has been a slight reduction in hospital specific admissions, which has halted the year on year increase since 2003.

Recommendations are:

- Public Health to work with commissioners to industrialise routine delivery of Identification and Brief Advice (IBA) across all health, community and social care settings.
- Develop a joint working policy, procedure and care pathway for clients with mental health and alcohol misuse problems (significant co-morbidity with mental illness requires pathway development into alcohol / mental health dual diagnosis services). Use referral tools and pathways already agreed by commissioners and providers.

Substance Misuse

- Illicit drug misuse among adults (16 to 59 years) in England and Wales declined in 2012/13 to 8.2%, of which the South East region was the third highest, around 8.4%.
- Applying the current South East figure is to the Kent population results in over 67,000 people having used drugs at least once in the last year.

Recommendations for commissioning include:

- Raise awareness through campaigns in the press, radio and through partner newsletters including workforce initiatives about the risks of substance misuse. Give consideration to wider distribution of culturally appropriate resources for new communities.
- Develop pathways for generic young people's risk reduction services, from brief advice to referrals for specialist services to be jointly carried out by commissioners across Child Health, KDAAT and KCC Education.
- The integrated drug and alcohol services as envisaged in the new treatment specifications will need to link into mental health services at all levels, including signposting and referral to IAPT.

Vulnerable / High Risk Groups

Learning Disabilities

- QOF data shows a Kent prevalence of 0.44% (slightly below the England average) or 5,209 adults with learning disabilities in 2011/12, an increase of 0.09% from 2007/8. In contrast local authority data for 2011/12 indicates a smaller population of 0.39% or 3390 adults with learning disabilities, implying that approximately 1,819 people may not be accessing or needing local authority services.
- Key priorities are improved recognition of adults with learning disabilities, understanding their specific needs and identifying reasonable adjustments to deliver accessible, effective services:
  - Training and awareness of learning disabilities among service providers, including GP surgeries and other providers of universal services.
  - Increased access to services through use of reasonable adjustments and by promoting easy read materials and other communication methods to support the health and wellbeing of adults with learning disabilities.
  - Ensure that every person who is on an LD register has been offered and had a health check.
  - Develop care pathways for specific conditions to include the needs and reasonable adjustments of people with learning disabilities, especially:
    - Epilepsy
    - Cardiovascular disease
    - Dementia
    - Diabetes
    - Falls
    - Optical care
    - Dental care

Offenders

- Based on surveys carried out between 2008 and 2011 there were approximately 3,741 offenders accommodated in prison. Higher proportion offenders are in the age group 20 to 49 years. Apart from Dover Immigration Removal Centre the highest proportion of offenders from BME groups was found in HMP Canterbury but this establishment was closed at the end of March 2013.

- The number of community offenders in the Kent Probation workload has remained largely unchanged from 2008/09 to 2012/13 and at March 2013 stood at 4303 with an annual turnover of some 5,300 individuals.
- There is a high rate of non-attendance at appointments offered within healthcare at some prisons in Kent such as refusal of psychological interventions associated with the Integrated Drug Treatment System and low uptake of Hepatitis B vaccination, coupled with high rates of smoking and hazardous drinking.
- Since April 2013 healthcare commissioning and the assessment of health needs of those offenders in prison is the responsibility of NHS England whilst those in the community have access to community commissioned services.
- Community offender management is currently undergoing significant change under the Government's "Reducing Reoffending" programme and will be in place for April 2014.

Recommendations

- NHS England is to prioritise development of clear pathways and referral processes that enable offenders currently in, as well as leaving, custody to access community drug and alcohol services, mental health services and other health care and improvement services including health checks.
- Sheppey prison estate should implement a Medicines Management Performance Framework to optimise and improve prescribing practices.
- Bedwatch and escort events should be subject to a special review to ensure that as many clinical services as possible are offered in the prison.
- There should be a specific review of In Patient facilities in HMPs Elmley and Swaleside.
- With the Kent Prison estate to be designated "resettlement prisons" with effect from 1st April 2014 steps should be taken to ensure that those offenders leaving a Kent resettlement prison have a clearly defined physical and mental healthcare pathway and registration with a local GP which is understood by the new emerging community offender organisations and their service providers.

Carers

- The 2011 census estimates 151,777 people, or 10.4% of Kent's total population, provide unpaid care. This proportion is higher than the regional average of 8.9% and the national average of 10.2%. This is an increase in 23,253 people or 18.1% since the last census in 2001.
- Out of the Kent local authority districts, Thanet has the highest proportion of unpaid carers with 11.6% or 15,502 residents. Tunbridge Wells has the smallest proportion of unpaid carers with 9.2% or 10,539 people.
- The proportion of unpaid carers in Kent who provide care for less than 20 hours a week dropped from 71% in 2001 to 64.2% in 2011. This is in contrast to the proportion of unpaid carers in Kent who provide care for between 20 to 29 hours a week which increased from 9.3% in 2001 to 12.1% in 2011, and those who provide care for more than 50 hours a week which also increased from 19.7% in 2001 to 23.6% in 2011. This pattern is comparable across the Kent local authority districts and at the regional and national level.

Recommendations described in the chapter on carers in the JSNA website, remain unchanged.

Children in Care (CiC)

- Latest estimates from Kent & Medway Safeguarding Team show that the number of CiC has risen consistently over the last five years until 2012, in line with national trends.
- In July 2013 there were a total of 1,827 CiC from Kent placed within Kent with a further 206 placed outside Kent in other local authorities (OLA) including Medway.
- Numbers across districts vary, from 306 in Thanet (16.7% of the total CiC population from Kent), to 23 in Tunbridge Wells (1.3% of the total population of CiC from Kent).
- A significant number of CiC from other local authorities (OLA) are also placed within Kent. In July 2013 a total of 1,225 CiC from OLA were living in Kent, with Thanet having the highest proportion (231 children or 18.9% of all OLA CiC in Kent).
- In December 2012 there were also 202 Unaccompanied Asylum Seeking Children (UASC). These children are likely to have significant health and wellbeing needs compared to indigenous CiC.
- The results of individual health assessments currently provides the following information on the health needs of CiC from Kent who had been looked after for at least 12 months (as of 31/12/12):
    - 93% had their immunisations up to date
    - 80% had their teeth checked by a dentist
    - 76% had received an annual health assessment
    - 47% of CiC who had an assessment of their emotional and behavioural health had issues which were cause for concern
    - 2.6% (n=30) were identified as having a substance misuse issue, an increase from 2.1% the previous year although this is thought to be an underestimate
- After the 2010 OSFSTED/ CQC inspection of services for CiC, an Improvement Board was established with a CiC Health & Wellbeing sub-group focussing on quality improvement in key areas ranging from timeliness of assessments to multi-agency training for practitioners.
- NHS reforms resulting in the new landscape and configuration of jointly responsible organisations will be a significant challenge to ensure that standards for safeguarding processes for CiC are maintained. For example, for CiC from OLA, the CCG in which the child was living when they became looked after are responsible for commissioning the child's initial and review health assessments and any secondary healthcare needs rather than the host CCG.
- Improvements made to the Kent Adoption Services have resulted in a significant increase in the workload of medical advisers who are required to provide comprehensive assessments of adoptive children and foster carers. Capacity issues within the service have been recognised as a significant risk by CCGs and a Medical Adviser Task and Finish Group has been established to co-ordinate a response to this issue.
- Legislative changes in 2012 mean that all young people securely remanded now become CiC. Work is underway by KCC and NHS England to establish the size and health needs of this new population.
- KCC Public Health are leading a needs assessment for CiC and Care Leavers in Kent which will provide a detailed population profile, review of services available

and the views of CiC. It will attempt to address gaps in information such as health needs and potential demand for primary care services. Much of the analyses will depend on capability of accessing linked datasets across health and social care to understand relative service use by CiC and the rest of the population. This work should be developed alongside the KIASS information system.

Veterans (New chapter)

- Kent has strong military links and includes bases that are home to a significant number of serving personnel. Local modelling suggests there are approximately 130,000 veterans in Kent and Medway, with the highest density in Thanet, Dover, Shepway, Swale and Medway.
- There are currently no specialised services for veterans in Kent beyond the Medical Assessment Programme. Primary Mental Health Care in Kent and Medway includes Increasing Access to Psychological Therapies (IAPT) services.
- The Armed Forces Network was established in 2013 to provide information about free at the point of access mental health services for ex-military personnel across Kent and Medway.

Recommendations are made in four key areas:

  - Transition from Defence Medical Services to the NHS by facilitating GP registration prior to discharge and improving transfer of medical records.
  - Public Health to raise awareness around the principle of prioritisation to improve physical health services for Veterans.
  - Local implementation of the national Murrison Report which describes the mental health needs of veterans and an action plan for improvement.
  - Support for the Armed Forces Community Covenant and develop closer working arrangements between CCGs and districts, such as the Civilian Military Partnership Board in Dover to articulate veterans' issues locally including the impact of defence cuts.

Gypsy, Roma and Traveller Populations (New chapter)

- Kent has a higher proportion of Gypsy, Roma and Traveller populations compared to many other parts of the country. There is very limited data about this population, although the limited evidence has found that the Gypsy, Roma and Traveller populations experience poor levels of health, even compared with other marginalised groups; high rates of infant mortality, and difficulties in accessing healthcare have been cited in the evidence. Poor school attendance, low educational attainment and high levels of illiteracy are also particularly acute problems for Gypsy and Traveller children. This leads to poor knowledge and awareness of how to access health services particularly primary care.

Recommendations

- Additional health trainers or community workers that have an understanding of the language and cultural issues should be considered for areas where there is a relatively high proportion of Gypsy, Roma and Traveller populations. It would ensure representation for wider community groups, including Roma community members and male representatives from the community.
- Services that aim to change lifestyle behaviour such as the Stop Smoking Service and drugs and alcohol services should actively ensure that there is appropriate outreach offered to Gypsy, Roma and Traveller Communities.

- Provision of training that improves the knowledge of staff around the cultural needs of Gypsy, Roma and Traveller communities, particularly those that are delivering primary health care services. Training could be formal, but could also be offered online or via the production of a DVD to ensure wider coverage.
- Educating health care professionals, community members, and community leaders to raise awareness is vital if the health needs of this community are to be met. The production of DVDs explaining how and when to access different health services in Slovak or other languages could help.

Sensory Impairment (New chapter)

- Latest (2010/11 data) Public Health Outcomes Framework data indicate Kent having relatively lower rates of sight impairment (AMD, glaucoma and diabetic retinopathy) compared to the England average.
- The Kent County Council registers for sensory impairment show more than 7,700 blind, 9,000 deaf and 1,400 deaf/blind people as of April 2011. However other national estimates suggest that these numbers could be only 33%, 10% and 25% of the expected figures respectively.

Recommendations

- There is a need to carry out health promotion campaigns aimed at raising awareness of the need for regular sight and hearing tests, targeted particularly at risk group's e.g. older people, diabetics, young people at risk of hearing impairment from the effects of loud music and noise in the workplace.
- Develop and implement clearer pathways for accessing integrated care services and assessment as well as the delivery of services, for example Eye Clinic Liaison Officer posts and consistent vision screening for children in Kent schools.
- Undertake further analysis to better understand how sensory impairment influences / overlaps with other programme areas eg. risk of falls and fractures in the elderly, learning disabilities.

Sexual Health

- Prevalence of HIV is increasing in Kent including late diagnosis. In 2011 the highest rates of diagnosed prevalence of HIV among Black Africans aged 15-59 per 1,000 population in the South East included Shepway (79.4/1,000).
- The numbers of residents accessing HIV related care increased by 6.4% from 2011 to 2012 except Maidstone where numbers remained the same and Dover where numbers decreased.
- Number of repeat terminations is increasing in Kent.

Recommendations include:

- Conduct qualitative research to understand why some HIV positive patients present late in the course of their disease
- Increase HIV testing through primary care and secondary care for patients who present with clinical indicator diseases
- Offer HIV testing in GUM and CASH to 100% of the patients receiving an asymptomatic screen or who have a concern about being at risk of an STI

- Expand the EHC scheme through community pharmacies to females up to the age of 30 years
- Conduct research to find out about barriers to protecting yourself against STI's /using barrier methods

Teenage Pregnancy

- The rate of under 18 conceptions in England has fallen to its lowest rate for 30 years. The rate of under 18 conceptions has declined in Kent by 26% from a baseline established in 1998.
- In Kent, in 2011 the rate of under 18 conceptions is 31 per 1000 15-17 year olds compared to the England rate which is 30.7 per 1000. The rate of under 16 conceptions in Kent for 2009-11 is 6.4 per 1000 13-15 year olds compared to 6.7 per 1000 in England.
- The rates vary across districts and wards of Kent. The highest rates are found in the coastal towns of Thanet, Swale and Folkestone.
- A strategy to reduce under-18 conceptions and improve outcomes for young parents will be consulted upon in early 2014. Its key recommendations are:
    - Use information better, to intervene early, improve care pathways, meet need, drive innovation and deliver evidence based practice.
    - Ensure an equitable, accessible and young people friendly sexual health service is in place across Kent.
    - Coordinate Kent wide social marketing activity which will build resilience and enable young people to make the right choices for them.
    - Ensure effective and equitable PHSE with a strong focus on sex and relationships, building emotional health and wellbeing.
    - Extend the Family Nurse Partnership to deprived localities and / or high levels of conception rates.

Domestic Violence

- The Home Office ready reckoner tool estimates more than 150,000 cases of sexual assaults, domestic abuse and stalking in Kent & Medway during the last year, costing more than £317 million to the health and social care services but most of these go unreported.
- Overall, in Kent repeat victimisation rates are increasing with the highest numbers of reported incidents were in Dover and Thanet, closely followed by Ashford and Shepway. Canterbury and Sevenoaks had the lowest repeat victimisation rates.
- On average there are five domestic homicides a year in Kent & Medway.
- During 2012/13, a total of 23,409 incidents of domestic abuse were reported, an increase of 4% from the previous year.
- Thanet (2,795 incidents – 0.5% lower than previous year) and Swale (2,016 incidents – 0.7% lower than previous year) reported the most incidents. The same areas also reported the highest number of incidents during 2011/12.
- The areas with the lowest number of reported incidents were Tunbridge Wells (1,005 incidents – 2% lower than previous year) and Sevenoaks (876 incidents – 2% higher than previous year). Both these areas also reported the lowest number of incident during 2011/12.

- There are now a total of 12 one stop shops across Kent and Medway providing legal support and advocacy. There has been a steady increase in their utilisation 891 visits in 2010/11 to 1259 visits in 2012/13.
- Among the key recommendations are to disseminate accredited training across Kent & Medway organisations that are certified competent to deliver it. This mainly involves raising awareness over availability of wider services and referral pathways not just MARACS processes for the most severely affected women.
- Ensure that the needs of children affected by domestic violence perpetrated by parents as well as within their own relationships are identified and met.

Breastfeeding

- Breastfeeding coverage up to April 2013 had been slowly improving over the previous 3-4 years, although still under the 95% coverage required by DoH. Best coverage was found in West Kent CCG and Canterbury & Coastal CCG area where coverage was 92%. Swale and Thanet CCGs had 89%.
- Since April 2013 coverage rates across the county have been falling and are now as low as 72% for Kent (Q2 2013/14). CCG coverage rates vary from just 67% in Thanet to 84% in Canterbury & Coastal CCG area.

Targeted Action

- Public Health have been and will continue to engage with GP Practices and Child Health Surveillance to ensure recording of breastfeeding status is as timely as possible and raise coverage rates to over 90%.

Long Term Conditions

Cardiovascular Disease and Vascular Health Checks

- As per previous estimates, CHD prevalence in Kent overall still appears to be increasing in line with national trends, largely due to higher reporting and case finding rates. Thanet district appears to have relatively higher Coronary Heart Disease mortality rates compared to the rest of Kent while Tonbridge and Malling have relatively lower levels.
- Latest 2012/13 estimates show admissions for heart failure have shown some increases in Thanet and West Kent CCGs but reduced slightly in Canterbury, DGS and South Kent Coast CCGs.
- Rates of revascularisation procedures in 2013 show higher proportion of activity being repatriated from London to local centres in Kent and slightly reduced numbers of CABGs alongside increased angioplasties.
- Based on the 2012/13 eligible population, there are an estimated 456,201 patients who are eligible to receive an NHS Health Check living in Kent. This equates to an annual target of 91,241 patients to be invited once every five years. The current commission agreement also includes extra funding for out-reach programmes to target hard to reach groups.
- Between April 2011 and March 2013 different commissioning arrangements between East and West Kent which compromised delivery of the health check programme, leading to non-achievement of the DH set targets for 2012/13 in West Kent. From April 2013, KCHT were commissioned to deliver the NHS HC programme across Kent. This included contracting directly with GP and

pharmacy providers as well as the out-reach aspect of the programme. KCHT have also contracted directly with GP practices to deliver the invitation part only of the NHS HC. There are now only 6/209 practices that are not engaged in the delivery of the programme.

Diabetes

- There are 69,061 people in Kent aged 17 or over on a diabetes register. In March 2011 there were 66,290. This is an increase of 2,771 (4.2%). The CCGs with the highest prevalence of recorded diabetes are Thanet and Swale CCGs and those with the lowest are West Kent and Canterbury and Coastal CCGs.
- It is estimated that 17,497 people in Kent have undiagnosed diabetes increasing prevalence by another 20%.
- Canterbury Coastal and West Kent CCGs have the highest number of undiagnosed patients.

Recommendations

- Given the strong link between obesity and diabetes, Kent Healthy Weight Pathway for Adults needs to be integrated better. Tier 3 services are now provided across Kent from 1st April 2013 and are now the gateway to bariatric surgery.
- Kent Paediatric Diabetes Units may wish to look at the practice of Maidstone and Tunbridge Wells NHS Trust when considering how to reduce admissions related to children with diabetes.
- Optimising the health check programme to find the 'missing thousands' and increase appropriate referrals into lifestyle programmes will continue to be a priority for public health.

Chronic Obstructive Pulmonary Disease

- QOF recorded prevalence of COPD is 1.7% in Kent and Medway with another 1% estimated undiagnosed or 12,000 people. Prevalence is rising across the CCGs with the highest in South Kent Coast and Thanet CCGs. DGS CCG is estimated to have a much higher number of undiagnosed patients.
- Mortality rates for COPD are highest in Swale (26.9 per 100,000) and South Kent Coast CCG (36.9 per 100,000) and lowest in Ashford (16.5 per 100,000). This is related to deprivation and smoking prevalence. Nationally the trend is rising in women and falling in men.
- Commissioners need to ensure that primary care services for early diagnosis and treatment of COPD is integrated well with Smoke Free and Smoking Cessation initiatives.
- Improving public and patient engagement aimed at 'finding the missing thousands' to increase reporting and case finding rates.
- Evaluation of pilots in East Kent (using spirometry) and West Kent and DGS area smoking cessation teams using International Journal of COPD questionnaire
- Prioritise service improvement particularly in areas of deprivation and in addressing disparity of outcomes between CCGs in Kent.
- Deployment of community respiratory nurses and acute sector outreach into the community to improve diagnosis and treatment.

Cancer

- Over the last ten years, the incidence rate for all cancers in Kent and Medway has remained steady for males, with a slight increase for females. Incidence of skin cancer continues to increase. There appears to be a downward trend in mortality for all cancers in both males and females in Kent and Medway. Cancer of the breast, lung, colorectal and prostate together remain the four most common cancers in Kent and Medway and account for about 50% of all cancer diagnosed and causes of death from cancer. Lung cancer remains the main cause of death from cancer.
- Most of the existing recommendations outlined in the JSNA chapter to improve health and wellbeing outcomes associated with cancer still apply.
- The national 2012/13 Cancer Patient Experience survey on service quality and satisfaction involved responses from three Kent Acute Trusts results of which include some areas rated well and others bad. For example 20% of patients had visited their GP three or more times before they were referred to the hospital.
- Improvement still required in raising awareness amongst GPs and the public around early diagnosis and treatment of cancer.

Stroke

- Latest QOF data shows that in Kent & Medway 30,500 people were recorded as having a stroke or TIA. This is a prevalence of 1.7% across Kent and Medway (equal to the national prevalence). The lowest prevalence of stroke was seen in Medway with just 1.3% of the population appearing on a stroke register, the highest prevalence of 2.1% is seen in South Kent Coast CCG area. Thanet CCG area has the second highest prevalence with 2.0%, followed by Canterbury & Coastal CCG (1.9%), Ashford CCG (1.8%), DGS CCG (1.6%) and Swale CCG (1.4%).

The South East Coast Cardiovascular Strategic Clinical Network (SCN) have recommended:

- All acute and community providers should be recording, completing and returning the Sentinel Stroke National Audit Programme (SSNAP) data as this is the only national standardised stroke audit system to enable benchmarking and recording of quality of services.
- CCGs to review existing stroke models of care, in line with the work currently being undertaken within Surrey and Sussex, to ensure that the existing model of care (District General Hospitals, linked by Telemedicine) is cost effective, sustainable, meets quality standards, and offers the best possible patient outcomes.
- The Integrated Stroke Service Specification (ISSS), which was developed by the previous county wide Stroke Networks for Kent, Surrey and Sussex and contains best practice guidance for stroke services, should be used as the basis for commissioning stroke services.

Older People's Health

Falls and Fractures

- In 2011/12 there were 1,758 emergency admissions for hip fractures in the over 65 population compared to the previous year 2010/11 which had 1,721. The

majority of these hip fractures are usually as a direct result of a fall. This shows a slight increase of emergency admissions for hip fractures. Falls is still a major public health issue for Kent and to reduce the numbers of falls further, more work needs to be done.

Recommendations:

- To support local population in engaging with preventative interventions, particularly those in the 65+ age group and those 50 years and over with multiple conditions
- Carry out further needs analysis of falls in residential care and hospitals.
- Have in place postural stability community therapeutic exercise programmes in each CCG area ensuring a process of monitoring, feedback and the evaluation of services.
- Review and redesign of Falls Clinics and falls ambulance call out services.

Excess Winter Deaths

- 25,700 excess winter deaths were recorded for England and Wales for the winter 2010/11, a ratio of 17% compared to the summer months. In comparison, the three rolling average ratio for Kent during the period 2007/11 was 17.6%, equating to an average of 856 deaths per year. There is significant variance between districts, the lowest for this period being 11.7% (Maidstone) and the highest 26% (Tunbridge Wells).

Recommendations are:

- Increase 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 due to cold weather.
- The use of risk stratification to identify high risk / complex frail, elderly patients who are likely to die during winter is an example of how the seasonal mortality agenda can be linked to wider health and social care integration programmes in Kent.
- Another example is to promote cold weather alarms for vulnerable people in cold weather, as part of assistive technologies programme led by Families and Social Care.

Dementia

- Improving diagnosis rates is a key strategic objective, from 38% (based on 2011 QOF data) to 60%. It is estimated that by 2015, assuming a 60% diagnosis rate, 12,805 people will be diagnosed with dementia across Kent. This means that in two years an additional 5,632 people will need to be assessed as they enter the dementia pathway as people who are newly diagnosed.
- The 2012 urgent care needs assessment across the 3 systems in Kent show a marked increase in rates for dementia related emergency admissions rates. The 2011 hospital bed day audit across Kent & Medway showed that, in up to 50% admissions that were audited, no substantive acute care had taken place at the time of audit, and that up to 40% of those admissions were waiting for residential care placement. Most of the admissions audited were emergency and complex frail elderly.

- The recent Public Health led epidemiological study, using risk stratification showed the highest prevalence of dementia in the very high intensive users of hospital services (approximately 15%), as well as higher levels of multi morbidity, mortality rates and falls. Further analysis showed that the proportion of very high intensive users with only dementia was as low as 5%, while the remaining 95% who had dementia, had at least one other chronic condition.
- A number of initiatives have already been implemented under the auspices of dementia friendly communities, ranging from diagnostic support to assistive technologies.

Recommendations

- Further work is still required to improve integrated care pathways 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.

Multiple Morbidities (this is explained in the Integration chapter)

Adult Mental Health

- Currently the data for adult mental health is poor. There are various reasons for this, some due to the National Implementation of PBR and other local data issues. On this basis an accurate assessment of need is not possible at this stage. The prevalence estimates in the JSNA show Kent to have similar mental health needs to the England average. Only when the cluster arrangements are mature will we be able to make a clear assessment. In the interim it is recommended that an urgent clinical and equity audit is conducted in secondary mental health service data.
- The data on psychological therapies is also incomplete. However, the part year data shows that South Kent Coast is making good progress in referrals to psychological therapy. West Kent and DGS have considerable unmet needs. Recommend that greater publicising of IAPT counselling services is undertaken and the self-referral publicised.
- Ensure that targeted groups eg veterans, men (45-55) and BME groups get access to psychological therapy via this route.
- Employment rates for people on long term care plans is lower than the national rate across the whole of Kent CCGs – with Thanet and SKC having the lowest rates in the county.
- Hospital data in 2012 showed that Thanet had by far the largest proportion of patients admitted to hospital for schizophrenia (72 per 100,000 people) in Kent. The Kent average admission rate for that year was 35 per 100,000.
- In Kent 121 people (aged over 15) committed suicide or died by undetermined causes in 2012 with South Kent Coast CCG having the highest rates.
- Kent had just over 3000 hospital admissions for self-harm in 2012 similar to the England average.

Some of the key recommendations:

- Review and refresh the 'Live it Well' Strategy in light of new commissioning arrangements and national priorities ensuring a greater focus on recovery, prevention and equity of access.

- Prioritise the mental health of people in Thanet and ensure that services are accessible, equitable and joined up in that locality.
- Improve the knowledge, publicity and awareness of counselling services across Kent and particularly in Dartford, Gravesham & Swanley and West Kent.
- Ensure that mental health services from primary care are sufficiently resourced and equipped to meet demand and unmet need in Kent and that equity is evidenced across Kent CCGs.
- Ensure that services for younger adults are appropriate and joined up with CAMHS services to ease transition into adult services.
- Refresh the current suicide prevention plan for Kent and prioritise methods to tackle self-harm and links to police and the criminal justice system.
- Improve referrals made for employment opportunities and increase links with training and employment.

Screening

- Latest data shows that while breast cancer screening coverage rates have been consistently higher than national standard (70%) across Kent, Canterbury and Thanet CCGs have fallen below the national standard of 80% coverage rate for cervical cancer screening. Analysis of the bowel cancer screening over the last 4 years have revealed pockets of coverage less than 50% in most CCGs.
- Concerns and the need for concerted action on
    - coverage/uptake
    - known inequalities
    - analysis of need not yet mapped map and measure associated inequalities
    - the need for accurate and timely information to enable those groups or individuals not taking up these public health services to be targeted

Health Protection (including immunisation)

- Immunisation rates, including MMR, are relatively high in Kent, but further improvements are necessary to reach the target of 95% for two doses at age five years.
- “Tuberculosis (TB) cohort review” is now well established in Kent and Medway and is expected to improve outcomes.
- Commissioning of TB services should take account of the geographical areas (Gravesham) and sub-groups of the population with the highest incidence (non-UK born).
- Continued effort to improve screening is required to meet the target of 2,300 chlamydia diagnoses per 100,000 population (aged 15-24).
- The proportion of adults presenting late with HIV in Kent is 49%. Although this is not significantly different to the national average, effort should be made to reduce this proportion.
- There are areas within Kent with a relatively high fraction of mortality attributable to air pollution. Guidance is available from the Department for Environment, Food and Rural Affairs and Public Health England to support the development of local action plans.

Pharmaceutical Needs

- Work has started to combine both the West & East Kent assessments and update and review the combined report, taking into account any recent changes to legislation, population changes and changes to the pharmaceutical list. This review will be carried out according to national guidance.
- Latest analysis indicates no immediate need to commission more community pharmacy services, but that commissioners should target current services more appropriately according to need and look to give choice to patients by providing services that are best placed for the patient, health need and location.
- In addition the West Kent needs assessment recognise that for some services pharmacies will be one of a number of providers, who should be commissioned to work collaboratively with each other to avoid duplication and ensure best use of resources.

Other Health Care Services

Urgent Care

- Until 2012 Emergency Department (ED) attendance rates in Kent & Medway appeared to have changed little over the last three years, the number of emergency admissions has risen by more than a third in the last six years whereas rates have increased by approximately 10%.
- ED is the main route in for emergency inpatient admissions and represents the most of the rate of increase in activity and spend in non-elective admission activity.
- There have been activity increases in important programme areas particularly Ambulatory Care Sensitive conditions, falls in the elderly, dementia, alcohol and under fives.
- Analysis indicates a significant proportion of urgent care activity is related to older people with health and social care needs linked to dementia, falls and end of life.
- This cohort will be complex, have multiple morbidities requiring an integrated health and social approach which can be successful depending on a whole systems transformational change towards an integrated care team approach using risk stratification and patient empowerment methods through self-care and self-management.
- While completeness of inpatient data is fairly robust, attendance data needs to be improved and explore how information on key programme areas such as falls & fragility fractures in the elderly and alcohol use can be better recorded.

End of Life Care

- The majority of deaths in Kent were caused by chronic conditions including cancer (28%), respiratory disease (15%), coronary heart disease (12%), stroke (8%) and other circulatory disease (9%).
- Analysis of deaths in Kent suggests that sudden death ranges between 25% and 42%. This suggests that between 3381 and 5679 deaths in Kent were unexpected and could not have been identified as requiring some EOLC input in 2011/12.
- Deaths for those aged >75 years are important as they account for 67% of all deaths and thus most closely mimic the preferences of those nearing the end of their lives.

- The national end of life programme on 'Finding the missing 1%' recommends a proactive approach towards identifying patients who may be at an end of life stage and initiating advance care planning as early as possible.
- Apart from improving completeness of palliative care registers, the risk-stratification approach, part of the wider health and social care integration programme in Kent, can help focus commissioners on those with the highest chance of death and ensure integrated care delivery as early as possible. It should be developed into a key element of EOLC planning in Kent and Medway.

Planned Care

- Patient satisfaction rates around access to GP services show Kent generally in line with national levels. There is consistently lower satisfaction in getting an appointment within 48 hours and advance bookings.
- Latest data on outpatient data shows high FU/FA ratios for cancer and dental specialities. Historical differences between East and West Kent PCT areas continue with higher Clinical Oncology ratios in west Kent versus higher Medical Oncology ratios in east Kent.
- The total hip replacement rates have started to decrease over the last two years, with the exception of Swale CCG, for which the figures have increased and are now considerably higher than the Kent average.
- The total knee replacement rates have also started to fall over the last two years, with the exception of Canterbury & Coastal, Swale and Thanet CCGs. Figures for each of these CCGs have increased during this time with the highest being Thanet CCG.
- The rates of cataract operations appear to have decreased across all of the CCGs for 2011/12 followed by a slight increase in 2012/13.
- Wide variation in rates of skin lesion removal procedures exists across all CCGs however their trends appear to have plateaued with the exception of Canterbury CCG where it has increased slightly.

Maternity and Babies

Some of the areas have already been discussed in other sections. Recommendations for NHS and local authority commissioners are around pathway improvement and optimisation across all areas in Kent:

- Smoking cessation support to be incorporated in the role of midwives and maternity services by December 2014 across all maternity units. The Babyclear programme, delivered by midwives, for screening to validate smoking behaviour will be built into the maternity care pathway and routinely undertaken at time of booking for all mothers.
- Support for breast feeding initiation and on-going support into the community is systematically embedded by August 2014.
- Care pathway for teenage parents is mapped, commissioned and followed in by December 2014.
- Pathways in place to reduce the rates of infant mortality and the universal healthy child programme, identifies at risk infants and supports mothers on an on-going basis.
- All antenatal and postnatal screening programmes are meeting national standards in Kent and uptake is monitored and services performance managed.

Dental Health

- NHS dental access rates for the years 2011-13 indicate Kent is lower than the South East Coast regional average (42% & 46% respectively). This disparity in dental access may be a lack of capacity, or a lack of ability to use dental services.
- While most children were free of tooth decay, some 19% of 5-year-olds and 23.6% of 12-year-olds in Kent and Medway were estimated to have experience of tooth decay. Although lower in prevalence and severity when compared to the national average, there are geographical variations across Kent.

Accidents and Injuries (New chapter)

- Accidents account for 13% of emergency hospital admissions and 5% of total hospital admissions nationally. Estimates, of the ratio of financial return on injury prevention work, range from e.g. 50 to 1 for bicycle helmets and 17 to 1 for smoke alarms. Unintentional injuries are the leading cause of death for people under the age of 39, and are the second biggest cause of Years of Life Lost (YLL), among people aged 15-64 (i.e. 'working age population') behind cancer.
- Deaths and serious injuries on Kent's roads have shown a long-term reducing trend. The number of people killed or seriously injured in 2012 was 25% lower than the 2005-2009 average. Nationally, over the same period, there was a 17% reduction, suggesting that the long-term reduction has been greater in Kent than in England overall. However, in 2012 the number of people killed or seriously injured in Kent increased slightly by 1%, whilst nationally, casualties fell by 1%. Further investigation of the extent of road and transport-related injuries by district is required.
- National data suggests that Kent experienced more unintentional injuries relating to burns and to falls in children under five than national averages, up to 2010/11. Further investigation is required to identify whether this represents a longer term trend, and if so, the possible reasons for this.

Sustainability (New chapter)

There is a clear interdependency between public health, social care and sustainability and Health and Wellbeing Boards are required to consider wider social, environmental and economic factors that impact on health and wellbeing- such as access to green space, the impact of climate change, air quality, housing, community safety, transport, economic circumstances and employment. This chapter looks at how we can improve delivery of public health outcomes through taking a sustainable approach focussing on these, amongst other, priorities for Kent.

A sustainable health and care system requires an integrated approach, improving quality of life and meeting the needs of current and future generations, whilst simultaneously protecting and enhancing the natural environment. Through considering economic, social and environmental impacts in our decision making we can ensure that our approach to delivery of health and social care in Kent is sustainable, with outcomes benefitting our residents now and into the future. Local planning and commissioning should consider and address the impact of environmental factors that can impact positively or negatively on health, in particular:

- Housing and fuel poverty

- Transport
- Climate resilience
- Air quality
- Workplace and supply chain
- Natural environment

Housing & Homelessness (New chapter)

- Between July and September 2013, 238 households in Kent were classified as homeless and in priority need (as defined by the homelessness legislation in the Housing Act 1996), a reduction of 3% for the same period in 2012.
- In September 2013, 550 people in Kent were living in temporary accommodation, an increase of 0.5% on the same period of 2012.
- A total of 33,608 people were on housing waiting lists across 11 Kent Districts (1 district data not available) as at 1st April, 2013, an estimated increase of 2%, the highest since 1995.
- Impact on welfare reforms may significantly impact on rental payments particularly for tenants in private housing over the next few years.

Key recommendations include:

- Integrated approach to commissioning and processes to address falls prevention in the elderly and fuel poverty, including contribution that housing services by district authorities can make.
- Improve awareness and access to services for homeless; rough sleepers; sofa surfers; those in temporary accommodation who often have complex health conditions

Integration (New chapter)

A new section on Integration will replace QIPP and describe information on the Kent programme such as:

- Latest progress on the Kent *HASCIP:* A compact agreement is in place between community mental health, community health and social care which describes how organisations will work together to enable care coordination – multi-disciplinary team (MDT) meetings, coordinated by the GP, using risk stratification to identify patients, with an outcome of an anticipatory care plan. The aim of this is to enable people to self-care and self-manage, using assistive technologies and personal budgets and greater use of service in the voluntary sector. Some key achievements include:
    - 92% practices have signed up to NHS England Risk Stratification Direct Enhanced Service & supporting MDTs.
    - Co-location of community health and social care teams in Dartford Gravesham and Swanley CCG areas.
    - 29 out of 35 practices in South Kent Coast using an agreed proactive care model of integrated care.
    - 25 patients in South Kent Coast receiving an integrated personal budget.
    - Health and Social Care Coordinators working with GPs in Canterbury, Swale and West Kent have received over 2000 referrals since January 2013.
- Latest achievements of the Integration Pioneer, its different workstreams and the spread of innovation particularly Kent participation in the national Year of Care Funding Model programme.

- Explanation of the emerging ‘House of Care’ model conceived by NHS England that will enable whole system change to manage patients with long term conditions.
- The emerging importance of multiple morbidities, the impact on our health and social care services. The latest risk stratification analyses indicate that the highest intensive users (approximately 5% of the population) of hospital services are mostly elderly patients with complex needs and multiple morbidities, representing almost 60% of total unscheduled hospital admission spend in the whole population. The need has increased considerably for a whole system change moving towards a proactive integrated care approach, irrespective of single disease or single programme areas.
- The use of risk stratification approach to understand impact of population need on service utilisation: This has given commissioners a unique whole system baseline profile across different services, particularly hospital and adult social care and substantively contributed to the necessary evidence base and strategic planning of the local health and social care integration programme, and the cornerstone for Kent CCGs’ transformational plans over the next three to five years.
- The importance of whole systems intelligence and data sharing: to develop a framework to understand how use of health and social care services varies across the whole population, how and what services need to be transformed and improved, and more importantly building local evidence for whole system change, moving towards an integrated model of care.

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