Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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	**NHS South Kent Coast CCG**
Boundary Differences	**n/a**
Date agreed at Health and Well-Being Board:	**12/02/14 (1st draft)** **17/09/2014 (2nd draft)**
Date submitted:	**19/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£3,884,000.00**
2015/16	**£13,283,000.00**
Total agreed value of pooled budget: 2014/15	**£3,884,000.00**
2015/16	**£13,283,000.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS South Kent Coast CCG
By	

	Hazel Carpenter
Position	Accountable Officer
Date	

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	<Name of council>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

<Insert extra rows for additional Health and Wellbeing Boards as required>

c) 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**
	SKC Better Care Fund Programme Plan HIGH

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

The South Kent Coast vision for integrated health and social care is for patients to always be at the heart of their care , receiving coordinated, high quality services without organisational barriers that are easy to access 24/7, and that maximise their ability to live independently and safely in their community (in their own homes wherever possible). We will ensure service users and their carers can navigate the services they need and that their health and well-being needs are always met by the right service in the right location.

We will achieve this by building integrated health and social care teams around every patient. These teams, linked to every GP practice, will undertake integrated health and social care assessments and coordinated care planning to pro-actively manage patient's conditions and needs in the community, helping people to stay out of hospital or to recover more quickly after a hospital stay.

Our plans for the Better Care Fund will be achieved by a number of schemes that are focused on ensuring that services work together to provide better support for people with long term conditions, older people and people with disabilities. These services will support patients to maintain independence at home and provide earlier treatment in the community to prevent people needing emergency care in hospital or care homes. They will supportpatient education and empower people to make decisions about their own health and well-being. We will deliver this by:

- Building on and enhancing some of the local projects already implemented or planned in our 5 year strategy and;
- Introducing other schemes to ensure faster evolution of what we are already setting out to achieve.

b) What difference will this make to patient and service user outcomes?

By working in new and innovative ways we aim to achieve the following:

- Focus on prevention and targeted interventions to support peoples overall health and well-being;
- Ensure services respond rapidly and more effectively to patient's needs, especially at times of crisis;
- Support carers and empower individuals to do more for themselves;
- Improve the overall patient experience of the delivery of care

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

As set out in the CCGs five year strategy the overall vision to ensure the best health and care for our community will result in changes to current service configuration. Achieving the CCG's vision will require building sufficient capacity in the community, including the workforce, whilst reducing capacity in acute hospitals in order to deliver the following:

- Out of hospital services to be integrated and wrapped around the most vulnerable to enable them to remain in their own home for as long as possible. Patients will be supported by a package of care focussed on their personal health and wellbeing ambitions;
- Acute hospital services will be specialist facilities whether for physical or mental health needs and will be highly expert to ensure high quality. Hospitals will act as hubs for clinicians to work out from and utilise their skills as part of broader teams as close to the patient as possible.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

With a high elderly population in South Kent Coast and increasing numbers of people who have one or more long-term conditions we aim to focus the Better Care Fund on prevention, reducing the demand and making the most efficient and effective use of health and social care resources.
Our plans for the Better Care Fund support the delivery of the CCGs five year strategy which has a strong focus on the management of long term conditions and the subsequent impact long term conditions has on the local health and social care systems. The plan will also support the delivery of the five year East Kent Strategic Plan (2014-2019).

Given the extent of integration set out in our plans there are considerable changes to the current ways of working and the existing workforce across multiple organisations. This will require us to begin work on re-shaping the provider market to enable delivery of our plans over time; this may take the form of an Integrated Care Organisation.
South Kent Coast CCG has developed an Integrated Commissioning Strategy in partnership with the Local Authority and both Dover and Shepway District Councils. This Strategy identified four shared aims toward which we are working together:

- To improve the health and wellbeing of people in Dover and Shepway living with long term conditions, enabling as many people as possible to manage their own condition better;
- People with disabilities and older people will be supported to actively participate in

the lives of their local communities, enabled by environments that are inclusive, accessible and safe for all;
- To support families and carers in their caring roles and enable them to actively contribute to their local communities and;
- To ensure that the best possible care is provided at the end of people's lives.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Integrated Teams, Rapid Response & Reablement (supported by local Intermediate Care group)
Agree amendments to existing ICT service specification and communicate with stakeholders-Q1 14/15
Agree trajectory for achieving 60%:40% split for step down/step up community hospital beds-Q1 14/15
Further work to defined enhancement of rapid response-Q1 14/15
Complete modelling of activity to determine therapist input required 7 days a week-Q1 14/15
Commence pilot of an integrated intermediate care performance dashboard-Q1 14/15
Review evaluation of non-weight bearing / interim beds project and confirm model of care & investment for model-Q1 14/15
Implement integrated rehabilitation & non-weight bearing pathway (with additional beds if agreed - Q2 14/15
Implement changes to ICT to achieve next stage of integration-Q2 14/15
Integrate ICT single point of access with social services & ICT for all areas-Q2 14/15
Agree details of an integrated hospital discharge team and how it links to community pathways-Q2 14/15
Step up (40%) beds available in community hospital supported by revised criteria-Q3 14/15
Implement enhanced rapid response (1st stage) -Q3 14/15
Implement enhanced rapid response (2nd stage)-Q4 14/15

Financial savings from scheme to be redirected toward falls service

Enhance Neighbourhood Care Teams & Care Coordination (supported by Proactive Care & Primary Care Groups)
Agree further enhancement of NCTs-Q1 14/15
Integrate NCT single point of access with social services & ICT-Q2 14/15
Integrate NCT pathways with secondary care including the development of integrated discharge teams-Q3 14/15

Financial savings from scheme to be redirected toward falls service

Enhance Primary Care (supported by Primary Care Development group)
Agree pathway for proactive management of high risk patients and how MDTs fit with new schemes-Q1 14/15
Start implementing schemes to support over 75s Q1 14/15

1. Patients in nursing and residential homes will have an anticipatory care plan implemented, using the same principles as the Unplanned Admissions Enhanced Service around personalised care planning which includes the use of a minimum specification care plan, and having regular contact with the patient.
2. A review of patients who are housebound and have at least one long term condition using the same principles as the Unplanned Admissions Enhanced Service around personalised care planning which includes the use of a minimum spec. anticipatory care plan, and having regular contact with the patient.
3. Patients with more than 4 medications will have a medication review. Over two years the number of medications in total will be reduced by 10%.
4. Patients who are not in nursing or residential care, we aim to target those with the small number of ambulatory sensitive conditions as defined by the Kings Fund and provide them with self-care plans.
5. Over 75's Falls – Assessment in Home Environment.

Agree additional opportunities for enhancing primary care-Q1 14/15

Enhance Support to Care Homes (supported by local Care Homes group)
Recruit additional resource to CNS Older People team to enhance existing pathway and implement changes-Q1 14/15
Agree outcomes for scheme jointly with stakeholders-Q1 14/15
Implement revised service specification to formally reflect changes to existing contract-Q1 14/15
Develop stakeholder engagement plans-Q2 14/15
Integrate CNS for older people to consultant team, NCT, single point of access & ICT-Q2 14/15
Agree care homes discharge pathway from acute (linked to integrated discharge teams)-Q2 14/15
Develop an outline for a skills programme to increase care home quality of care and outcomes (agree pilot homes)-Q3 14/15
Commence a pilot of the agreed skills programme in at least 5 homes-Q3 14/15
Agree integrated anticipatory care plan/patient management plan to be used at point of hospital discharge-Q3 14/15
Further engagement to confirm ongoing developments-Q3 14/15

Integrated Health & Social Housing Approach (supported by Integrated Commissioning Group)
Agree local priorities following consultation on Accommodation Strategy-Q1 14/15
Commence reviews of jointly funded existing facilities (details tbc)-Q1 14/15
Assess and gaps in existing home safety check processes and agree future requirements-Q1 14/15
Implement extra care housing scheme at Deal-Q1 15/16

Falls Management & Prevention (supported by local Falls group)
Agree changes to local falls pathway and develop action plan-Q1 14/15
Communicate pathway with stakeholders-Q1 14/15
Develop details of pilot for postural stability classes in care homes-Q1 14/15
Develop details of local integrated ambulance falls response service-Q1 14/15
Undertake care homes postural stability classes pilot-Q2 14/15
Implement integrated falls pathway across -Q2 14/15
Implement local integrated ambulance falls response service-Q4 14/15
Pending savings from Schemes 1-2 , Implement local specialised falls and fracture prevention service-Q2 15/16

b) Please articulate the overarching governance arrangements for integrated care locally

The South Kent Coast Better Care Fund plans will be implemented and monitored using a commissioning project management framework. The delivery of the schemes will be supported by the local Integrated Commissioning Group which will report progress to the local Health and Well Being Board. Delivery of the plans will ultimately be the responsibility of the CCG's Governing Board.

All defined milestones and outcomes of the plan will be monitored at the CCG's Performance and Delivery Committee and reported for assurance purposes to the Governing Body. The Better Care Fund schemes and metrics will be included within the body of the Integrated Quality and Performance Report which is a standing agenda item on the Performance and Delivery Committee.

The committee feeds into the CCG's risk register and any risk to delivery or expected outcomes will be included via output from the committee. Whilst many of the metrics are nationally defined and officially reported annually, proxy measures will be used to monitor them in year, including the Levels of Ambition Tool, Atlas of Variation and SUS data.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

The Kent HWB will retain a county wide oversight of delivery of the BCF in line with CCG plans and local governance structures.

A county wide performance and finance group supported by the Area Team and involving all CCGs and KCC will be established in Sept 2014 to support development of the pooled fund and area section 75 agreements. It is recommended that this group retain responsibility for regularly reviewing progress on the BCF and making recommendations to the Kent HWB as appropriate.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	**Integrated Teams and Reablement**
1a	Integrated Intermediate Care Pathway & flexible use of community based beds
1b	Enhanced Rapid Response – supporting acute discharge/preventing readmission
1c	Integrated rehabilitation & Non Weight Bearing Pathway
2	**Enhance Neighbourhood Care Teams and Care Coordination**
2a	Risk Profiling to enable Proactive Care of patients who are at both high and

	low risk of hospital admission to deliver more coordinated patient care in the community
2b	Specialists to integrate into community based generalist roles
3	**Enhance Primary Care**
3a	Develop primary care based services with improved access and integrated with other community and specialist services
3b	Primary care service will support and empower patients and carers to self manage their conditions
4	**Enhance support to Care Homes**
4a	An integrated local community based Consultant Geriatrician and specialist nursing team providing support to care homes
5	**Integrated Health and Social Housing approaches**
5a	An integrated approach to local housing and accommodation provision supported by a joint Health and Social Care Accommodation Strategy, to enable more people to live safely at home and other environments and to enable people to be discharged from hospital in a timely manner into the appropriate environment.
6	**Falls prevention**
6a	Development of a local specialist falls and fracture prevention service
6b	Local integrated falls prevention pathways

5) RISKS AND CONTINGENCY

a) Risk log

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 and any financial risks for both the NHS and local government.

There is a risk that:	likelihood	impact	risk	Mitigating Actions
We fail to deliver the required workforce reconfiguration in the community and within secondary care to ensure that the workforce has the required skills and training to deliver all elements of the schemes and 24/7 availability.	3	5	15	Each responsible organisation to develop a detailed workforce plan to support delivery of each scheme.
We fail to develop the different skills and training required across multiple professionals and organisations.	3	5	15	Training and skills requirements for each scheme to be linked to workforce plan to support the delivery.
We fail to clearly define the appropriate Governance to support delivery of the plans and a fully integrated health and social care system	4	4	16	The plans will be governed jointly by the CCG and the local authority using joint metrics. The CCG will report delivery of the plans through existing assurance frameworks.
We fail to communicate our plans	2	4	8	Robust communication plan to

effectively,with the public and across organisations, to ensure that people know how to access services within the integrated system and that they are used appropriately				be developed to support delivery of each scheme.
IT systems across services do not integrate and therefore do not enable shared care plans between organisations and support integrated outcome measurement and monitoring.	2	4	8	Integrated system to support sharing of care plans to be developed as a priority. Integrated performance monitoring and reporting to be enhanced to take into account all schemes.
We do not effectively plan for the transition of service capacity and do not implement in stages to prevent destabilising the system.	3	4	6	Detailed modelling required to fully understand impact on acute capacity and requirements of community capacity to inform transition over a defined period of time including investment and dis-investment requirements.
The investment required into primary care for the full benefits of the plan falls outside the remit of the pooled budget and sits with NHS England.	4	4	16	To be discussed with NHS England.
We fail to deliver the cultural change required to support the new ways of working	2	5	10	Ensure whole health and social care system has shared vision and values to enable the delivery of required changes. Communication with organisations, staff and service users to be included in communication plan.
The Regulatory and legislative environment does not support the pace of change required across systems.	3	4	12	Provide feedback to NHS England on this issue via the Kent Pioneer Programme.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

To ensure delivery of the above schemes in 2015/16 a programme plan setting out details of the key milestones is in development and will be refined during 2014/15 to ensure clarity of when the changes come into effect and the implications of these

changes as well as the expected outcomes. The programme plan will also include contingencies if the plans are not delivered.

All partners across health and social care within Kent are committed to delivering the outcomes required of the Better Care Fund plan and the wider deliverables as part of Kent's Integrated Care and Support Pioneer programme. The Health and Wellbeing Board at a Kent and local levels will be responsible for monitoring outcomes being achieved and identifying further system changes that will be required to achieve success.

This will include reviewing areas that are working well and increasing the pace of delivery, or collectively deciding what should be stopped or amended.

Regular review through identified governance structures will be required to ensure whole system buy-in and there will be additional overview through contract monitoring and balance.

Contract negotiations for 2015/16 will address risks to acute service in the case of targets for reduction in admissions not being met. The 2015/16 contract will need to reflect a reduction in activity, with agreed compensation should reduction targets not be met.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

In South Kent Coast we have challenges in a number of areas including:

- the highest proportion of over 65's in the Kent & Medway area,
- inequalities in Dover and Shepway being in the bottom 2 deprivation quintiles
- Circulatory Disease is now the main cause of death followed by Respiratory Disease and Cancer.
- From a long term conditions (LTC) perspective SKC have a higher than Kent average for premature deaths (<75) from Coronary Heart Disease (CHD) with a percentage of GP practices reaching 60% of the expected prevalence of COPD and Hypertension.
- It is estimated that the number of people in SKC with dementia is expected to increase by 2026 by over 800.

There are a number of schemes already being developed or underway within the South Kent Coast CCG area which will have an impact on the health and social care system. Patients with long term conditions are known to be high user of health and social care services. The number of people with one long term condition is projected to be relatively stable over the next ten years. However, those with multiple LTCs is set to rise to 2.9 million in 2018 from 1.9 million in 2008.The additional cost to the NHS and social care for the increase in co-morbidities is likely to be £5 billion in 2018 compared to 2011. Our plans are designed to contribute to the systems that need to be put in place now to address the health and social care issues facing people with multiple long term conditions.

The NHS, local authorities and the voluntary sector have achieved so much already, but there is still a lot to do in managing the challenge of increasing prevalence of long term

conditions. Delaying onset of developing an LTC and slowing progression is part of a LTC generic model of care. Implementing this can have a positive impact not only on people's lives but on reducing health and social care costs. The overall impact of all initiatives within the BCF and the aligned work are to promote independence and self-care, to reduce demand on health and social care services, reduce premature admission to long term care where possible ensuring best use of the available resource. We are continuing to put people at the centre of decisions about their care through the following initiatives which all depend on the collaboration between health (acute, community, primary care) and social care to be successful:

SKC Initiative Number	Aligned Initiative	Aligned to SKC initiatives	Aligned to BCF schemes
1	Personal Health Budgets – SKC CCG piloted a national programme from December 2012-2014 offering Integrated Personal Health Budgets (IPBs) to 25 patients already in receipt of social care personal budgets in order to meet their health needs. SKC continue to offer IPBs following the end of the pilot.	2	1
2	The Over 75's Scheme and Unplanned Admissions Enhanced Service in Primary Care designed to ensure personalised care and proactive planning for the group of patients at high risk of admission to hospital ensuring that the patients are well supported in their own homes through health and social care service coordination and reduce, avert crisis and reduce dependence. This scheme will potentially impact schemes 7 & 8	7 , 8	1b,1c,2b,3a,3b,4a,5a,6b
3	Enable interoperability of patient records via Medical Interoperability Gateway (MIG).GP Practices will be linked up to other providers including acute, community, social services and mental health. Phase 1 is nearly complete with 90% of SKC practices sharing patient information with EKHUFT when the MIG goes live on 3rd September 2014.	2,5,10,11,13	1b,1c,2b,3a,3b,4a,5a,6b
4	INPS Outcomes Manager - Implementation of pathways tool entitled 'outcomes manager' in General Practice. GPs are made aware of local pathways during consultations when patients meet the specified trigger criteria. They are then guided through the pathway, which can include background information, risk calculators and gold standard data entry templates based on NICE guidelines. Pathways, with corresponding trigger criteria and data entry templates, are designed and built to specifically meet local requirements. They are then pushed to all practices in the area, where they are installed automatically. This will enable GP's to direct patients to self - management initiatives addressing both primary prevention and secondary prevention within care pathways ie: CVD	2,5,6,7,8,9,10,11	1a,1b,2b,6b
5	The Clinical Care Coordinator and Dementia Coordinator being piloted in Deal to support patients and their families/carers to access the most appropriate services to ensure early intervention and proactive support and management. The evaluation of both these roles will be used to inform integrated working and identify changes a that need to be made to existing provision in order to provide seamless care making the best use of the available resource	2,3,4,6,7,8,9,10,11,12,13	1a,1b,1c,2a
6	Developing services in the Victoria Hospital, Deal together with social care and the voluntary sector	1,2,4,5	1a,1b,1c,2b,3a,6b
7	The development of a primary and secondary prevention Cardio Vascular Disease (CVD) pathway together with public health – without timely intervention the risk of the complications of CVD are devastating to patients and their families and costly to the health and social care system ie; stroke	1,2,5,10,12	1a,1b,1c,2b,3a,3b,4a,5a,6b
8	The implementation of a new Diabetes patient management pathway – this is designed to move more care closer to the patients' homes via primary care and improve outcomes through increased education and better management	1,2,5,10,12	1a,1b,1c,2b,3a,3b,4a,5a,6b
9	The implementation of a new COPD pathway to improve the management in primary care of patients with COPD	1,2,5,10,12	1a,1b,1c,2b,3a,3b,4a,5a,6b
10	Integrated Urgent Care Centre (IUCC) designed together with social care to manage discharge at both the front end and back end of the hospital through a case management approach ensuring a proactive approach to safe discharge to the most appropriate place ideally the patient's own home promoting independence where possible	2,3,4,5,11,13,14	1a,1b,1c,2a,2b,3a,3b,4a,5a,6b
11	End of Life Improvement – implementing our end of life strategy, priorities for care,	2,3,4,5,10,1	1a,1b,3a,4

	preferred place of care, rapid access to support, coordinated care and symptom control	2,13,14	a
12	Promoting the use of Telehealth and Telecare -There are many small trials showing that appropriate use of Telehealth and Telecare can lead to improved outcomes and reduced admission to hospital and care homes. This in turn can improve the quality of life and deliver savings to the health and social care system. We have an example of a local patient who has benefited from Telehealth. The use of technology has allowed his needs as a patient to be met, whilst promoting his independence. Through his own admission, the patient claims Telehealth has changed his life completely; giving him 'full control of [his] life'. He has managed to achieve confidence and self-esteem which prior to being on Telehealth had been totally lost.	1,2,4,5,6,7,8,9,10,11	1a,2a,2b,3b,5a,6b
13	Resilience Plans – the funds allocated centrally to the CCG for system resilience have been used to pump prime elements of the BCF model of provision	2,3,4,5,7,8,9,10,11,12,14	1a,1b,1c,2b,3a,3b,4a,5a,6b
14	Prime Ministers Challenge Fund- a programme testing 8am – 8 pm, 7 days a week access to General Practice for 13 practices within the SKC CCG area. The evaluation of this programme will inform the development of the BCF initiative of enhanced primary care going forward	3,4,7,8,9,10,13	1a,1b,2a,2b,3a,3b,4a,6b

There are plans to improve the utilisation and appropriate use of existing short term beds. Work is underway on the patient pathway for the current intermediate care beds to improve the step up percentage. We are also considering housing options that will support flexible use and enable more people to live independently in the community with the right level of support that will include use of assistive technologies. This will also require responsive adaptations to enable people to manage their condition in a safe home environment. There is further work to do to make this a reality through the Kent wide multi agency accommodation strategy,

Workforce

The overall model of care recognises that we will see large number of people living with co-morbidities. This must drive service design to meet patient need but ensure that the current disease pathway is still important with an appropriate response built in. Therefore, a holistic and generic view of health and wellbeing should be taken for LTC care whilst embracing the use of technology. We have the benefit of a new post in the CCG, a Workforce Facilitator, who will be supporting the development of the team around primary care. The plan is to take forward the development of nursing in primary care, support the development of GP Trainees and also a more generic community nursing workforce with a range of skills which could, for example, include assessment for social care in order to reduce duplication. We also plan to develop the integration e local authority enablement services and health intermediate care services which would give a critical mass of skill workforce and would enhance the skills of the enablement workers. We wish to ensure that specialist nurses, who have traditionally had a specific disease focus for example; respiratory and heart failure have a more generic focus in order to meet the changing needs of the CCG population. The aim is for patients and their carers to gain access to higher quality, local, comprehensive community and primary care.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Alignment with local JSNA and local commissioning plans

The schemes outlined in this plan have been developed in partnership with social care commissioners and public health experts. The schemes, along with the CCG's overall commissioning plans, will support addressing the needs identified in the local Joint

Strategic Needs Assessment, particularly around the care of people with long term conditions and for those families and individuals supporting them. These health priorities are as follows:

- Being ready to respond to the impact of our ageing population;
- Tackling increasing inequalities;
- Improving access to primary care services;
- Managing patients mental health (including Dementia);
- Increasing access to care closer to home;
- Tackle patients' long term conditions;
- Tackle unnecessary and unfair variations in care;
- Improve management and identification of diabetes;
- Pro-active general practice (smoking, weight, alcohol, health checks etc.);
- Work closely with partners to tackle patients and carer wellbeing.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

- The CCG has submitted an Expression of Interest to undertake commissioning of primary care services for our local area and are very supportive of taking on co-commissioning arrangements locally.
- Because we know the local population and the local needs, we believe this opportunity would enhance our ability to deliver our five year strategy of moving more care into the community and out of the hospital environment, developing over time into an Integrated Care Organisation/s based in the community with primary care at it's heart.
- Critically, we believe that more local commissioning would enable us to further and more effectively address the inequalities of health care provision in our area.
- We believe that we can develop a new approach to commissioning which is co-operative and developmental, rather than transactional.
- Our approach to co-commissioning would be underpinned by a number of core principles:
    - We will co-commission primary care with all those who have an interest in primary care, including public health and general practice
    - We will be patient centred, continuing with our current engagement strategy
    - We want the ability to make strategic decisions and the local flexibility to make changes and ensure that local needs are met
    - We want to remain small and local and build on our strengths so that commissioning supports the relationships we have developed with the Membership and encourages practices to work together

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

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

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

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

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

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

The Better Care Fund plans set out a vision for a fully integrated health and social care system. The delivery of these plans will not have an adverse impact on the adult social care services and therefore patients and service users eligible for social care services will continue to receive the care they need.

By managing to enable people back to a level of care that means they can manage in the community this will reduce the impact on social care freeing up capacity for the increased demand on services.

Development of a Self-Care Strategy will support the prevention agenda which will benefit all organisations as will the development of a joint information advice and guidance strategy which signposts people to the right place.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

£3,884,000 for Section 256
£519,823 for Care Act
Total £4,403,823

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The new legal framework introduced by the Care Act 2014 will be implemented for the most part from April 2015 but some of the key changes (care costs cap and raising of the capital threshold) do not start until April 2016. In many cases existing duties are simply consolidated into the new legislation. However the Act does introduce a number of new duties and powers and makes some changes to existing duties and processes. On 6 June the Government released for consultation the draft regulations and guidance for the 2015 changes and KCC has submitted a formal response to these. The final versions will be issued in October this year. The draft regulations and guidance for the 2016 changes are expected to be issued for consultation later this year. We therefore do not yet have the final details of how the reforms will work.

In order to prepare for the significant changes being introduced by the Care Act, KCC has a Care Act Programme which encompasses several work streams/projects. From 2015 the most important changes concern eligibility, the new duties to provide support to carers, duties towards self-funders, powers to delegate most adult social care functions, new duties towards prisoners and the enhanced duties to provide information, advice and advocacy. From 2016 the introduction of the lifetime cap on care costs and the extended means-test are the two most significant changes. KCC anticipates that these 2016 changes in particular will involve assessing significant numbers of people who in the current system are self-funders and unlikely to be known by the local authority. KCC are therefore examining various mechanisms for this including the role of self-assessment and partner organisations in the statutory and voluntary sector.

v) Please specify the level of resource that will be dedicated to carer-specific support

£387,434 for Carers Provided by Crossroads and Dover Carers Support and including assessments and support, short breaks, primary care rapid support, and crisis short breaks.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There has not been significant change to budget from the original BCF plan

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

The Kent Joint Health and Wellbeing Strategy sets out a number of outcomes aimed at providing seven day health and social care services across the local health economy, for example:

- Ensure all agencies who are working with people most at risk of admission to hospital and long term care have access to anticipatory and advanced care plans and 24/7 crisis response services in order to provide the support needed;
- Ensure all people with a significant mental health concern, or their carers, can access a local crisis response service at any time and an urgent response within 24 hours.

All schemes within the local CCG plan require accessible 7 day a week service to support patients being discharged from hospital and prevent unnecessary admissions at weekends.

In South Kent Coast the enhanced multidisciplinary Neighbourhood Care Team is the main structure for providing post hospital care for any reason and some pre-admission intervention in the community.

c) Data sharing

i) Please set out the plans you have in place for 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. The CCG is moving forward with its plans for interoperability of patient records via Medical Interoperability Gateway (MIG). GP Practices will be linked up to other providers including acute, community, social services and mental health. Phase 1 is nearly complete with 90% of SKC practices sharing patient information with EKHUFT when the MIG went live on 3rd September 2014. Phase 2 has started which includes sharing acute records with GP Practices, as well as sharing GP Practices with other providers listed above

NHS
At present all NHS organisations must ensure that a minimum of 95 per cent of all active patient records have an NHS number. The NHS Information Standards Board mandates the use of the NHS number on both general practice and secondary care organisations.

The NHS standard contract states:
"Subject to and in accordance with guidance the provider must ensure that the service user health record includes the service user's verified NHS number. The provider must use the NHS Number as the primary identifier in all clinical correspondence (paper or electronic). The provider must be able to use the NHS Number to identify all activity relating to a service user."

Social Care
A 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.

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).

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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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 explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

Please see previous response for Governance arrangements around data sharing with regards to the MIG.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

In South Kent Coast the accountable lead professional for people at high risk of hospital admission is their GP. Risk stratification is undertaken by practices and shared with community nursing teams to identify those patients most at risk. These patients are recommended for Proactive Care to ensure coordination of all their health and social care needs to prevent hospital admissions. If the patients are under the care of the community nursing or intermediate care teams they are informed on how to contact a member of these teams 24/7 if they need to. All patients at high risk or hospital admission and put forward for Proactive Care have a joint care plan in place.

Risk Profiling (Pro-Active Care)
South Kent Coast CCG has been running a programme called Pro-Active Care which almost all practices are participating in. Pro-Active Care is a 12 week intervention by a multi-disciplinary health and social care team for risk stratified patients with multiple co-morbidities. The aim is to improve patient's self-management, their quality of life, medicines compliance and reduce A&E and associated hospital admissions.

Through risk stratification Pro-Active Care targets the patients at highest risk of hospital admission and then works its way through the lower risk patients. This is something that, over a year on, the first practices to run pro-active care are now starting to achieve after having seen all of their highest risk long term condition patients. In turn this means that the amount of clinical time and intervention decreases with lower risk patients and there is an expectation that such intervention will go some way to preventing these lower risk patients from deteriorating as fast thus prolonging their health and quality of life over the long term.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Pro-Active Care is delivered by a multi-disciplinary health and social care teams undertaking joint assessments, clinically led by a GP, and jointly agreeing anticipatory care plans for every patients going through the programme. A pharmacist offers a review of their medicines, a health trainer supports them to develop a healthier lifestyle and signposts the patient to other services in the community. Physiotherapists and

Occupational Therapists review the patient's needs. Social Services and Mental Health services also visit to offer advice and services if required. The GP remains the accountable professional for their patients.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

GP practices have confirmed 2% of overall population (approx. 4,000 individuals) have been identified via risk stratification and invited into scheme. Work is underway to develop individual care plans for each identified patient by end September 2014.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

The Better Care Plan includes schemes already included in the CCGs operational plans for 2014/15. For these elements a range of local CCG engagement activities have been undertaken throughout 2013/14 in preparation for the 2014/15 plans. The CCG has established several ways to have a regular dialogue with the local community and involve them in planning and improving services, through:

- three locality Patient Participation chairs' groups
- a Health Reference Group (HRG) to extend reach - including community representatives, local volunteers who work with the seldom heard such as homeless people, disability groups, mental health service users, children and young people as well as Healthwatch and other groups.
- a health network – to engage with a wider virtual group of individuals, community organisations and voluntary sector.

In preparation for the CCG commissioning strategy and the better care plans, the CCG held:

- A series of innovative, interactive planning workshops: including electronic voting to prioritise responses to urgent care needs, story-boarding to consider long term conditions and public health needs, and round table discussions to look at the best and worst aspects of intermediate care and mental health.
- Further consideration of local people's needs using a variety of methods: surveys, workshops, focus groups and joint working groups.

Key outcomes

SKC CCG developed a proactive approach to 'out of hospital' health and social care services, including:

- ‘Proactive care’ - a model led by GPs in primary care, working with patients, carers, and clinicians to support the elderly with long term conditions. The Health Reference Group is supporting work to test the approach for rolling this out to all practices.

- Review of intermediate care – patient and carer representatives were part of the steering group, plans were tested with focus groups of service users, including seldom heard communities.

- Co commissioning - working in an open and inclusive approach to co-commissioning services with patients and stakeholders, so that together they plan how Deal community hospital and local GP member practices, can provide community based care. Plans are now in place to pilot a clinical care co-ordinator post linked to GP practices in Deal. These plans were developed as part of the Deal conversations with patients.

  This approach is being rolled out across each local area in turn to ensure shared ownership of the plans with GP members and the wider community.

Activity	Date	# participants
Survey	Spring /Summer 2013	2000+
Deal Public Meeting	30 Aug 2013	430
SKC CCG Initial Workshop	28 Jan 2014	130
EKHUFT Outpatients Consultation Meeting	2 Feb 2014	65
SKC CCG Planning Workshop	23 April 2014	14

Benefits Delivered

A wide range of people have been involved and listened to at all stages of the out of hospital programme; GPs and Patient Participation Groups have moved their discussions from service issues to jointly planning delivery of community hubs and the services they provide. This will form the blueprint for ongoing conversations with our local communities about the detail of the commissioning of services in their area.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

The South Kent Coast Integrated Commissioning Group has overseen the development of the Better Care Fund Plan and has included representation from local providers to help shape the plan and the schemes within it. Details of each scheme has been shared,and shaped with representatives from the local acute trust, community trust and the mental health trust through the discussions at the Integrated Commissioning Group.

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

ii) primary care providers

Primary Care providers are represented on the Integrated Commissioning Group and the draft BCF plans have been discussed with primary care providers (as the CCG membership) at various committees and forums.

iii) social care and providers from the voluntary and community sector

The draft plans have been discussed and shaped at the local Health and Wellbeing Board which includes representation from the voluntary and community sector.

Working jointly with the Age Concern Deal Centre for the Retired, as part of the on-going Deal plan, a pilot dementia co-ordinator post has been developed to improve the local dementia pathway for patients newly diagnosed with dementia The post holder will be employed through the Deal centre, funded by the CCG A funding bid to enable the CCG to extend the pilot has been submitted to the patients in control programme, with a decision expected in early September.

Local voluntary and community organisations form a key part of the virtual health network and are often present at public meetings. Building on from this a mental health working group, consisting of representatives from Speak Up CiC, MIND Folkestone and the Mental Health Action Groups has been convened to support the CCG's onward 5 year mental health strategy.

Plans for the developing the Integrated Care Organisation model have been discussed with local social care providers who are keen to be part of any onward development.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The plans align with the delivery of the CCG's strategy, as outlined in section 2a above. The majority of the NHS savings will be realised by the reduced emergency attendances and admissions and a reduction in length of stays within the acute setting. The local acute trust supports the direction of travel described in the Better Care Fund Plan and the plan aligns well with the Trust's 5 year clinical strategy.

The plans will not have a negative impact on the CCGs constitutional targets as set out in the Everyone Counts: Planning for Patients 2014/15-2018/19. The plans should support

the delivery of these targets, in particular the A&E waiting times and the proportion of older people at home 91 days after discharge from hospital into Reablement/rehabilitation services.

Consideration will be required for future contracts to reflect revised activity levels, with recognition that non-performance against targets would be compensated.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
1
Scheme name
Integrated Teams and Reablement
What is the strategic objective of this scheme?
Integrated teams available 24 hours a day seven days a week will be contactable through single access points. Patients will know who they should contact within these teams whenever they need advice and support. The teams will undertake single assessments and coordinate onward referrals and comprehensive care planning and will provide enhanced rapid response to patients at high risk of hospital admission providing intermediate care and rehabilitation in the community. The teams will integrate with the hospital discharge planning and referral processes seven days a week and coordinate post-discharge support into the community linking with the community based Neighbourhood Care Teams, primary care and the voluntary sector.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Integrated Intermediate Care Pathway & flexible use of community based beds • Integrated pathway to coordinate referral management, admissions avoidance and care coordination across health and social care, supported by single access points; • Integrated assessments to ensure responsive onward referral to either rapid response services or intermediate care services ensuring transfer to most appropriate care setting (including patients own home); • Intermediate care provision to be provided at patients own home wherever possible by professional carers or by a multidisciplinary team of therapists and

nurses;
- Community hospital beds only to be used for comprehensive assessments, for patients needing 24/7 nursing rehabilitative care and for carer respite;
- Community based beds (in any local setting) will provide 60% step down from hospital and 40% step up to support timely hospital discharge and prevent avoidable hospital admissions and re-admissions. These beds will be used flexibly to effectively respond to changes in demand.

Enhanced Rapid Response – supporting acute discharge/preventing readmission

- Enhanced Rapid Response teams supporting admissions avoidance as part of intermediate care provision as well as respond directly to A&E referrals;
- The teams will be integrated with Emergency Care Practitioners to ensure enhanced skills are available and supporting the ability to keep sub-acute patients at home;
- The teams will include medicine management support as well as medical leadership and input from hospital consultants to enable continuous support at home;
- The teams will integrate with the Dementia Crisis Service which can receive referrals 24/7 providing support 24/7 to patients with Dementia and carers of people with Dementia to prevent hospital or care home admissions.

Integrated rehabilitation & Non Weight Bearing Pathway

- Integrated approach to support timely hospital discharge, rehabilitation and intermediate care for patients including non-weight bearing patients;
- Proactive case management approach to support timely transfer of patients from acute beds into the community and preventing admissions into acute from the community;
- Integrated step up and step down beds supported by a dedicated multi-disciplinary team, including therapists, social care and primary care input, to ensure timely patient flows.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Enhanced teams will be developed through workforce reconfiguration across KCHT and secondary care. Scoping of staffing reallocation and cost savings is underway, led by SKC CCG in collaboration with service providers.

Delivered by KCHT, ambulance services, EKHFUT, KCC

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Schemes were selected based on evaluation of high impact schemes identified by the Kings Fund and other best practice evidence, supported by evaluation of Public Health England information on long term conditions and where impact would be most effective in South Kent Coast.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduced emergency admissions;
- Reduced A&E attendances;
- Reduced hospital admissions and re-admissions for patients with chronic long term conditions and Dementia;
- Improve patient experience;
- Improve health outcomes;
- Reduced length of stay;
- Improved transfers of care;
- Reduced long term placements in residential and nursing home beds;
- Reduced need for long term supported care packages;
- Increase patients returning to previous level of functionality in usual environment

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The following indictors will be used to monitor success of the scheme:

- Reduce unplanned admissions by 250 through prevention of readmissions.
- Improve the step-down and step-up ratio for community hospital beds (target 60/40).
- Development of cross service clinical audit is in progress. This work will monitor multi-agency contacts to ensure effectiveness of integrated teams.
- Increase in Community Services admission avoidance (targets to be agreed)

What are the key success factors for implementation of this scheme?

This scheme will build on existing teams, but will redevelop fragmented pathways to create streamlined care from prevention to treatment through to end of life. Integrated enhanced services will be developed with clear and prescriptive deliverables and strengthen definitions of required skills mix within team. Providers and clinicians are currently engaged in agreement of redesigned specifications and pathways.

Scheme ref no.

2

Scheme name

Enhance Neighbourhood Care Teams and Care Coordination

What is the strategic objective of this scheme?

This model builds a team around the patient who focus holistically on the patients overall health and well-being and pro-actively manages their needs. These teams will be further enhanced to ensure wider integration with other community and primary care based services as well as hospital specialists working out in the community and mental health teams to ensure people can be cared for locally and in their own homes wherever possible and using technology for virtual ward rounds or consultations and remote

guidance for GPs rather than patients attending hospital. The teams will be aligned to every GP practice, will undertake Multi-disciplinary Team meetings and will include designated care coordinators for all patients.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Risk Profiling to enable Proactive Care of patients who are at both high and low risk of hospital admission to deliver more coordinated patient care in the community (see section d below for further details of the South Kent Coast Pro-Active Care Programme)

- Aligned to every GP practice the Neighbourhood Care Teams will be accessible 24 hours a day seven days a week and will coordinate integrated proactive care management of patients through a multi-disciplinary approach with patient involvement at every stage of the process including the development and access of anticipatory care planning to ensure patient centred care and shared decision making;
- The Neighbourhood Care Teams function as integrated teams and provide continuity of care for patients who have been referred for support in the community and form the main structure in providing post hospital discharge care and some pre-admission interventions as well as seamless coordination and delivery of End of Life care;
- The Neighbourhood Care Teams will form the main structure in providing post hospital discharge care and some pre-admission interventions and will be integrated with pathways to asses a patients home environment;
- Access into and out of the Neighbourhood Care Teams will be coordinated through clinically supported single access points. Patients who require assistance by more than one professional will receive coordinated integrated assessments. This single point of access will be integrated with social services and will be linked with secondary care via a flagging system to report when patients known to the teams have been admitted into secondary care;
- Each Neighbourhood Care Team will include input from the wider community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, and Social Care Managers as part of the multi-disciplinary approach;
- The teams will support patients with complex needs to better manage their health to live independent lives in the community, including supporting and educating patients with their disease management by using technology, for as long as possible empowering them to take overall responsibility for managing their own health;
- The Neighbourhood Care Team will be able to access the relevant care package required to support the person for the time required.

Specialists to integrate into community based generalist roles

- The enhanced Neighbourhood Care Team model requires specialist input from acute in the community to enable the management of care for more patients in the community for a range of specialisms (respiratory, diabetes, heart failure and COPD) including the care of the over 75s, this will include undertaking clinics and reviews of patients in or close to their own homes rather than in hospital. This

could include actual and remote approaches supported through the use of technology, such as video conferencing with acute specialists.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Enhanced teams will be developed through workforce reconfiguration across KCHT and secondary care. Scoping of staffing reallocation and cost savings is underway, led by SKC CCG in collaboration with service providers.

Provided by KCHT, KCC, and GPs

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Schemes were selected based on evaluation of high impact schemes identified by the Kings Fund and other best practice evidence, supported by evaluation of Public Health England information on long term conditions and where impact would be most effective in South Kent Coast.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduced emergency admissions;
- Reduced A&E attendances;
- Improve patient experience;
- Increase levels of patient self-management of long term conditions;
- Improve health outcomes;
- Reduced spend on drugs;
- Reduced duplications across the health and social care system;
- Reduce the needs for long term placements in residential and nursing homes.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The following indictors will be used to monitor success of the scheme:
- Reduce unplanned admissions by 108 through proactive care.
- Reduction of long term placements (10)
- Increase in Community Services admission avoidance (targets to be agreed)
- Development of cross service clinical audit is in progress. This work will monitor multi-agency contacts to ensure effectiveness of integrated teams and quality of anticipatory care plans.

What are the key success factors for implementation of this scheme?

This scheme will build on existing teams, but will redevelop fragmented pathways to create streamlined care from prevention to treatment through to end of life. Integrated enhanced services will be developed with clear and prescriptive deliverables and strengthen definitions of required skills mix within team. Providers and clinicians are currently engaged in agreement of redesigned specifications and pathways.

Scheme ref no.
3
Scheme name
Enhance Primary Care
What is the strategic objective of this scheme?
• Integrated community models of care centred on GP practices requires significant change in primary care working patterns. • Different models need to be developed to ensure the right levels of support and capacity is available within general practice and to support the development of sustainable local communities. • This will include a primary care hub in each town linking all practices around the local hospitals that will host primary care services 7 days a week from 8am to 8pm and work closely with the existing MIU to develop integrated working. • A pilot will commence in two towns with a view to including a 'hub' of practices in every community to improve access to a full range of local health and social care services which will support the move from a medical focused model of care and shifting towards a health and well-being focus.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
• Integration of all GP practices within a community offering extended primary care service 8am – 8pm 7 days per week, linked to the local hospital • A GP clinical system would be installed at the hospital and consulting rooms established for GP's and nurses. • The system would be linked via the Medical Interoperability Gateway (MIG) to all local practices and software installed to enable data entry onto multiple systems. • An integrated telephone system would be installed that enables all practices to have calls re-directed and to offer telephone appointment booking. • There will be an urgent visiting service provided by paramedics and supported by GP's. • In some cases patients may be transported to the 'hub' either by paramedics or other local transport services. • There will be primary care mental health specialist offering assessments either at the hospitals or at home. They will also provide support to GP's with mental health queries. • The service will be available to all patients within the CCG with an aim of increasing capacity within primary care and reduce burden on acute services **Develop primary care based services with improved access and integrated with**

other community and specialist services

- GPs have started to undertake proactive case management of patients including regular medication reviews, proactive working with patients to avoid admissions. This will require closer working with social services working with at risk patients to avoid crisis and better use of carer support services. This could also include virtual ward rounds of at risk patients following hospital discharge;
- GP practices to be clustered in hubs and configured in a way that enables different access opportunities for patients to include open access and access to other practices in the hub to improve responsiveness of service provision;
- Develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by primary care. This will require stronger integration with the Neighbourhood Care Teams as well as stronger links with and signposting to the voluntary sector;
- Integrated primary care provision will have greater support from specialist hospital teams to ensure on-going medical care for patients after hospital discharge by creating shared on-going care plans to avoid hospitals readmissions and stronger links with rapid response services to enable patients to remain out of hospital;
- GP practices to link with the support to care homes pathways to provide more intensive support.

Primary care service will support and empower patients and carers to self manage their conditions

- Professionals in primary care will promote the use of integrated personal health budgets for patients with long term conditions and mental health needs to increase patient choice and control to meet their health and social care needs in different ways;
- Primary care and the Neighbourhood Care Teams will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the community.
- The Neighbourhood Care Teams will educate patients about preventative services such as weight management and alcohol services as part of the multidisciplinary assessment;
- Patients will be supported by the Neighbourhood Care Teams and primary care to inform and take ownership of their care plans. Care plans have started to be shared via MIG functionality between health and social care professionals and this will be rolled out over the coming months.
- Improved signposting and education and access to signposting and education will be available to patients through care coordinators and Health Trainers to ensure patients are given information about other opportunities to support them in the community, including the voluntary sector, and community pharmacies. GPs will signpost patients with early signs of mental health concerns to the right services
- Develop a Health and social care information advice and guidance strategy to enable people to access services without support from the public sector if they choose to.
- Plans in place to implement enhancements in care for over 75's which includes anticipatory care planning for a range of cohorts: patients in care/nursing homes, patients in the community that have an ambulatory sensitive condition as well as patients that are housebound with long term conditions.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

- The providers within this scheme are essentially our GP Practices who work as independent contractors
- The integration aspect of this scheme is being supported by a nationally funded pilot to test this approach within two local communities and if successful will be rolled out across the entire CCG
- Initially this will be delivered by a local Community Interest Company (Invicta Health) and commissioned by NHS England but with support and guidance being inputted by the CCG
- If the pilot demonstrates the required enhancements to primary care, South Kent Coast CCG will commission the service going forward and with a view to rolling out across the CCG
- Many other providers will be involved as the integration work is accelerated that will include South East Coast Ambulance NHS Trust, East Kent Hospitals NHS Foundation Trust, Kent Community Health NHS Trust, Out of Hours providers, Mental Health providers, 111 as well as social services and voluntary sector providers.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

1. Improve the patient experience by:
   - Improving access to general practice by providing 7 day opening
   - Enhancing care through service integration
   - Providing more GP input for patients with complex needs

2. Address GP recruitment and retention issues by:
   - Addressing workload concerns
   - Developing alternative career structures

3. Develop service and system integration by:
   - Wrapping GP services around community services
   - Federating models of provision
   - Developing hub and spoke arrangements (the hubs will be located in two community hospitals and other hubs will be developed in other communities)
   - Integrating IT systems and shared access to medical records
   - More patients will be managed at home with greater community support.

The will improve access for patients by providing 7-day primary care and enhance the care for elderly and frail patients by increased availability of GPs and improved co-ordination and continuity. This is intended, in conjunction with other local schemes, to reduce demand on A&E and OOH.

It also allows practices to trial an alternative provision for OOH in collaboration with 111. The introduction of primary care mental health assessments will improve care for patients presenting with urgent mental health needs and reduce demands on secondary mental health.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduced emergency admissions;
- Reduced A&E attendances;
- Improve patient satisfaction and well-being;
- Increase levels of patient self-management of long term conditions;
- Increase levels of patients with personal health budgets and integrated budgets;
- Improve health outcomes by better use of prevention services.
- Increased levels of capacity within primary care
- Increased level of integration between healthcare professionals and providers

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The following indictors will be used to monitor success of the scheme:

- Reduce unplanned admissions by 259 through over 75s schemes impact on ambulatory care sensitive conditions and urinary tract infections.
- Development of cross service clinical audit is in progress. This work will monitor quality of anticipatory care plans.
- Increased GP opening hours
- Medication reviews

What are the key success factors for implementation of this scheme?

- Creating enhanced access and capacity within primary care
- Integration of services against delivery of certain requirements e.g. MH, IT
- Improved system efficiency to reduce A&E and OOH activity and improve patient outcomes and experiences

Scheme ref no.

4

Scheme name

Enhance support to Care Homes

What is the strategic objective of this scheme?

This model supports older people with a range of needs including physical disabilities and dementia will align specialists across multiple teams, including secondary care, to ensure patients in care homes have anticipatory can plans in place and those that are admitted to hospital have robust discharge plans in place before they are discharged in order to prevent re-admissions and to improve those patients care and support in the community.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

An integrated local community based Consultant Geriatrician and specialist nursing team providing support to care homes

- The integrated team for older people can be referred to directly and is aligned to the Neighbourhood Care Teams and the Integrated Intermediate Care teams to undertake reviews all care home discharges from hospital and A&E and ensure appropriate community based services are in place to support patients as part of their discharge planning. These discharge plans will be in place for every patient and known to all community based teams. The team will also undertake anticipatory care planning with the patients and their carers;
- The consultant works in the community providing advice to GP in the treatment and support for patients and along with the wider team provides additional support, advice and guidance to care homes, primary and community services in the management of older people;
- Access to specialist services such as Dementia Crisis will be available to support care homes, through the integrated working model of, 'Enhanced Support to Care Nursing Homes'

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The delivery chain is managed by CCG Commissioning comprised of clinical commissioner input and commissioning management support.
The CCG has commissioned a Consultant Geriatrician and part of the specialist nursing, element to date from our local Community Provider KCHT and is in process of commissioning two further posts from a CIC Invicta with an agreed start date for one post Nov 1st and the second post within the same timescale. The service specification sets out that the providers will work in a MDT, integrated way building on the existing integrated team structures currently in place.

The CCG has commissioned the Geriatrician Services from an independent organization, with a service specification in place that requires a model of integrated working.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The ratio of care nursing home beds per CCG capita (we have the highest in Kent)
An earlier pilot of the Enhanced support to Care Nursing Homes demonstrated a reduction in A&E attendances and subsequent financial savings. A 54% of all clients reviewed in care homes had their medications reduced or changed and there was an increase in the number of Care Management/ACPs initiated for patients in care nursing homes.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in

headline metrics below
• Reduced emergency admissions from care nursing homes; comparing admission rates before and after the pilot • Reduced A&E attendances from care nursing homes comparing admission rates before and after the pilot • Reduce unnecessary prescribing; patients seen by the Consultant Geriatrican reviews medications and stops, reduces or changes prescriptions • Improve patient satisfaction through personalised care planning; patients (and their families) have improved awareness of understanding of their care, what is required of them and what to expect from the provider(s). Indirectly communication is improved around, capacity and DNAR information
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
• Admissions data feedback loop will be via the established CCG care nursing home dashboard, that sets out nos. of admissions from care homes (rate of beds), top diagnosis rates, HRGs and Primary Diagnosis • While social care performance monitors individual care nursing home contracts, the CCG and LA meet every 6 weeks to triangulate performance/quality data and information to agree comes to target to provide support, advice and guidance in the care of the patients supported.
What are the key success factors for implementation of this scheme?
The following indictors will be used to monitor success of the scheme: • Reduce unplanned admissions from care homes by 90. • Development of cross service clinical audit is in progress. This work will monitor quality of anticipatory care plans. • Medication reviews

Scheme ref no.
5
Scheme name
Integrated Health and Social Housing approaches
What is the strategic objective of this scheme?
To improve the utilisation and appropriate use of existing housing options and increase the range if housing options available to people and to ensure it's used flexibly and enables more people to live independently in the community with the right level of support. This will also require responsive adaptations to enable people to manage their condition in a safe home environment.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
An integrated approach to local housing and accommodation provision to enable,

supported by a joint Health and Social Care Accommodation Strategy, to enable more people to live safely in a home and other environments and to enable people to be discharged from hospital in a timely manner into the appropriate environment.

- Current bed based facilities (step up and step down) to be flexible and broadened to use housing schemes;
- Promote developments of wheelchair accessible housing to support the reduction of costly adaptations;
- Responsive timely adaptations to housing;
- Preventative pathways to enable patients and service users to return to (following hospital and care home admissions) and remain in their homes safely including full holistic home safety checks;
- Flexible housing schemes locally;
- Increased provision of extra care housing locally, including a facility to support patient rehabilitation or carer respite for short periods of time with clear criteria and processes for accessing such facilities;
- Different types of supported accommodation for those with learning disabilities and mental health needs.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

To be delivered by KCC, Shepway and Dover District Council, KCHT, and KMPT.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Plans developed due to evidence of lack of appropriate accommodation facilities resulting in delayed transfers of care and reduced quality of life.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduction in emergency hospital admissions;
- Reduced A&E attendances;
- Reduced residential care admissions;
- Reduced care packages;
- Increased personalisation;
- Reduced delayed transfers of care;
- Increased patient experience as more people maintain level of independence in their own home.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The following indictors will be used to monitor success of the scheme:

- Reduced length of stay
- Reduced delayed transfers of care by 2.5%.

What are the key success factors for implementation of this scheme?

Improvement in discharge process and improved access to appropriate housing options

Scheme ref no.

6

Scheme name

Falls prevention

What is the strategic objective of this scheme?

Development of falls and fracture prevention services for older people to undertake screening and comprehensive assessment aimed at identifying and treating the underlying causes of falls, such as muscle weakness, cardiovascular problems, medication and housing issues.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Development of a local specialist falls and fracture prevention service

- This service will work closely with the Neighbourhood Care Teams, Rapid Response and Intermediate Care teams to undertake proactive and responsive screening and multi factorial assessments to identify causes of falls and make arrangements for preventative approaches.

Local integrated falls prevention pathways

The existing falls pathway will be refreshed to reflect the various settings the patient could present, e.g. GP, MIU, Walk in Centres. The pathway will clearly show the appropriate action professionals should take when dealing with a potential faller or patient that has already fallen. The pathway will include signposting to vision screening, hearing tests, medication reviews, exercise groups and environmental such as housing assessments.

- Level of current services across locality will be more integrated to include the increased level of input from geriatrician for integrated management and integration with other professionals e.g., pharmacists, chiropodists, podiatrists, opticians, audiologists and the voluntary sector;
- Develop an Integrated Ambulance Falls Response Service;
- Improve availability and awareness of therapeutic exercise programmes (postural stability classes) via community classes and domiciliary based.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

South Kent Coast CCG has been working with colleagues from EKHUFT, KCHT, the voluntary sector, CCG GPs together with patient representative to develop falls pathway. The commissioners involved from the CCG are Sue Baldwin and Hilary Knight.

Investment in specialised falls and fracture prevention service is contingent on savings identified by schemes 1 and 2.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

South Kent Coast CCG has seen a rise in the number of non-elective admissions due to falls over the last 3 years. There were 894 new attendances at the outpatient fracture clinics in East Kent Hospitals University Foundation Trust (EKHUFT) for South Kent Coast patients aged 65+ for the period 1 April 2012 - 31 March 2013. By focussing on falls prevention the CCG hopes to see a decrease in these numbers. The development of a robust falls prevention pathway and scoping of relevant services will inform patients and professionals of what is available to them, e.g. Active for Life, walking groups etc.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduction in falls and secondary falls;
- Reduction in hip fractures;
- Improve patient experience and levels of self-management;
- Reduced emergency admissions;
- Reduced A&E attendances.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The CCG should see a reduction in falls related attendances in secondary care, we will be able to measure this by comparing activity data prior to and after the refreshed pathway. We will engage with patients to understand their experience of the falls prevention service.

The following indictors will be used to monitor success of the scheme:

- Reduce admission from falls by 37

What are the key success factors for implementation of this scheme?

The main key to success will be for the refreshed pathway to be adopted by the relevant agencies to ensure that patients are signposted appropriately to the correct service, providing the patient with a positive experience and seamless service.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Kent Health and Wellbeing Board
Name of Provider organisation	**East Kent Hospitals University NHS Foundation Trust**
Name of Provider CEO	Stuart Bain
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	**22,510**
	2014/15 Plan	**22,034**
	2015/16 Plan	**21,028**
	14/15 Change compared to 13/14 outturn	-1%
	15/16 Change compared to planned 14/15 outturn	-3%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	195.25
	How many non-elective admissions is the BCF planned to prevent in 15-16?	753

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

Name of Health & Wellbeing	Kent Health and Wellbeing Board

Board	
Name of Provider organisation	**Kent Community Health NHS Trust**
Name of Provider CEO	Marion Dinwoodie
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	**22,510**
	2014/15 Plan	**22,034**
	2015/16 Plan	**21,028**
	14/15 Change compared to 13/14 outturn	-1%
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