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Better Care Fund planning template – Part 1

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

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

1) PLAN DETAILS

a) Summary of Plan

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

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2015/16	**£122m**

b) Authorisation and signoff

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

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

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

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

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

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

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

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

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

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

West Kent

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

North Kent

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

East Kent

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

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

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

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

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

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

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

West Kent

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

North Kent

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

East Kent

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

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

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

participation groups and the local health and social care integration implementation groups. HASCIP Steering Groups on a local level have patient and service user representatives and as part of the operational integration programme regular surveys on integrated care are undertaken with patients by Kent Community Health NHS Trust and inform operational implementation and strategic planning.

Adult Social Care is currently undertaking a survey with service users on their current experiences of integrated care and support. The outcomes of this survey will be used to inform further development within integration and can help inform implementation of the BCF plan.

Kent is committed to meaningful engagement and co-production with the public and wider stakeholders and as a Pioneer will use ICASE (www.icase.org.uk) as a mechanism to provide updates on our progress within integration and the implementation of the Better Care fund. The communication leads from across all partners are working together to develop and integrated communication strategy.

Following the Kent Health and Wellbeing Board on 12 February the Kent plan has been shared via www.kent.gov.uk with a link to the HWB webcast, the draft plans, a summary presentation and questionnaire on the contents of the plan. Kent Healthwatch have assisted in the promotion of the feedback mechanism for the draft BCF plan and are engaged on developing an action plan to further involve the public on design and delivery of the schemes within the plan.

e) Related documentation

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

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

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VISION AND SCHEMES

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

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

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

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

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

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

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

Across Kent new Secondary Care models will seek to manage urgent and planned care as separate entities for optimum efficiency. Hospital based urgent care will work as part of the total system connected with primary and community services. Together they will optimise patient flows to deliver the most cost effective service with coordinated care around people with complex needs.

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By 2016 we will have reduced the need for hospital acute admissions by 15% by having co-ordinated health, social and community services that meet the needs of our Kent citizens 24 hours a day, seven days per week. We will have shared information systems with integrated care plan sharing, monitoring people in their own home including self-monitoring and fully supporting independent living

By 2016 the Kent citizen can expect fast community responses within 4 hours to mirror the targets and pressures in the acute trusts. This will be achieved by changes in workforce based around the GP practices working together in neighbourhoods as part of the integrated care teams, co-ordinating care and accountable for delivering this 24/7 care backed up by consultants and specialist nurse working in the community.

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

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

b) Aims and objectives

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

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

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

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

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

<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.

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- 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c) Implications for the acute sector

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

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

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

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

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

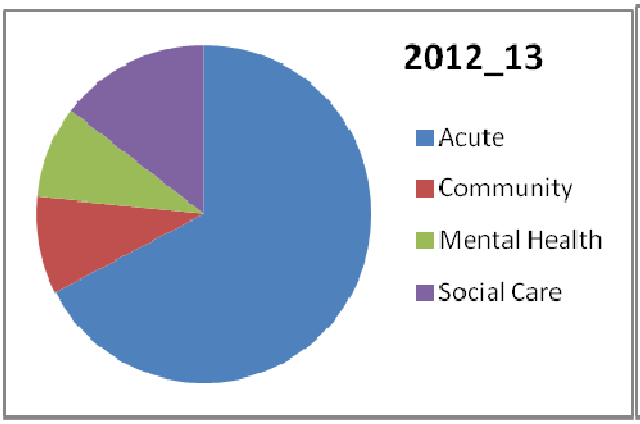
Detailed investment and benefit management plans will be designed throughout 2014/15 in line with CCG and Social Care commissioning plans. A summary of the local plans is:
West Kent: Mapping the Future sets out ambitious targets for reducing urgent care costs by £25m by 2018-19. Our plans for the forthcoming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

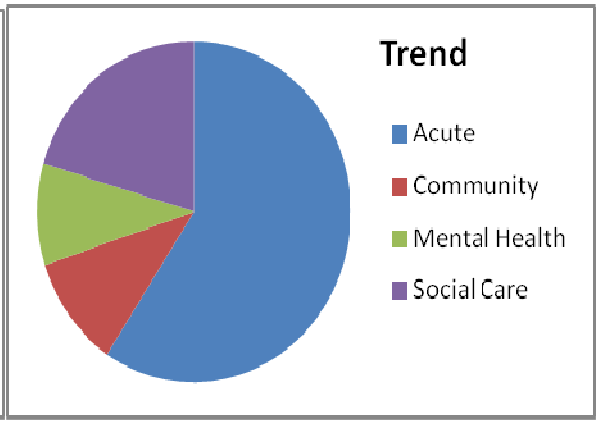
North Kent: The key implication for the Acute sector will be the reduction of non-elective admissions (NEL), based on audit work undertaken across North Kent by The Oak Group and The Kings Fund this ambition is set at 15% over two years:

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

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

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





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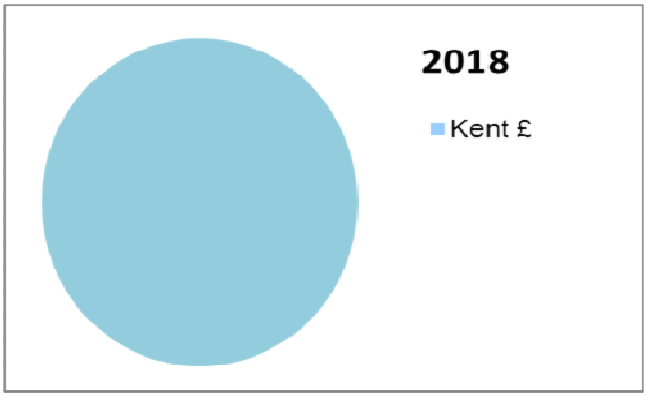

d) Governance
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

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

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

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

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

NATIONAL CONDITIONS

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

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

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

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

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

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

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

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

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

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

b) 7 day services to support discharge

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

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

West Kent

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

North Kent

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

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

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

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

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

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

A small proportion of NHS numbers are held within KCC's Adult Social Care System SWIFT. Monthly batches of client records are sent to the NHS matching service (MACS) and if they can match to a single record on their system they return the NHS number which is uploaded into SWIFT.

Within KCC the NHS number is predominately used to facilitate the matching of data sets for Year of Care and Risk Stratification, it is currently not for correspondence or to undertake client checks, the numbers are too low. Social Care would currently use name: address and date of birth as the key identifiers at present.

KCC achieved approx. 80% matching of records to NHS numbers when started. The MACS service is due to close at some point (no date given yet) so KCC are in the process of transferring to the Personal Demographics Service (PDS).

Further work will need to take place to ensure NHS number is used in all correspondence. The BCF will be used to further support this shift and Adult Social Care has made a commitment to use NHS number within all correspondence.

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

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

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

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

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

Kent has a clear information governance framework and we are committed to ensuring all developments take place within established guidelines.

Work has already taken place to develop information governance arrangements between social care, community health and mental health providers and further work is taking place to adopt the NHS information sharing clause in all social care contracts.

Within Year of Care Kent has provided an IG brief to the national YOC team explaining the past and proposed methodology of data sharing.
As a Pioneer Kent is a participant in a number of national schemes reviewing information governance and supporting national organisations to "barrier bust" this includes the 3 Million Lives IG workstream, a Department of Health lead workshop on Information Governance on 28 February and contributing to the work of Monitor on exploring linking patient data across providers to develop patient population resource usage maps.

Within our Better Care Fund plan and as a Pioneer Kent will continue to ensure that IG does not act as a barrier to delivery of integrated health and social care.

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

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

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

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

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

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

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

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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

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

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

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