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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

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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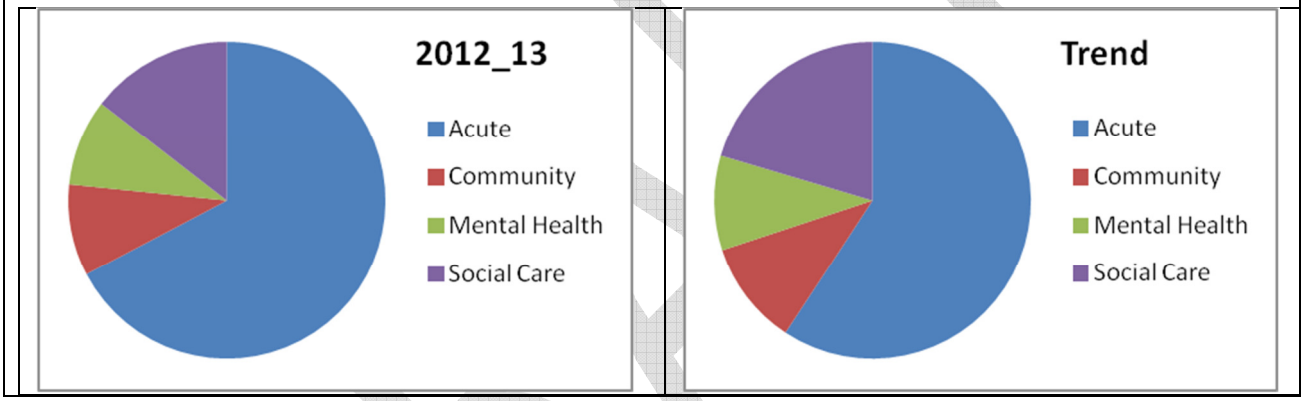
Detailed investment and benefit management plans will be designed throughout 2014/15 in line with CCG and Social Care commissioning plans. **Further work will take place prior to submission in April to quantify the impact on the acute sector and contingency if savings are not achieved. This will take 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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2) NATIONAL CONDITIONS

a) Protecting social care services

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

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

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

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

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

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

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

b) 7 day services to support discharge

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

As part of our Kent Pioneer programme we are committed to not only providing seven-day health and social care services but also furthering this to a proactive model of 24/7 community based care. Adult Social Care has recently shifted working hours to be 8-8, 7 days per week as standard.

Kent is also committed to effective reablement to ensure people remain at home or are facilitated to return home, supported across Kent by enhanced rapid response and urgent

care services to further support admission avoidance and timely discharge.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

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

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.**

		• 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.