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	West Kent CCG
Boundary Differences	There are some boundary differences between West Kent CCG and Sevenoaks District Council affecting the Swanley area. In developing this plan discussions planned to take 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 ITF pooled budget: 2014/15	£5,136,000 Kent Wide contribution
2015/16	£26,394m CCG contribution only
Total agreed value of pooled budget: 2014/15	£5,136,000 Kent Wide contribution
2015/16	£101,404m Kent Wide contribution

b) Authorisation and signoff

Signed on behalf of the West Kent Clinical Commissioning Group	
By	Ian Ayres
Position	Accountable Officer
Date	26 March 2014

Signed on behalf of the High Weald Lewes Havens Clinical Commissioning Group	
By	Frank Sims
Position	Accountable Officer
Date	26 March 2014

Signed on behalf of Maidstone Borough Council	
By	Alison Broom
Position	Chief Executive
Date	26 March 2014

Signed on behalf of Sevenoaks District Council	
By	Pav Ramewal
Position	Chief Executive
Date	26 March 2014

Signed on behalf of Tonbridge & Malling Council	
By	Julie Beilby
Position	Chief Executive
Date	26 March 2014

Signed on behalf of Tunbridge Wells Borough Council	
By	William Benson
Position	Chief Executive
Date	26 March 2014

Signed on behalf of the West Kent Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Dr Bob Bowes
Date	26 March 2014

Signed on behalf of the Kent Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Roger Gough
Date	26 March 2014

c) Service provider engagement

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

Kent is an Integrated Care and Support Pioneer – providers from across the health and social care economy are partners and stakeholders in our Pioneer programme and were involved in developing the blueprint for our integration plans which the Better Care Fund (BCF) is based upon. Delivery of Mapping the Future is the West Kent integration work plan included in the successful Kent wide Integration Pioneer bid. The Integration Pioneer Working Group who have produced the Kent plan is a mixed group of commissioners and providers

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.

As part of the development of the BCF plan engagement events have taken place with providers via our existing Health and Social Care Integration Programme, the Integration Pioneer Steering Group and through a facilitated engagement event led by the Kent Health and Wellbeing Board under the Health and Social Care system leadership programme. The Kent HWB undertook a mapping exercise across the care economies to review current activity and priorities.

During February and March 2014 further engagement activities have taken place on a local area basis to ensure providers are aware and engaged with the contents of the plan. This has included commissioning intention discussions as part of contracting monitoring and negotiation meetings. 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). Presentations on the BCF and how it fits into the context of the West Kent CCG Strategic Commissioning Plan have taken place at the West Kent HWB (18 March 2014) and the Kent HWB (26 March 2014).

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. On a local level there is sustained involvement with the public through patient participation groups and the local health and social care integration implementation group.

Across Kent there is a commitment to meaningful engagement and coproduction with the public and wider stakeholders and as a Pioneer we will use the Integrated Care and Support Exchange (ICASE) as a mechanism to provide updates on our progress within integration and the implementation of the Better Care Fund.

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.

We will seek to further engage the public on the contents of the BCF plan on an on-going basis via local networks.

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/needsassessments/
Kent Health and Wellbeing Strategy	Health and Wellbeing Strategy.pdf
Kent Integrated Care and Support Programme Plan	**To be inserted**
Mapping the Future presentation – select version	MTF_Operational_Considerations_v311.pp
WKCCG 5 year Commissioning Plan	**To be inserted**
Pioneer Bid	EMBARGOED Pioneer bid FINAL 011113.do

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 a care economy that is sustainable for the future with improved outcomes for people. Our vision is to be providing care that crosses the boundaries between primary, community, hospital and social care with services working together, along with voluntary organisations and other independent sector organisations, to forge common goals for improving the health and wellbeing of local people and communities.

Mapping the Future sets out a whole system approach for West Kent where all health and well-being system partners use their individual and collective efforts to tackle the root causes of health and well-being problems where people are encouraged and supported to take greater responsibility for their health and healthy choices (the Blueprint). This blueprint places self and informal care at the centre, enhancing the capacity of communities and individuals to support themselves and each other. People are fully informed and take part in planning their care helping are supported to stay at home and independent longer.

It introduces a new model of Primary Care focusing on three distinct but interlinked areas of care (preventative, proactive and reactive care) creating larger scale GP led multi-disciplinary teams which are wrapped around a suitably sized group of practices.

It supports the provision of more capable and cost effective out of hospital proactive care and brings together elements of urgent care, elective care, self-care, reablement services and end of life care.

The teams will include clinically-led professionals that take a care management and coordination role for patients who are elderly and those with the most complex needs. They will operate within a framework of clear clinical pathways spanning the health and care system and will have access to consultant opinion to enable them to support patients, most often without the need to send them to hospital.

The focus will always be to support citizens to manage and coordinate their own care whenever possible. Community based support and prevention will be available to residents of West Kent. A core offer will be developed and commissioned which will ensure a comprehensive range of universal support services are available to people. Some will be targeted services for particular populations e.g. smoking cessation, weight management, employment support. Other support services commissioned via voluntary sector organisations will help reduce demand on more specialist health and social care services through preventative activities. Some will be linked to care pathways, for example, falls prevention classes, while others will offer universal access e.g. carer support, or dementia support.

NHS 111 will continue to provide advice online and by phone to patients and carers supported by GPs. This will be complemented by an integrated *Information, Advice and Guidance* service which will enable residents to access information and will enable those working within health, social care and housing services to signpost people to other support available within local communities.

Self and informal care will be an important part of the new system, with more people and their families being supported to manage their own care and long term conditions through the use of smart technology. Integrated telecare / telehealth solutions will be backed up, where necessary, by trained staff working in an integrated telecare / telehealth monitoring centre, who will be pro-actively monitoring changes in activity and health condition, alerting integrated community teams where further intervention to prevent increases in care needs.

Mobile clinical services (MCS) will provide direct care to people at the point it is needed by taking care to the patient wherever possible and clinically appropriate to do so. The MCS will work as a complementary workforce to the new Primary Care System using similar pathways, protocols and medical records.

MCS will be supported to help people remain at home, through the development of a new integrated (health and social care) intermediate care/ reablement service with a workforce trained to deliver comprehensive care that supports independence, recovery, maintenance of existing situation or for some people, quality end of life care. The breadth of these services will be enhanced to include best practice use of assistive technologies to complement hands on care.

Community based integrated care teams will be established to provide targeted, proactive co-ordinated care and support to those people identified as being of highest risk of hospital attendance or increasing use of care services.

New Secondary Care will seek to manage urgent and planned care as separate entities for optimum efficiency with some highly specialised services concentrated in larger centres. Hospital based urgent care will work as part of the total system connected with primary and community services and mobile clinical services. Together they will optimise patient flows to deliver the most cost effective service with coordinated care around people with complex needs. It is anticipated that this will allow secondary care services to be provided with a more community base model that reduces dependency on beds and buildings.

To enable mapping the future to be delivered we will look to develop our approach to risk management to ensure that financial and contractual levers are aligned and promote access to shared information management systems

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?

Objectives

West Kent CCG and Kent County Council are committed to commissioning care for people to ensure these commitments are honoured. Mapping the Future has identified that in the West Kent health system a significant reduction is required over the next 5 years in the level of activity which is currently delivered as non-elective care in hospitals. This is required

- to ensure that the urgent care elements of the local health system can function safely and efficiently,
- to ensure that those patients requiring planned care do not experience unexpected delays due to emergency pressures
- to enable the system to operate at optimum capacity which allows it to cope with peaks in demand when necessary

- to allow as much of a patient's diagnosis and care delivery to take place in a planned and therefore well managed way
- to allow people with health and social care needs to be in greater control of their health and social care support and are enabled to keep themselves well through access to self care services
- to allow a reduction in the level of funding spent on care provided in hospitals and residential care and use this more effectively to provide care in a planned way and outside of the hospital or care home setting
- to meet the challenges presented as a result of demographic demand pressures

Outcomes Sought

- Consistent, high quality health and social care services that are interconnected and available round the clock
- A system that offers the most effective and efficient care so that people get the right care in the right place by professionals with the right skills the first time
- Proactive care which aims to prevent people from developing illnesses and limiting the severity of their conditions
- Individuals and carers are active partners in their care, receiving personalised and coordinated services and support
- Care is organised in a way that enables people to be as independent as possible and to only visit hospital when it is absolutely essential
- Health and care services that are efficient in the way they use resources

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

Success will include:

- Buying more provision of reablement and 7 day access to services keep people independent in their own homes
- Investing in falls prevention services to prevent falls and fractures in the first place (a major cause of health and social care spend)
- Rapidly developing integrated care through the bringing together of inreach and outreach services, community hospital provision, and GP out of Hours as part of a network of integrated multi-disciplinary teams. All of this will be delivered with strong medical/clinical leadership and joint assessment processes.
- Minimising use of physical resources i.e. hospital buildings and maximise use of human resources i.e. skilled workforce with a multi-disciplinary health and social care approach
- Supporting the principle of unequal investment to close the health inequality gap by addressing specific needs in specific areas to improve health outcomes

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.

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 are to secure cost reductions totalling £10m.

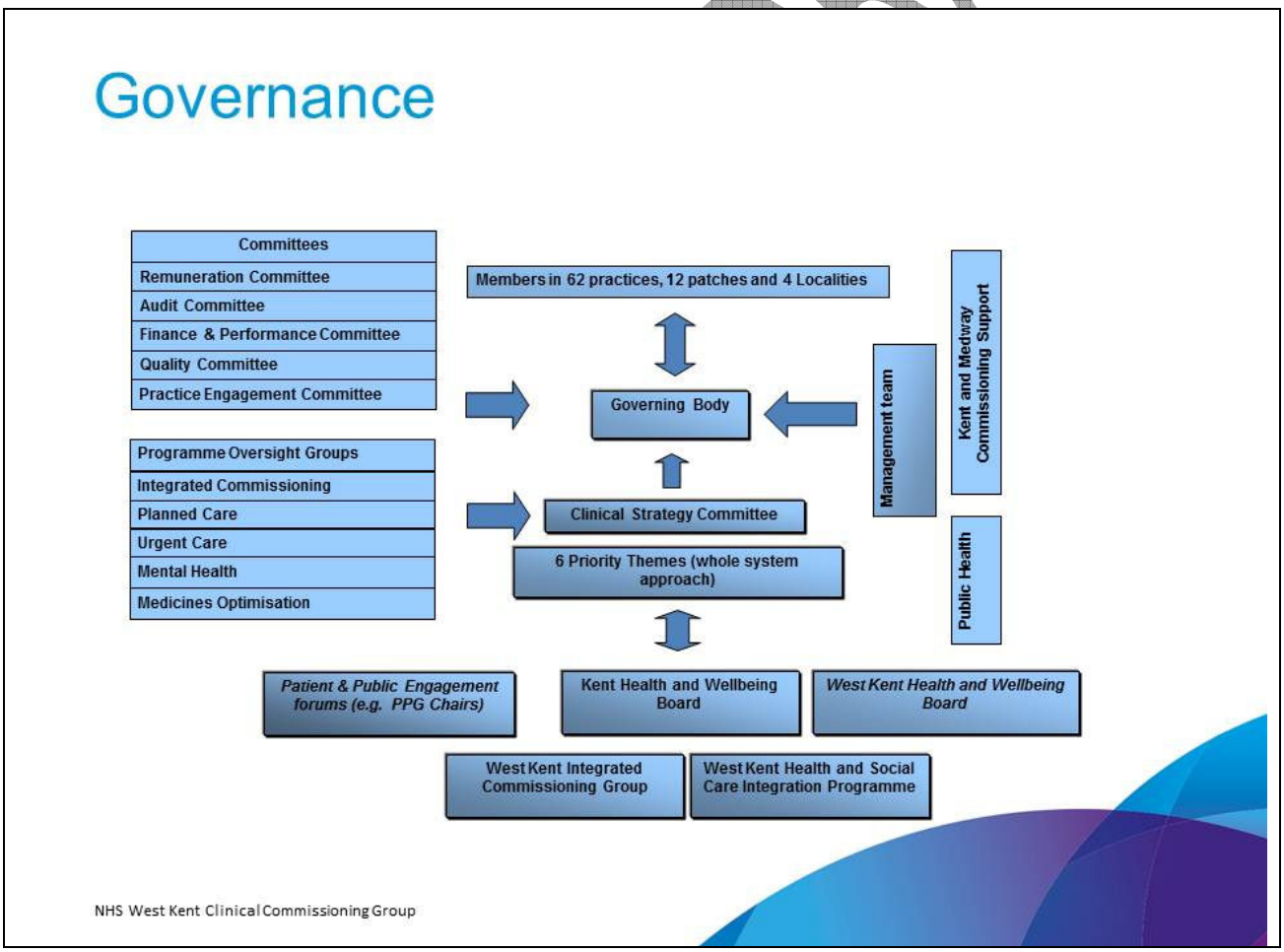
In order to drive out this level of cost reduction, there will need to be significant reduction in the level of emergency admissions and A&E attenders in the acute care setting. By the end of 2015-16 the target level of avoided urgent care admissions could represent up to 18% of the level of today's emergency admissions.

In the event that these admissions are not avoided, the CCG will continue to incur costs above planned levels, putting at risk the longer term sustainability of the local health system.

Contingency plans will need to be put in place to underpin the risk of this scenario.

e) Governance

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



2) NATIONAL CONDITIONS

a) Protecting social care services

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

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

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

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

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

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

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

b) 7 day services to support discharge

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

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

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

c) Data sharing

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

The prime identifier across health and social care in Kent is the NHS number. Further work may need to take place to ensure this is used in all correspondence.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Health and social care providers must use the NHS number as the primary identifier and WKCCG will work with key stakeholders and key providers to identify practical ways to achieve compliance. The BCF will be used to further support this shift and Adult Social Care has made a commitment to use the 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))

West Kent CCG is taking a leadership role in Information Management & Technology to ensure that all inter-connected parties will use these interoperability standards and that their activities are coordinated. As part of our risk stratification approach we have also explored using a data warehouse to aggregate data from different sources into a consistent format.

Across Kent 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.

West Kent CCG is taking a leadership role in IM&T to ensure that IG controls are in place across all NHS system users.

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

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

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

d) Joint assessment and accountable lead professional

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

The GP will be the co-ordinator of people's care, with the person at the centre and services wrapped

around them. This is already being delivered through an MDT approach across Kent, and health and social care using common assessment documentation and the development of a shared anticipatory care plan.

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

- All people in care homes to have agreed care plans including EOL understood by the citizen and the relatives where appropriate.
- Citizens and health and social care professionals to have access real time to agreed health and social care information.
- Consultants (in long term conditions) to increasingly no longer have caseload but outreach to support primary care to deliver high quality complex care.
- Expanded and co-ordinated community capacity to meet the citizen's priorities without necessarily having to utilise NHS and social care services and resources.

3) 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

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

Draft Risks	Risk rating	Mitigating Actions
		focus on developing detailed business cases and service specifications. • • Implementation supported by Year of Care as an early implementer site.
Cost reductions arising from a reduction in residential and care homes do not materialise	**HIGH**	**Further modelling required to test assumptions prior to submission.** • 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications. • Implementation supported by Year of Care as an early implementer site.
Reductions in delayed transfer of care are not achieved	**HIGH**	**Further modelling required to test assumptions prior to submission.** • 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications. • Implementation supported by Year of Care as an early implementer site.
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / care home activity by 2015/16, impacting the overall funding available to support core services and future schemes.	**HIGH**	**Further modelling required to test assumptions prior to submission.** • 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications.