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 (DGS)**
	Swale
	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
Boundary Differences	DGS: While the local authorities of Dartford and Gravesham are co-terminus with the CCG boundaries, the Swanley area falls within the boundary for Sevenoaks District Council, with approximately 42% of the Sevenoaks district population within the DGS CCG boundary. Swale: Swale CCG represents approximately two thirds (78%) of the population of Swale borough council. local (CCG) health and wellbeing boards, as well as review by the Kent health and wellbeing board will ensure any gaps or issues are identified and minimised.
Date agreed at Health and Well-Being Board:	**26/03/2014**
Date submitted:	**14/03/2014**
Minimum required value of ITF pooled budget: 2014/15	**£5,816.2**

2015/16	**£30,676.54m**
Total agreed value of pooled budget: 2014/15	**£5,816.2m**
2015/16	**£30,676.54m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Dartford, Gravesham and Swanley CCG
By	Patricia Davies
Position	Accountable Officer
Date	<date>

Signed on behalf of the Clinical Commissioning Group	Swale CCG
By	Patricia Davies
Position	Accountable Officer
Date	<date>

Signed on behalf of the Council	Kent County Council
By	Paul Carter
Position	Leader of Council
Date	<date>

Signed on behalf of the Health and Wellbeing Board	Kent Health & Well-being 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 proposed plans are underpinned by work already in progress within North Kent (including with Medway CCG and Medway Council) to review and understand the current health and social care landscape and develop the local vision and sustainable plans for the future. As such health and social care commissioners, and health providers have been part of two Kings Fund facilitated workshops (in each area) to review audit data from acute and community hospitals and agree key actions aimed at ensuring that people are treated within the most appropriate care setting for their needs. Workshops were held on 19th (DGS area) and 22nd (Swale / Medway area) November 2013 and the second stage workshops were held on the 6th (Swale / Medway) and 18th (DGS area) February.

In addition to this work the following forums have been used to discuss the Better Care Fund, as well as the wider issues outlined within the NHS Call to Action:

- Kent Health and Wellbeing Board
- Swale, and Dartford, Gravesham and Swanley Health and Wellbeing Boards
- CCG / KCC Integrated / Strategic Commissioning Meetings
- Attendance at District / Borough Council meetings
- Executive Programme Boards for Dartford, Gravesham and Swanley and Medway / Swale.

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

Feedback has been gathered, considered and reviewed through a number of events locally as part of the development of the CCGs Two year Operating Plan and Five year Strategies. Ongoing engagement has been aligned with the annual engagement programme for commissioning plans and undertaken via the Patient Reference Groups / Patient Participation Groups within each CCG, which will continue during Quarter 1, to gain feedback and assurance that the proposed schemes address concerns, issues and ideas raised during earlier discussions.

A deep dive consultation was also undertaken with patients and carers on a community services review. The feedback from this has also been fed into the development of the BCF 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**
Project plans in development	
Draft CCG Operating Plans 2014-2016	
Better Care Fund Vision document	
Integrated Discharge Team service specification / Heads of Agreement	
NHS DGS CCG and NHS Swale CCG Community Services Review Developing the Future Model based on Patient Insights DEEP DIVE REPORT	

2) 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?

Our vision for whole system integrated care is based on what people have told us is most important to them (details available within the CCG Community Services Engagement Deep Dive document). Through patient and service user workshops, interviews and surveys across Dartford Gravesham Swanley and Swale we know that what people want is choice and control, and for their care to be planned with people working together to help them reach their goals of living longer and living well. They want their care to be delivered by people and organisations that show dignity, compassion and respect at all times.

We recognise that realising this vision will mean significant change across the whole of our current health and care provider landscape. Whilst our GPs will play a pivotal role within this, all providers of health and care services will need to change how they work, and particularly how they interact with patients and each other. The CCGs and local authority commissioners who make up the North Kent Health and Social Care economy are committed to working together to create a marketplace, and to effect the required behavioral and attitudinal change in the acute sector, to ensure that this happens at scale and at pace.

We aim to provide care and support to the people of North Kent (Swale and DGS) in their homes and in their communities. We want to achieve a health economy that is sustainable for the future. Our vision is of primary, community, mental health and acute care services working seamlessly together, with local authority, voluntary, and other independent sector, organisations, to deliver improvements in both health and well-being for local people and communities.

We recognise and will build into our vision recommendations from the report of the commission on future models of care delivered through Pharmacy.

We will:

- Keep people at the heart of everything we do, ensuring they are involved and listened to in the development of our plans
- Maximise independence by providing more integrated support at home and in the community and by empowering people to manage their own health and well-being
- Ensure the health and social care system works better for people, with a focus

on delivering the right care, right time, right place, providing seamless, integrated care for patients, particularly those with complex needs

- Safeguard vital services, prioritising people with the greatest health and social care needs and ensuring that there is clinical and professional evidence behind every decision.

Get the best possible outcomes within the resources we have available; delivering integrate services wherever possible to avoid duplication

Our vision - What this will mean for our health and social care services

Effects on services

We think it is important to be clear about what this will mean, especially because this is not new investment in the system, but a re-organisation of existing funding and services. There is likely to be an increase in the support available in the community through an investment in self-care and early intervention, and by managing demand in this way, a decrease in the need for more intensive social care support or health support at acute level, with corresponding changes in acute services. We will be working towards single health and social care assessments that will require a much closer level of integration between primary health (GPs, community Pharmacists), community health (e.g. district nursing, physiotherapy), mental health (e.g. primary care mental health workers, dementia nurses), social care (support to live independently) voluntary sector support, and local authority (housing, benefit services) so that these services can identify, support and intervene much earlier to prevent a crisis occurring or someone feeling they are unable to access the support they need.

This will require a different way of working from our service providers and will require us to develop an infrastructure that will allow both the voluntary and community sectors to play a greater role of supporting people more effectively in their communities. If we are successful, funding for unplanned admissions to hospital will be reduced because people will not need to go to hospital in the same numbers as they do at the moment, and lengths of stay will be shorter and people will not need to access long term social care

This is easy to say and hard to do. Recognising that the way that change is done is as important as the change that is aimed at, the next four principles set out 'rules' we are proposing to govern what we do to achieve this vision. The following summarises the key impact on healthcare providers:

Acute Trusts and Ambulance Trust	Reduction of bed pressures, via
	
	• Reduction in non-elective admissions by 15% over two years at:
	  ○ Dartford and Gravesham NHS Trust –
	  ○ Medway NHS Foundation Trust -
	• Reduction in length of stay
	  ○ Dartford and Gravesham NHS Trust –

		○ Medway NHS Foundation Trust – NB – contracts currently in negotiation.
	Community health providers including mental health	Increase in community activity – to be defined.

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?

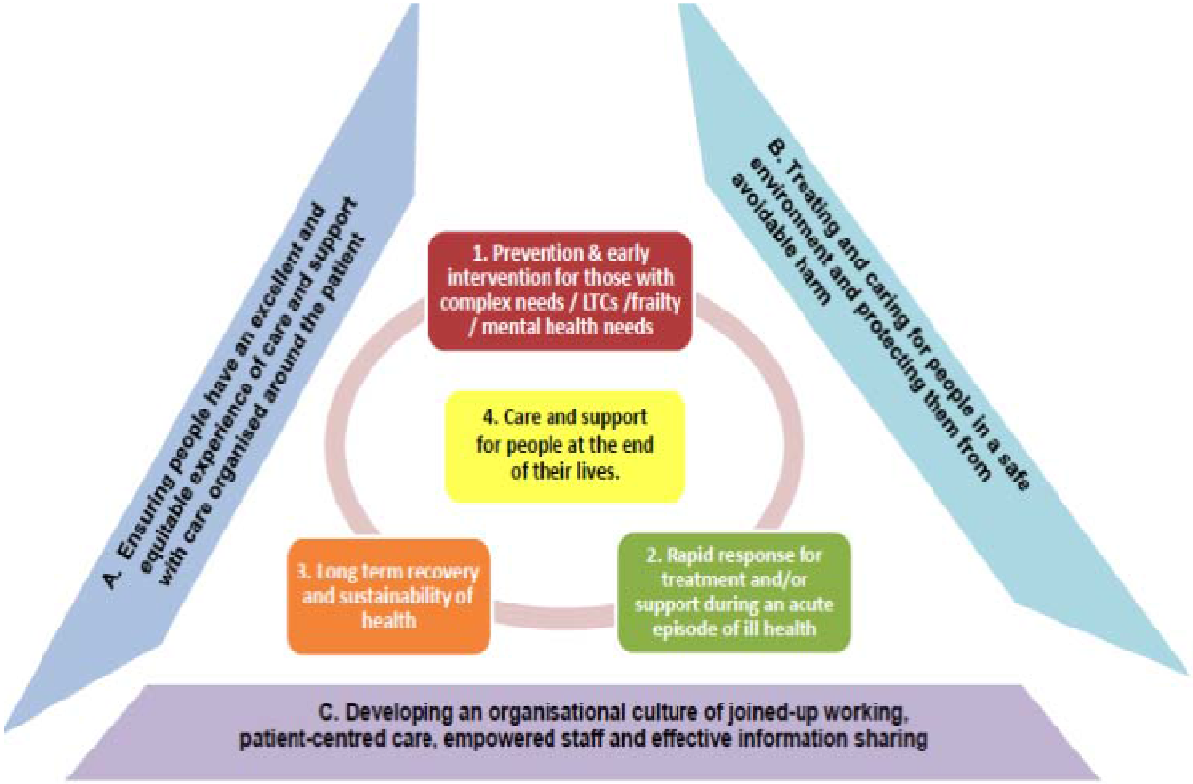
We recognise that realising this vision will mean significant change across the whole of our current health and care provider landscape. Whilst our GPs will play a pivotal role within this, all providers of health and care services will need to change how they work, and particularly how they interact with patients and each other. The CCGs and local authority commissioners who make up the North Kent Health and Social Care economy are committed to working together to create a marketplace, and to effect the required behavioural and attitudinal change in the acute sector, to ensure that this happens at scale and at pace.

We aim to provide care and support to the people of North Kent (Swale and DGS) in their homes and in their communities. We want to achieve a health economy that is sustainable for the future. Our vision is of primary, community, mental health and acute care services working seamlessly together, with local authority, voluntary, and other independent sector, organisations, to deliver improvements in both health and well-being for local people and communities.

Measuring success

We will measure our success primarily by analysis of demand for acute health services (such as emergency bed days) and formal social care services (such as a paid agency carer supporting someone at home, or someone moving into residential or nursing care home), using current levels of demand as a baseline (and allowing for the impact of demographic change so the 'baseline' keeps pace with population change and growth). We will build on the Outcomes Framework which has been developed to support the CCG. This has a major focus on patient and carer experience, and triangulating data from several sources to measure outcomes. The Outcomes Framework structure is shown in the diagram below:

NHS Outcomes Framework Domains



We will also use other measures that show us whether the system is effective, such as delayed transfers of care, the effectiveness of short-term recovery-focused services like re-ablement, and patient and user experience of services. We will therefore seek to deliver services that have a positive impact as measured by these measures.

3.2 This strategy is based on 3 core principles:

i. People will be empowered to direct their care and support, and to receive the care they need in their homes or local community.

ii. GPs will be at the centre of organising and coordinating people's care.

iii. Our systems will enable and not hinder the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system

To achieve this we are engaging with local health and care providers, and associated public, private and voluntary and community sector groups, to “co-design” models of care that will engage with and meet people’s aspirations and needs. The following sections provide a summary of what this will mean, in practice, and the specific BCF investment

areas for the next 2 years that will deliver on our aims and objectives.

Open, Honest and evidence-based

It is recognised that the basis of the funding for the Better Care Fund is money that is already committed to health and social care services of many different types. Some services will need to change to support the aim set out above, others will need stability. Discussions should be open, honest and evidence-based in order to make sure we use the money in the best way.

Early intervention and supporting independence

The plans set out in the Better Care Fund should align with existing or developing strategies, such as the CCGs, Kent County Council and Local Authority Strategic Plans, including the Kent Health and Well-being Strategy, Pioneer plan and Health Inequality plans. A key principle of all of these strategies is that people experience the best outcomes when they are able to live independently at home, and supporting them to do so will be a theme throughout all proposals in the Integration Plan. There will be other important themes, including coherence and integration of services, the importance of identifying vulnerability and acting to prevent deterioration, ensuring professional judgement is valued and free to be flexible, and that services are person-centred.

Support for everyone

It is recognised that health and social care services for older people make up a major part of activity in health and social care generally; but we will also focus proposals on reducing demand amongst working age people with disabilities and people of all ages with mental health issues. There is a need to ensure that the skills of service users are continued to be developed thorough integrated approaches by providers, to reduce the level of service required to meet people's needs. The approach will focus on the skills and abilities of each individual and seek to build on these to achieve greater independence and less reliance on services. Therefore, proposals under the Better Care Fund will not be solely focused on supporting older people at the expense of others.

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

A Proposed Model

We are proposing to develop the model over the next five years recognising the work that has been done over the last year. Evidence suggests that successful models of integration are both vertical and horizontal and require therefore time, system leadership and education to emerge and develop fully. This should not be under-estimated.

Successful models for example Torbay, Trafford and Canterbury (New Zealand) all demonstrate success over a gradual period, based around iterative service improvement that constantly evaluates and adapts the model to achieve the greatest success and outcomes. We understand the need for pace and the financial climate dictates that the system needs to change in the short, medium as well as the longer term. There is a commitment from the whole system, to deliver quick wins now, to release funds and create operational head-room to provide the foundations for the next stage towards full integration. We will design and commission new system-wide models of care that ensure the financial sustainability of health and social care services; a proactive, rather than a reactive model that means the avoidance of emergency hospital and care home admissions. We will build on our current plans with providers, KCC and North Kent District Councils, to deliver the critical transformational changes required to deliver the key priorities identified by our public and patients. These will include;

1. **A united approach to advice and information on community and public sector services.** This will include developing robust and reliable sources of advice and support for older people before they become frail or need to access the statutory system; and providing universal information and advice about services from all partner agencies, which should be quick to access, clear, friendly and personalised. This will include developing access to transport for vulnerable people who need it to prevent social isolation and access to medical appointments. We will ensure that Patients can See their pharmacist more often and have more opportunities to discuss their health and wellbeing and early detection of serious illness. Be signposted to community services and facilities aimed at helping to address some of the underlying determinants of health. This includes links with existing services such as:

    - **Postural Stability**

    Falls and fractures are a significant public health issue particularly amongst older people with estimates that one in three people aged over sixty five will fall each year and one in two people aged over eighty. It is estimated that falls account for between 10% and 25% of ambulance callouts at £115 per call-out. Postural Stability group exercise programmes improve the balance, strength, gait/mobility and confidence of frail, ambulant older adults at risk of falling. KCC currently commission community based postural stability classes through a variety of public and voluntary sector providers as an integral part of an emerging Falls Framework and care pathway but provision has been fragmented. Significant work is underway with KCC Social care to tender a new integrated enhanced model during 2014/15.

    - **Winter Warmth**

    Excess Winter Mortality (EWMs) are the ‘extra’ deaths that occur in the winter months compared to the rest of the year. The causes of death are complex and interlinked with cold weather, fuel poverty, poor housing and health inequalities, as well as infectious diseases such as flu and noro-virus, and the extent of snow and ice. Many, but not all are likely to be

preventable.

KCC and Local Borough Councils, commission and provide a range of interventions to support at risk groups including funding low level interventions through Home Improvement Agencies, supporting Eco provision for at risk households, training frontline service providers and grant funding for a volunteer led homeless shelter.

2. **Coordinated and intelligence-led early identification and early intervention.** Implementing community record and information sharing between the range of organisations supporting individuals at risk of requiring more support in the future. Ensuring that the workforce are able to feed back as much intelligence as possible as to the needs of the service users they are supporting and how service delivery and deployment of available resources can be improved.

3. **Integrated Primary Care Teams - GPs will be at the centre of organising and coordinating people's care. We** will invest in primary care, through the reconfiguration of enhanced services and the secondary to primary care shift / shared-care and funding arrangements with other providers. We will ensure that patients can get GP help and support in a timely way and via a range of channels, including email and telephone-based services. The GP will remain accountable for patient care, but with increasing support from other health and social care staff to co-ordinate and improve the quality of that care and the outcomes for the individuals involved.

   We will deliver on the new provisions of GMS, including named GP for patients aged 75 and over, member practices determining the model for out-of-hours services, which should be integrated and as seamless as possible with main stream primary and community services. Flexible provision over 7 days will be accompanied by greater integration with mental health services, and a closer relationship with pharmacy and voluntary services. Our GP practices will collaborate in networks focused on populations between 9,000 and 15,000 within given geographies, with community, social care, mental health and specialist services, organised to work effectively with these networks. A core focus will be on providing joined-up support for those individuals with long-term conditions and complex health and social care needs. People with a long-term condition should expect Pharmacists and GP's working in partnership to ensure the best possible care, with linked IT systems Pharmacists to help them to manage their medicines needs on an ongoing basis. With Support available from pharmacists and their teams to enable self-management of patients conditions so that they can stay well in and out of hospital. This will include early detection of problems or deterioration in their condition through routine monitoring. Pharmacists will be able to consult with them in a range of settings appropriate and convenient to them. For example pharmacy consulting rooms, GP practices, home visits,

We expect the core team that will function around the GP network to be as follows:

- Generalist District Nursing Service (see specification attached). This will include District Nursing sisters who will act as case holders and managers working with and delegating work to their team of registered staff nurses, health care assistance / re-ablement workers, using peripatetic skills across therapy, nursing and social care.
- Named Social Care Workers who together with district nurses will take responsibility for case management (inclusive of enablement and re-ablement services)
- Named community Pharmacy of patients choice
- Primary Care Mental Health Practitioner (see job specification attached)
- Primary Care Dementia Practitioner (see job specification attached)
- Primary Care Health Visitor linked to vulnerable adults using public health skills (NHS England responsibility)
- Health Trainers, Health prevention workers and Health and Social Care navigators
- We would expect District Nurses to provide end of life care but access hospice and palliative care specialists (on discussion with GP and the MDT as required)

The core team would have strong working links with community support services using voluntary sector providers such as the voluntary sector and District Councils and housing providers to ensure full packages of care, equipment and adaptations are provided to meet the needs of the patient, carers and the wider community.

We would expect the acute sector and specialist clinicians to work increasingly flexibly, within and outside of the hospital boundaries, supporting GPs to manage complex needs in a "whole person" way. In particular we see acute geriatricians, respiratory consultants and diabetiologists supporting risk stratification and maintenance management as required. Assistive technology, telecare and telemedicine will be more effectively used to support patients to be independent.

4. **Investment in community capacity as described above, to enable people to meet their needs with support in their local community.** The integrated primary care teams will be based around the General Practice networks and focused on the needs of patients. They will deliver robust rapid response where this is appropriate, long term condition management, geriatrician, mental health, social and voluntary sector care, equipment and housing support. They will actively support GP practices to identifying people who are at risk of admission to hospital or residential / nursing home care where indications are that, with some immediate intensive input, equipment and support, such admissions can be avoided. They will work seamlessly with the Acute Hospital and social care, through the integrated discharge team, to ensure that patients receive the

treatment they need and are rapidly discharged with health, social and voluntary sector care and housing support to return back to independent living. Assistive technology, telecare, telemedicine and Disabled Facilities Grant (DFG), will be more effectively used to support patients to be independent and they will be actively utilised in care homes with support to enable patients to be managed when in acute crisis.

5. **Rapid Response services 24/7 linked to the Local Referral Unit (LRU) and Crisis response (Community Based) –** This will focus on admission avoidance and where possible attendance avoidance, where patients either known to the system or unknown, have reached crisis point. It is anticipated that through more robust integrated community working, that the number of patients unknown will be reduced. However, it is accepted that patients will have long term and enduring conditions that will require rapid response at times of acute need. Similarly, people without long term conditions, may require time-limited support to prevent exacerbation of an acute health or social care episode. This team will be centralized to cover a greater geographical area than for GP networks, to ensure effective use of skills and resources. However, there will be strong links between the Local Referral Units and networks. For example, acceptance of each other's assessments and referrals.

   There will also be an improved approach to crisis management and recovery. Supporting rapid escalation and action when a crisis occurs in the life of an older person; this is likely to involve a coordinated response from all agencies (including social care and mental health) working in multi-disciplinary teams, 7 days a week, to provide intensive support in the short term and encompassing services such as respite care and supportive discharge planning. Support should focus on ensuring that when the crisis is over older people and their carers remain as independent as possible and avoid short term crises triggering a deterioration which leads to long term health or social care need.

   The team will comprise:

   - Duty Social worker / case managers
   - Nursing Staff
   - Therapy staff (minimum OT and Physiotherapy plus technicians and re-ablement workers)
   - Access to enablement and domiciliary care to provide 24/7 support as required
   - Crisis Mental Health Teams (including functional and Dementia)
   - Social and Voluntary Sector Care Crisis response services
   - Clinical assessment utilizing specialist nurses, paramedic practitioners and roving GPs

6. **Integrated Discharge Team (Hospital in-reach and links to LRU for early**

supportive discharge and admission avoidance. 7 days per week (8am – 10pm) – (See attached specification and Heads of agreement)

7. **Community Hospital Re-design and Estate reconfiguration using evidence for the Oaks Group and Kings Fund.** It is accepted that the current community hospital resource is not fit for purpose or utilized appropriately. Re-profiling of beds and criteria is required, in line with the Kings Fund and Social Care Accommodation solutions work which includes the definition of medical cover required to support any non-acute bed based facility. Community Hospital services will become integrated health and social care centres that will enable patients to receive the appropriate rapid support that they need. In addition as part of the Social Care Accommodation Strategy support in Extra Care Sheltered Housing will be developed to support avoidance of admissions to hospital and long term care and hospital discharge. A review of KCC accommodation is currently in progress as part of the development of the strategy, and includes links to all partners in health and housing. This work is aiming to ensure understand and manage the market, linking into the needs analysis and ensuring that future care is provided in the most appropriate setting for individuals.

   A joint accommodation strategy and implementation plan is required, with appropriate range of accommodation available. This needs to include, care for vulnerable adults needing accommodation and care input, including those with dementia, learning or other disability or with mental health needs unable to remain in their home such as extra care housing. Extra care provides the security of having your own home as well as the availability of having care on site. This will include health and social care centres running within community hospitals. Further projects and schemes will be developed to support implementation of the Strategy following completion of the current review.

<u>Suggested Metrics for development</u>

In line with the overall Kent level Better Care Fund metrics we will monitor achievement against the following metrics:

- Permanent admissions to residential and care homes: Reduction in admissions based on rate of council-supported permanent admissions to residential and nursing care
- Effectiveness of reablement – those 65+ still at home 91 days after discharge. Performance to be between 82-88% and not show a reduction over 2 years.
- Delayed transfers of care: Reduction in DTOC using total number of delayed transfers of care for each month.
- Avoidable emergency admissions: 15% reduction in admissions.
- Local Metrics:

- Social Care Quality of Life
- Injuries due to falls in people aged 65 and over

It should be noted that the indicators relating to delayed transfers of care (reported on an acute Trust basis) and avoidable emergency admissions (a composite indicator) are currently based on the data for Dartford, Gravesham and Swanley CCG / Dartford and Gravesham NHS Trust. This is due to the need to review the data for Swale CCG, which relates to a proportion of the activity at Medway NHS Foundation Trust. Work will be undertaken to review the baseline data and levels of ambition for all indicators and finalise trajectories by September 2014.

However, to support these higher level indicators the following will be measured locally:

- **Reduction of emergency admission by minimum of 15% from a 2012/13 baseline** (significant progress in 14/15 – link to the Oaks group Non-qualified admissions of reduction by 10-15%). The expectation is that there will be a significant decrease in patients attending and being admitted non electively for specifically HF, CVD, COPD, diabetes, which are the areas for highest inequalities.

- **Increase in the number of patients discharged from A&E with support** and reduction in the number of patients re-attending. (80% w/e 12th Jan)

- **Reduction in Length of Stay per speciality** to within a minimum of HRG trim point per condition.

- **Primary care – 80% over 75yr and those with complex needs have an accountable GP** and have been reviewed to understand their needs and packages of care. Clear specification, for the management of patients in care Homes.

- **Patient experience** – identifying that patient accessing greater support that manages their condition

- **Increasing the number of patients who die in their place of choice.** Increasing the number of patients to 90% who are at the end of life stage to be on the end of life care register and have agreed plan in place with all relevant providers of their care. Improved anticipatory prescribing and access to end of life medicines

- **Increasing the % of patients diagnosed with dementia from 50% to 65%** with 90% having an agreed treatment plan in place and enacted with appropriate professionals and voluntary sector support.

- **Increase in the number of patients receiving planned care for HF, CVD, COPD, diabetes**. (Note in order to support the reduction in the more expensive non-elective admissions.)

- **Integrated Primary Care Teams within the defined locality areas,** including acute physicians, community nursing and therapy, Pharmacy input, mental health

and social care, resulting in the total achievement of non-elective reductions, care home reductions, mental health placement reductions. We see this as the enabler to the achievement of the above metrics.

- **To achieve the financial efficiencies defined**, and operate within designated financial envelope for health and social care.

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.

At a time when we are planning to make significant investments in community-based, person-centred health and care services, pressures and demands on our acute services continue to grow, and local authority social care budgets are facing a prolonged period of real-term reduction, increasing the risk that individual care needs will not be met.
Our BCF plan is about applying targeted investments to convert this potentially negative cycle into a positive one, driven by improved outcomes for individuals, communities and the health and care economy as a whole.
This means:

- Supporting people to live independently and well
- Releasing pressure on our acute and social services
- Investing in high-quality, joined-up care in and around the home

The Better Care Fund proposals details how it will provide:

- protection for social care services
- seven-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- better data sharing between health and social care, based on the NHS number
- a joint approach to assessments and care planning and, where funding is used for integrated packages of care, an accountable professional
- agreement on the consequential impact of changes in the acute sector, with an analysis, provider by provider, of what the impact will be in their local area alongside public and patient and service user engagement in this planning, and plans for political buy-in. This work is being undertaken over the next few months and will be completed by the end of June 2014.

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).

Joint agreement was made at the Executive Programme Board / Kings Fund Workshop on February 20th 2014, to reduce emergency admissions by 10% in 14/15.

Risks of non delivery

The key risks of not achieving the reduction in emergency admissions are:

- Non-delivery of the A&E target of 95%
- Unsustainable financial position for both the providers and the CCG

e) Governance

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

How we will govern and manage these developments?

Across North Kent, we have invested significantly in building strong governance that transcends traditional boundaries. The Health and Wellbeing Board and the local health and Wellbeing Board are maturing and our transformational plans and programmes are formally discussed and approved at local borough governance levels within each local authority and CCG. The North Kent CCGs of DGS and Swale CCG have implemented the following governance arrangements to support the system changes and implementation of schemes. These include:

- We have established Executive Programme Boards in both Swale/ Medway and DGS localities where the Executives of the Provider organisations, CCG and KCC meet monthly to discuss and develop system changes to deliver improved outcomes for our patients.
- Regular monthly Strategic Commissioning meetings are held with KCC to discuss and agree Strategic Commissioning priorities and partnership working.
- HASCIP working groups are operational in DGS and Swale CCGs
- CCG Clinical Cabinet Committees

An overview of the governance structure is included as Appendix 1

a. Providing effective oversight and co-ordination

Regular briefings to the Health and Well Being Boards are designed to help to ensure effective debate and engagement at a borough level, and that our plans are directionally aligned with the priorities of local communities.

Throughout this process, we will ensure that the local Health and Wellbeing Boards for each borough remain central to the development and oversight of the proposed schemes making up our Better Care Fund, with a principle of pooling as much health and care funding as is sensible to do so, and with a focus on developing our joint commissioning and outcomes frameworks to drive quality and value.

Across North Kent, the Executive Programme Boards, combining health and local

authority membership, will continue to provide direction and sponsorship of the development of integrated care across the geography. This will ensure we have a comprehensive view of the impact of changes across North Kent, and that we are able to make the necessary shared investment across our region in overcoming common barriers, and maximising common opportunities.

Discussions have taken place and we propose a joint project management approach to review the current schemes in detail, add to them and ensure that there are clear implementation plans for delivery. Furthermore, there is a requirement to continually evaluate impact of schemes to ensure that we learn and adapt and mover towards full integration. We therefore propose a project director to be appointed across the CCGs and KCC, supported by an appropriate team. This team will report into respective Boards, the Executive Programme Board, which providers and KCC attend and through the local and Kent Health and Wellbeing Boards.

3) NATIONAL CONDITIONS

a) Protecting social care services

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

Central to these plans is the need to build capacity and resilience into all health and social care teams, by making best use of sharing information and resource, and use of technology to streamline processes. The aim is to have a joint plan that will deliver the required savings for both health and social care to ensure that both are financially sustainable over the next 2-5 years.

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

All proposed schemes include the need to ensure that integration between health and social care providers is central to delivering the overall aims. Joint performance metrics have been developed to ensure that there is improved quality of care for patients that deliver the required savings impact for both social care and the CCG and not cost shifting.

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.

Multiagency Executive Programme Boards are in place within the DGS and Swale/ Medway care economies. These boards consist of Senior level representation from health and social care commissioners, and health providers. Within these Boards, key programmes have been agreed and are monitored. This includes the delivery of schemes to reduce emergency admissions and facilitate discharge of patients, as outlined within the Urgent Care plans for each area, and funded during 2013/14 by additional winter funds.

These schemes include the implementation of an Integrated (social care, acute and community, GP, mental health) Discharge Team who are based within the local acute Trusts 7 days per week to reduce emergency admissions and facilitate patients discharge. Monitoring is in progress, and the CCG has committed to continue commissioning this team while impact can continue to be demonstrated.
In addition, emergency care redesign projects are in progress within the local Acute Trusts to ensure consultant level leadership is available with Emergency Departments 7 days per week.

During the NK executive commissioner (CCGs and KCC) and provider planning and agreement meeting on the 29th January, it was agreed that in order to be in the best place possible to achieve our joint vision current integrated working across acute, community, mental health and social care needs to be accelerated in 2014/15. Three priority areas were agreed for 2014/15 and these are included in the BCF.
These were:

- **Integrated Discharge Team model expansion** – achievement of full recruitment and implementation of the team as per the specification provided linked to an in

year 10% reduction in conversion to admission within contracts. The areas of conversion reduction will be drawn predominately from the HRG categories as highlighted within The Oaks review.

- **Integrated Dementia service** within the community and rapid response teams to prevent unnecessary attendance to acute care and facilitate timely and appropriate discharge where an episode of acute care is required.
- **Integrated Primary Care teams** – There is recognition that this will not happen overnight across the whole area as skill shift, enhancement, recruitment and Trust will be required as well as the process for working through appropriate cluster of GP Networks. It has been proposed to cluster DGS practices using collaborative agreements in the first instance with practice population sizes of between 9 - 15,000 based on the Cumbria experience. This will be developed in line with the LRU expansion as described above. This will be fully developed in terms of detail for the final submission along with a timeline for implementation commencing in 2014/15.
- **Access to records** – the shared IT infrastructure and record is seen as an **enabler** to achieve the above. This work has been commenced and led by Dr David Woodhead and full timeline for implementation will be built into the final submission. However, we anticipate requesting support from the Pioneer to ensure the complexities and risks around IG are mitigated.

To accelerate the above initiatives, the CCG and KCC are proposing to jointly commit £1million each (subject to the plan being approved and allocation from NHS England being received) for a specific funding pot to pump prime the above initiatives in 2014/15. Work has commenced on the detailed specifications and heads of agreement for the Integrated Discharge Team, Integrated primary Care teams and the dementia specialist care service, and this work is being taken forward as part of contract negotiations for the 2014/15 year. These are included in Table 3 of section 6.3.
The Joint Programme Management Office will take forward the proposals and will report to the Executive Programme Board and organisational governance structures on progress.

Swale and DGS CCG has submitted a bid for the PM Challenge Fund to accelerate the integrated primary care team model. Proposals from GPs are currently being worked through in terms of developing federated models of practices working with integrated teams 7 days per week.

c) Data sharing

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

A proportion of NHS numbers are held within KCC's Adult Social Care System SWIFT.

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

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. The NHS number is predominately used to facilitate the matching of data sets for Year of Care and Risk Stratification, not for correspondence or to undertake client checks, the numbers are too low. We would use name: address and date of birth as the key identifiers at present. Further work will be required to ensure NHS number is used across all correspondence.
KCC achieved approx. 80% matching of records to NHS numbers when we started, improvement to this percentage would need significant additional resource.
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).

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))

Yes

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.

Yes

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.

We are developing single health and social care assessments that will require a much closer level of integration between primary health (GPs), community health (e.g. district nursing, physiotherapy), mental health (e.g. primary care mental health workers, dementia nurses), social care (support to live independently), and local authority (housing, benefit services) so that these services can identify, support and intervene much earlier to prevent a crisis occurring or someone feeling they are unable to access the support they need.

GPs generally identify that patients who are at high risk of hospital admission already have an accountable lead professional. The aim of the new integrated primary care teams will be to support patients and the GPs to identify patients earlier through targeting and MDT working. Joint plans will be implemented through the integrated primary care teams and as part of implementation of the new GMS contract. This will include support for people with both physical and mental health, especially dementia, needs.

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
Workforce – issues with recruitment across all sectors due to proximity to London / aging workforce	4x4 = 16 (RED)	Liaison with Education providers required to support longer term delivery of workforce Integration of health and social care teams and use of technology to improve pathways and processes releasing capacity.
Financial sustainability on NHS Providers	4x4 = 16 (RED)	To be considered through contract negotiations.
Failure to deliver the reduction in acute emergency admissions	3x4 = 12 (AMBER)	Provider agreement to the reduction by 10% of emergency admissions in 14/15. Detailed BCF plan and project management approach to implement the System changes Governance systems in place for monitoring impact
Lack of GP engagement in supporting the integrated primary care teams	2x3 = 6 (GREEN)	GP Board and member practice support for this development. Service re-design being led by GP Board members BCF funding prioritising the development of this service
Lack of patients behavioural change to affect reductions in A&E attendances and admissions	3x3 = 12 (AMBER)	Implemented a Health Help Now App for patients to help them navigate the health system (currently has reached 10,000 contacts) Improving access through the integrated primary care team and minor injury / walking services. Supporting patients that attend A&E for a primary care condition, to access their GP or alternative service.