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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**

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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 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):
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 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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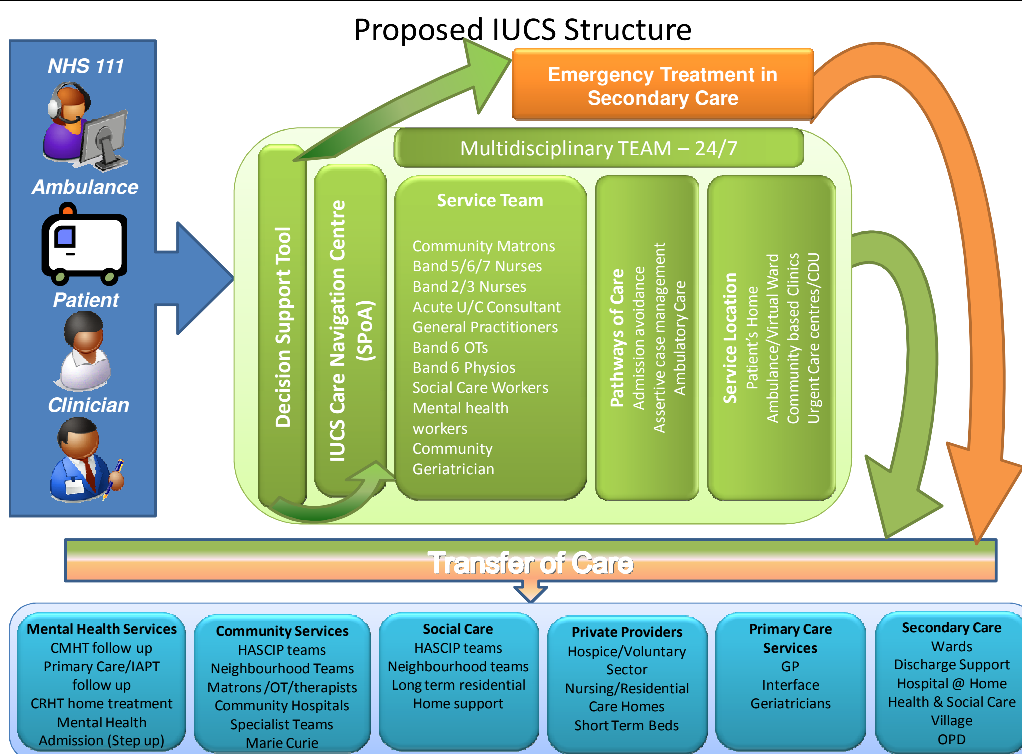

Mental Health Services

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

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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. 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.

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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
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.		