Better Care Fund

Vision Document

North Kent CCGs

Swale, and Dartford, Gravesham and Swanley CCGs

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.

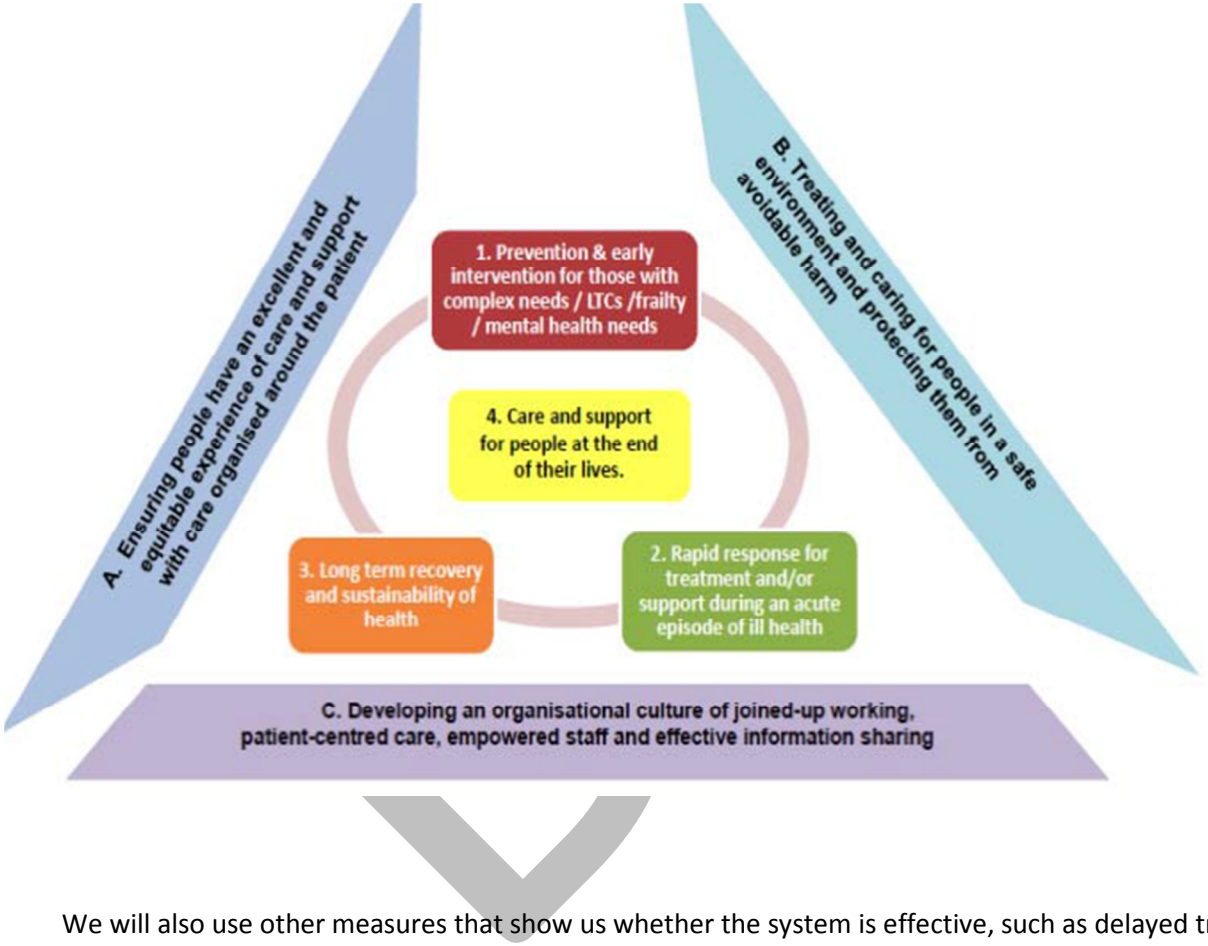
This will require a different way of working from our service providers and will require us to develop an infrastructure that will allow both the voluntary and community sectors to play a greater role of supporting people more effectively in their communities. If we are successful, funding for unplanned 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

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

- **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.

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

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

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

- 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.

6.10 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.

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

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.

Appendicies

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

DGS Health Economy Integrated Discharge