Better Care Fund planning template – Part 1

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Kent County Council**
Clinical Commissioning Groups	**NHS Canterbury & Coastal CCG**
Boundary Differences	**There are some boundary differences between the CCG and local District authorities.** **Whilst the CCG wholly covers Canterbury City Council's areas, the CCG also covers parts of Swale Borough Council, Dover District Council and Ashford Borough Council.** **In developing the plan discussions with these areas has taken place to ensure consistency of outcomes.**
Date agreed at Health and Well-Being Board:	
Date submitted:	
Minimum required value of BCF pooled budget: 2014/15	
2015/16	
Total agreed value of pooled budget: 2014/15	
2015/16	

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**NHS Canterbury & Coastal CCG**
By	Bill Millar
Position	Chief Operating Officer
Date	01/03/14
Signed on behalf of the Council	**Kent County Council**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

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

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. 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.

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

In addition to these arrangements, the BCF plan has been developed through a series of "business as usual" strategic groups with senior representation from all service provider organisations, including:

- Whole Systems Board
- Integrated Commissioning Group
- Urgent Care/Long Term Conditions Board
- Planned Care/Long Term Conditions Board

As well as senior representation, membership also includes frontline staff from medical, nursing, mental health backgrounds, other health and social care professionals, and colleagues from Public Health.

During February and March 2014, and into the new financial year, further engagement activities are scheduled on a local area basis to ensure all providers are aware and engaged with the

contents of the plan.

d) Patient, service user and public engagement

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

The blueprint for Kent becoming an Integrated Care and Support Pioneer is based on detailed engagement with patients, service users and the public. Kent Healthwatch is assisting in outlining the evaluation of objectives and outcomes against I Statements.

On a local level there is sustained involvement with the public through patient participation groups and the local health and social care integration implementation groups. As part of the operational integration programme regular surveys on integrated are undertaken with patients by providers and the CCG.

Kent is committed to meaningful engagement and co-production with the public and wider stakeholders and as a Pioneer will use ICASE (www.icase.org.uk) as a mechanism to provide updates on our progress within integration and the implementation of the Better Care fund.

Patients, service users and the public have played, and will continue to play, a key role in the development of sustainable plans for health and social care across the CCG. We will seek to further engage the public on the contents of the plan throughout February and March, and into the new financial year, via local networks. The CCG has existing forums for engagement with patients, care homes and volunteer agencies which will support the projects

Patients and service users are already involved in designing services and shaping change through patient advisory and liaison groups and representation on boards and steering groups. We have a strong relationship with our local HealthWatch organisation, represented on the district Health and Wellbeing Board. This means that commissioner plans involve patients and service users, who offer challenge and a unique perspective before implementation of service change.

Finally, the NHS Call to Action has provided us with an additional platform to further strengthen our engagement with the public. It gives health and care leaders the opportunity to explain the unique pressures facing the NHS and Social Care, and build understanding and broader engagement into future strategy and plans.

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
Canterbury and Coastal Health Profile	To be inserted
Kent Health and Wellbeing Strategy	To be inserted
Kent Integrated Care and Support Programme Plan	To be inserted
NHS Canterbury and Coastal CCG Plan on a Page	To be inserted
NHS Canterbury and Coastal CCG Strategic	To be inserted

Commissioning Plan	
Canterbury and Coastal Health and Wellbeing Board Organogram	To be inserted

VISION AND SCHEMES

a) Vision for health and care services

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

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

The fundamental, underlying, principle which reaches across all of the following domains is that the CCG is keen to ensure that care is be delivered as close to where patients live as possible. The consequence of this is that patients will be able to access a variety of services in a variety of locations –including their own home, their pharmacy, the optometrist, their GP surgery, community hospitals as well as district hospitals. We recognise that collectively planning improved care and support services requires significant transformation of existing methods of service delivery.

The vision for the Canterbury & Coastal locality is that through integrated working with partners we can deliver services which are fully integrated and support the following:

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

For the past two years, the health and social care community has been working collectively towards creating an integrated system of care that seeks to wrap care and support around the needs of the individual, their family and carers and helps to deliver on this wider vision

Our programme of work acknowledges that patients and carers should expect a high quality, compassionate, safe and personal service based around their needs, present and future. They should be enabled to take ownership of their health and social care and with that accept responsibility for their health behaviour and use of health and social care services.

Our ambition over the next five years is that through continuous evaluation and learning from elsewhere, our residents will be able to access further community facilities of this nature. Our approach recognises that whilst services are currently delivered by different organisations, organisational boundaries in the future will continue to be more permeable and flexible with

staff working to support and care for people as part of interdisciplinary endeavour. Services must be based around the needs of people, not around organisations.

We also recognise that developing a broader range of community-based services will require the collective pooling of resources to effect the movement of funding from acute and long term care models to those new community based services. All BCF stakeholders will continue to experience considerable financial challenges and therefore our transformation programme is designed to generate significant efficiencies within the whole system of care to ensure that the health and care system remains sustainable and of high quality.

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.

Building on a long history of joint commissioning of services, the BCF provides further opportunity to commission services together. Our ultimate ambition remains the pooling of all current resources committed to the commissioning of health and social care services as we endeavour to spend the "Kent £" wisely.

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?

We will use the Better Care Fund to:

- 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.
- Take the transitional steps that achieve transformation of health and social care – delivering the 'right care, in the right place at the right time by the right person' to the individual and their carers that need it.

- Reduce unnecessary activity within secondary care by ensuring the right services are available and accessible, within the community, for people when required.

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

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

Integrated Commissioning:

- Together we will design and commission new systems and models of care that ensures the financial sustainability of health and social care services in Kent. These services will give people every opportunity to receive personalised care at, or closer to home to avoid hospital and care home admissions.

- We will use an integrated commissioning approach to buy integrated health and social care services where this makes sense.

- The Health and Wellbeing Board will be an established systems leader, supported by clinical co-design and strong links to innovation, evaluation and research networks. Integrated Commissioning will be achieving the shift from spend and activity in acute and residential care to community services, underpinned by JSNA, Year of Care financial model and risk stratification. We will have a locally agreed tariff system across health and social care commissioning.

Integrated Provision:

- A proactive model of 24/7 community based care, with fully integrated multi-disciplinary teams across acute and community services with primary care playing a key co-ordination role. The community / primary / secondary care interfaces will become integrated.

- We will have a workforce fit for purpose to deliver integrated health and social care services. To have this, we need to start planning now and deliver training right across health, social care and voluntary sectors. We will also need to ensure that we link in with

our partners within education

- An IT integration platform will enable clinicians and others involved in someone's care, including the person themselves, to view and input information so that care records are joined up and seamless. We will have overcome information governance issues. Patient held records and shared care plans will be commonplace.

- We will systematise self-care/self-management through assistive technologies, care navigation, the development of Dementia Friendly Communities and other support provided by the voluntary sector.

- New kinds of services that bridge current silos of working where health and social care staff can "follow" the citizen, providing the right care in the right place.

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

c) Description of planned changes

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

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

The CCG has developed a 5 year Commissioning Plan which incorporates evidence for change using the JSNA, patient feedback and evidence from the existing partners.

The specific schemes relating to the BCF are detailed in the embedded document:

d) Implications for the acute sector

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

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

Detailed investment and benefit management plans will be designed throughout 2014/15 in line

with CCG and Social Care commissioning plans.

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. Increasing community capacity should act not only to promote the integration agenda, but also to support the delivery of these key performance targets.

Savings in the health and social care sector need to be generated by shifting activity into the community, and making the entire sector more focussed on prevention. We are also mindful that hospital based care must be sustainable and it is crucial that as less money and activity is delivered in the acute sector as a result of the BCF initiatives, costs in that sector either reduce or are refocused on specialist activity.

If costs in the acute sector are to be shed, in practical terms, this means reduced staff in the acute sector. This is within the context of a shift to 24 hours, 7 days a week working and so innovative work with staff to develop pioneering solutions is crucial. As a consequence of moving to a more prevention focussed agenda, workforce redesign is a priority. As acute activity starts to fall off, and community activity rises, re-training the workforce will become increasingly important and workforce development to meet changing needs is part of our wider transformation programme. Roles that were once only available in the hospital will still be required, but in a different setting. In the longer term, the BCF will need to have a scheme focussed on workforce and training to ensure we have the correctly qualified staff working in the right places and with the right patients to create the integrated health and social care system patients, service users and their families deserve.

e) Governance

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

Kent's governance for delivering as an Integrated Care and Support Pioneer is set out in the attached governance, the responsibility and management of the Better Care Fund will sit within this.

Existing governance structures through the local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group provides advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within the HWB and on the Integrated Pioneer Steering Group.

As part of the governance arrangements there will be monitoring of the financial flows associated with implementation of the Better Care Fund. Through the integrated commissioning groups the leadership of the CCGs and providers will have a clear and shared visibility and accountability in relation to BCF.

2) NATIONAL CONDITIONS

a) Protecting social care services

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

At a time when we are planning to make significant investments in community-based, person-centred health and care services, we are seeing rising demand on our health and care services, as we get better at keeping people alive longer and see our population age. Against this backdrop, 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 social care system as a whole. We recognize that the BCF alone will not resolve the financial challenges faced by Social Care, but we are confident that as part of our overarching transformation plans, these will be met.

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.

Our primary focus is on continuing to develop new forms of joined up care which help to ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and the local health and social care economy as a whole. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focusing on the supply of services. Social care is also responsible for commissioning of carer support services which enables carers within Kent to continue in their caring role, often it is the carer who may have health needs that deteriorate.

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

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

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

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.

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

Moving health and social care services from five to seven days is a key commitment across the Health and Social Care system. The day of the week on which a person becomes ill (or recovers from illness) should not be the determinant of the services that someone can receive, or the speed with which they can access services or return home.

But simply having services available seven days a week isn't enough. Services across primary, secondary, community and social care also need to be co-ordinated. We already have several well established seven day established community services, for example, district nursing and joint care managers, and have begun to further enhance other service availability

A detailed plan for a 7 day service will be developed during 2014/15 as part of our capacity modelling for implementation in 2015/16

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 CCG are working together on the development of an information sharing platform and Adult social care staff all have access to GCSX secure email.

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

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

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

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

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

Within Year of Care Kent has provided an IG brief to the national YOC team explaining the past and proposed methodology of data sharing.

As a Pioneer Kent is a participant in a number of national schemes reviewing information governance and supporting national organisations to "barrier bust" this includes the 3 Million Lives IG workstream, a Department of Health lead workshop on Information Governance on 28 February and contributing to the work of Monitor on exploring linking patient data across providers to develop patient population resource usage maps.

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

d) Joint assessment and accountable lead professional

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

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

- All people in care homes to have agreed care plans including EOL understood by the patient and the relatives where appropriate. This scheme for Canterbury is already counted under QUIPP.

- Patients and health and social care professionals to have access real time to agreed health and social care information.

- Consultants (in long term conditions) to increasingly no longer have caseload but outreach to support primary care to deliver high quality complex care.

We have a well established system of risk stratification already in place to identify patients at high risk of hospital admission. The system supports accountable lead professionals to work in a more proactive and preventative way, identifying patients before they become unwell and ensuring they have a tailored care plan in place.

The introduction of new arrangements for GP contracting next year provides an opportunity to adapt the way in which the tool is used. The tool will need to be used to identify the top 2% high risk patients from each practice and from that will also need to include the development of a care plan. The plan will identify a named accountable GP within the practice who has responsibility for the creation of each patient's personalised care plan. In addition, the plan will also specify a care co-coordinator, who will be the most appropriate person within the multi-disciplinary team to be the main point of contact for the patient or their carer to discuss or amend their plan. This could be the GP or it could be another member of the integrated neighbourhood team. This process will ensure MDT input into care, coupled with professional accountability.

To support risk stratification and motive further joint working, a complimentary CQUIN will come into effect in April 2014. The CQUIN will incentivise community health services to work in a more multi-disciplinary way with primary care, to deliver improved proactive care management.

RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
The savings and efficiencies needed to	Very High	The proposals within the

fund whole system change that meets people's health and social care needs may not be delivered through the work planned.		Better Care Fund submission have been costed and likely efficiencies estimated. There is very little evidence base with few examples of full implementation of schemes. Progress post implementation will be closely monitored but likely impact will be based on a culmination of interventions.
In order for the hospital sector to release efficiencies, it will need to close beds as activity drops.	Very High	
Work carried out under the Better Care Fund will need to be managed and monitored. Resources have not yet been identified to undertake this essential function. NHS facing 10% real terms budget cut in administration in 2015/16	High	Resources are being discussed and will be allocated from both health and social care.
Shifting resources to fund new schemes may destabilise current services and providers, particularly in the acute sector.	High	Proposals been jointly developed, including service providers. This has enabled a holistic consideration of the benefits of each proposal
Work outlined may not adequately ensure the Protection of Adult Social Care services.	High	
Operational pressures and the current high volume of business change will restrict the ability of our workforce to deliver the projects needed to make the vision of care outlined a reality.	High	Proposals include investment in infrastructure and development to support overall organisational development.
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / home care activity by 2015/16, impacting the overall funding available to support care services and future schemes	High	Proposals have been developed using a wide range of available data. 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed Business Cases and service specifications
The introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, will result in	High	

a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.		
Workforce Education establishments will be required to review current training schemes to support ability to transfer care	High	
The CCG and KCC may suffer reputational damage if we fail to deliver the outcomes detailed..	Medium	Proposals have been developed through a rigorous process of consultation and engagement, review and scrutiny.
Community and social settings may be unable to pick up increased demand as care moves away from acute settings.	Medium	Savings generated through work under the Better Care Fund will be used to increase capacity in community and social settings.
The lack of detailed baseline data and the need to rely on current assumptions may mean that financial targets are unachievable.	Medium	Proposals are based in all available information and will be refined as work progresses.