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Owner: The Kent Health and Wellbeing Board

Date: 21 March 2016

Version No: 4 (Draft)

1. The Kent Vision for Integrated Care

Kent's Better Care Fund for 2015/2016 was about implementing the building blocks for establishing an integrated system that will "*transform services within the community so they support independent living, empower people and place a greater emphasis on the role played by the citizen and their communities in managing care"* (Kent JSNA). Delivery within the plan has resulted in establishing programmes of activity across the health and social care footprints in North, East and West Kent that will increase the pace and scale of integration and development of the New Models of Care as outlined in the NHS England Five Year Forward View and associated guidance.

The Kent plan for 2016/17 will build on these early developments to support the implementation of Sustainability and Transformation plans (STPs) and ensure a fully integrated system by 2020. This will be achieved through sustaining the current system – with targeted improvements to support urgent care, delayed transfers of care, reablement and commissioning of out of hospital provision and the maintenance of social care services. But with an eye to the future and the development of local integrated health and social care models which incorporate a broad range of person centred and outcome focussed interventions, encompassing prevention, early intervention, primary and community health services, social care, home care, residential and nursing care and in reach to acute health care.

1.2 The Kent Context

The county council is largely responsible for adult and children social care services; it currently works in partnership with 7 Clinical Commissioning Groups and 12 District Authorities that commission related health care and housing services respectively. The provider landscape is also extensive, with 4 acute trusts spread over 7 hospital sites, 2 community health providers across the county, 1 mental health and social care partnership trust, 1 ambulance trust and many third sector and voluntary organisations including 4 hospices.

Kent has a population of 1.5 million. Overall, the population of Kent is predicted to grow by 8.4% over the next seven years, representing an extra 123,000 people. Including significant growth in North Kent due to the development in Ebbsfleet. The biggest increases are to be expected in the older age groups; 65 to 84 and over 85. The 65 to 84 growth is anticipated to be 21.4%, an extra 49,000 people, but the largest increase will be in the over 85 age band, at 27.1%. This represents an additional 10,000 people.

1.3 What will change?

As in 15/16 the Better Care Fund will contribute to improving the following outcomes identified within the Health and Wellbeing Strategy:

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

- People with dementia are assessed and treated earlier.

It is recognised that we need to go further and faster in order to deliver the whole system change required, developing greater alliances and exploring appropriate footprints in planning and integration. At the Kent Health and Wellbeing Board on 27 January 2016 *(https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=790&MId=6179&Ver=4)* all Clinical Commissioning Groups and Social Care identified how they will meet the ongoing challenges with the development of STPs and the development of areas such as the MCP, ICO and Mapping the Future. A commitment was given to use the BCF to ensure implementation across Kent and see significant change to:

- Improve people's experience and promote their health and wellbeing
- End the current crisis driven model of care
- Create a value driven and outcome focussed culture that nurtures creativity and innovation in meeting people's needs
- Support people to access good quality advice and information that enable them to self-care/manage
- Create the right conditions which enable people to find solutions that support their wellbeing outside of traditional medical or service driven models of care and support
- Encourage community development and increase volunteering, befriending and good neighbour schemes
- Support carers in their vital role through the provision of advice and individually tailored support
- Provide flexible and proactive models of care and support that can increase and decrease according to need
- Free professionals up from the rules and bureaucracy; to do the *right thing* and provide person centred holistic support that promotes wellbeing
- Provide responsive models of long term care that can flex up or down according to people needs
- Bring services together to ensure better communication and better use of resources and create a better experience for people

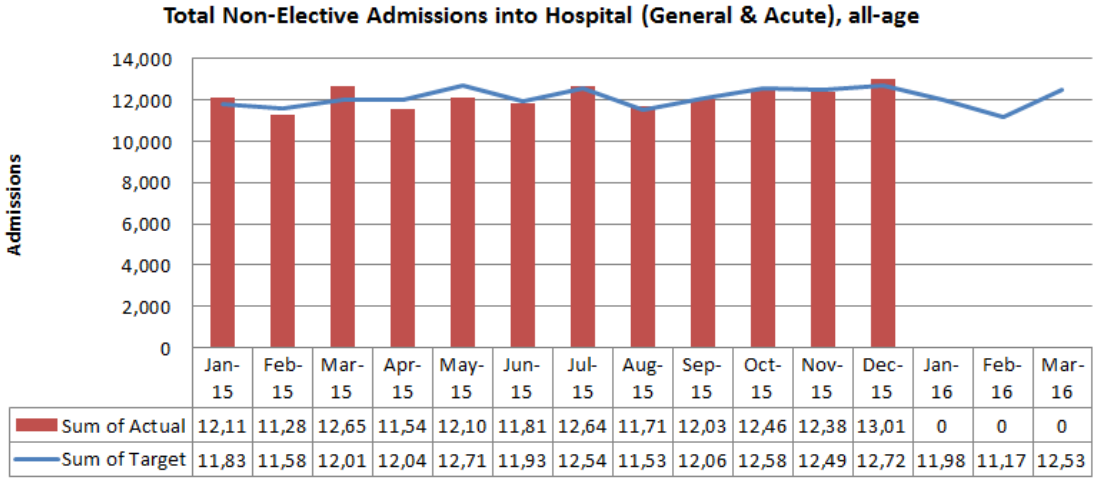
For those users of services this will make it clearer around:

- *"What care will you receive?"* – clear service models and pathway specifications
- *"Who will provide your care?"* – provider/organisational models, the new shape of integrated, local out of hospital providers (ICOs/MCPs/Vanguards), acute physical provision and acute mental health provision
- *"Who will commission your local services?"* – commissioning models with local Health and Wellbeing Boards, aligning primary and specialist commissioning to seek devolution within the new models of care.

2. The Case for Change

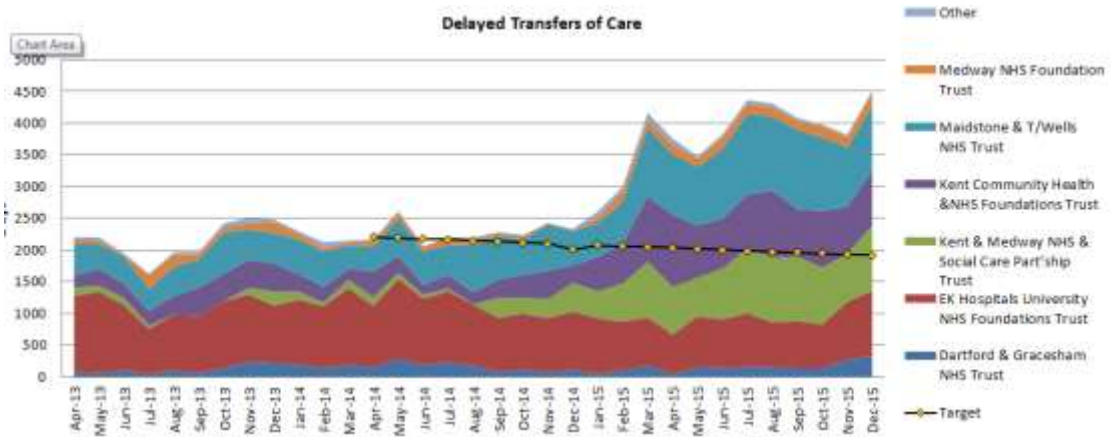
Kent has continued to use information provided through a Public Health led longitudinal study using risk stratified (based on a local version of the King's Fund tool) Kent whole population person level linked datasets to demonstrated variation in service utilisation (and costs) over time, across different services and different risk stratified groups. The Kent LTC Year of Care Programme comes to an end in March 2016. The programme has successfully built a linked data set comprising data from 12 health and social care organisations and 128 GP practices. The programme has also used risk stratification to identify a cohort of patients most likely to benefit from integrated care services. This approach is now being used to support the development of capitated budgets for intermediate care organisations being developed in East Kent. Kent's approach to the use of risk stratification is described in a case study on the NHSE website which can be found by following this link:
http://www.nhsiq.nhs.uk/media/2747711/risk_scores_case_study.pdf

As part of the BCF plan for 15/16 a 1% reduction in non-elective admissions was targeted. The graph below evidences that this has been achieved and continues to help control demand.



	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sum of Actual	12,11	11,28	12,65	11,54	12,10	11,81	12,64	11,71	12,03	12,46	12,38	13,01	0	0	0
Sum of Target	11,83	11,58	12,01	12,04	12,71	11,93	12,54	11,53	12,06	12,58	12,49	12,72	11,98	11,17	12,53

In line with national trend DTOC figures have risen, but priority work continues to achieve the 2.5% national target with a 3.5% stretch.



Delivery of the Better Care Fund during 15/16 has identified what has worked well and where continued improvements are required in 16/17. Examples of what has worked well are:

- Governance structures – allows for open debate, planning and monitoring of delivery
- Alignment of commissioning and integration of commissioning
- Joined up provision – IPCTs, IDTs, and real inclusion of the voluntary sector

Some examples of the results from this include in North Kent a 1% reduction in ambulance conveyance, low DTOC – Nov 1.74% and better patient experience.

In Thanet the establishment of a detailed integrated working programme plan overseen by an 'Integrated Executive Programme Board' – co-chaired by KCC and the CCG. Integration is being driven at a local level with the development of strong town based (Margate, Ramsgate, Broadstairs and Quex) integrated health and social care teams. These have been built to enable GP practices to increasingly work together to join health and social care within a single infrastructure. This local service model will be supported through a multi-disciplinary 'hub' based at the local acute hospital, to be developed in 2016/17.

3. Integration Plans 16/17

The planning template identifies the detailed areas of spend for the Kent 16/17 BCF. Each health economy via the existing BCF Section 75 agreement has governance and programme and project management arrangements in place to deliver the required new models of care. For example an Integrated Executive Programme Board exists in Thanet and South Kent Coast with a multi-agency approach.

In broad terms the plans and how each of these areas will contribute to the required national conditions is outlined below.

2016/17 Schemes	National conditions supported by the scheme
• Integrated working through local models that deliver 7 day access:	• Delivery of 7-day services • Data sharing between health and social care
• Develop models that support integrated working	• Joint approach to assessment and care planning • Invest in NHS commissioned out of hospital services
• Self-Management	• Invest in NHS commissioned out of hospital services • Delayed Transfers of Care
• Maintenance of Social Care	• Maintain provision of social care services
• Disabled Facilities Grant	• Invest in NHS commissioned out of hospital services

2016/17 Schemes	National conditions supported by the scheme
	• Delayed Transfers of Care
• Implementation of the Care Act	• Maintain provision of social care services
• Carers support	• Invest in NHS commissioned out of hospital services • Delayed Transfers of Care
• Delayed Transfers of Care – action plan	• Invest in NHS commissioned out of hospital services • Joint approach to assessment and care planning • Delayed Transfers of Care

Risk sharing agreements and contingency plans for delivery of the Better Care Fund are outlined in the Section 75 agreement. Some key risks identified in the delivery plan are:

There is a risk that:	Mitigating Actions
Increased pressure on Acute care could result in additional long term placements or long term social care input. Lack of rapid response for health and social could result in additional admissions to hospital and long term care.	BCF plans and Kent's Pioneer Programme designed to develop service models to mitigate risk. KCC Adult Social Care Transformation is also targeting this risk.
Shifting of resources may destabilise existing providers, particularly in the acute sector.	The development of our plans will be conducted within the framework of our Kent Pioneer Programme. This facilitates whole system discussions and further work on co-design of, and transition to future service models.
The implementation of the Care Act will result in an increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	Ensure the use of the Care Act money is in line with allocation.
Primary care not at the centre of care-coordination and unable to accept complex cases.	Engagement with clinical leads and primary care providers essential as part of implementation of the BCF and Pioneer programme.
Absence of effective demand management, investment in voluntary sector and equipment will result in additional NHS and social care admissions.	Monitor/tracking systems in place to assist in determining effectiveness – further development of performance based dashboard.
Workforce and Training – The right workforce with the right skills	Workforce and training is a key objective of Kent's Integration

may not be available as required to deliver the integrated models of care. The types of training to deliver new models of care may not be in place. Additional risk is presented by age demographics of GPs and future resources impacted by retirement.	Pioneer Programme. A programme of work is structured to explore the requirements of future workforce and implement changes to meet these requirements.

4. The National Conditions

The table below identifies how the plan will meet the national conditions:

Maintenance of Social Care Services Significant work to transform social care services has taken place during 15/16, alongside the implementation of the Care Act. £28.7m will be used from Kent's Better Care Fund to maintain social care and continue to support the significant numbers of people with complex needs, who live in their own homes, want to stay and be supported in their own homes and those who require carer support services which enable carers within Kent to continue in their caring role. Kent Adult Social Care has developed a clear vision to support integration by 2020 with the model described through three groups of approaches; Promoting Wellbeing, Promoting Independence and Supporting Independence. This is a means of describing differing types of interventions that support people accessing 'the right care at the right time' in order to be as independent and well as possible at all times.
7 day services For 16/17 £2.1m directly linked to delivering 7 day services – this includes building on successful pilots for GP extended hours in the Vanguard and implementation of a 7 day community equipment service across Kent. In Thanet steps were taken towards a proactive model of 24/7 community based care with adult social care shifting working hours to be 8am to 8pm, seven days per week as standard. Further work is now taking place within the Adult Social Care Transformation Programme to identify the steps required to achieve extended working hours in all areas of delivery.
Data sharing Areas have been developing their Local Digital roadmaps which include exploring how to improve data sharing across systems. The footprint covers North Kent including implementation of hospital access to GP records via Vision 360, initially for A&E department at D&G and then for other providers; East Kent (working on developing the Medical Interoperability Gateway) and West Kent who are piloting a Care Plan Management System in conjunction with KCC and other partners. This seeks to bring health and social care information together by taking a direct feed from partners' systems. Crucially, the information collected can then be used to create one holistic care plan; this is contained within CPMS and can be updated and used by everyone.

Work on the Kent Integrated Data Set has also resulted in 128 out of 195 (66%) GP practices signed up to share their data. Following presentations to GP patch meetings 20 (out of 61) practices in West Kent have now signed up. 8 out of 14 practices in Ashford have now agreed to share their data.

Arrangements are in hand to continue the linked dataset once the Year of Care Programme ceases at the end of March. A Memorandum of Understanding has been drafted to underpin the partnership and funding arrangements for the Kent Integrated Dataset. Funding is also being sought from NHSE for programme management support to CCG's to develop capitated budgets. Jonathan Bates, CFO at Thanet and South Kent Coast CCG's will chair the new Kent Integrated Care Payments Group involving commissioners and providers which will lead the work on developing capitated budgets. The PSSRU will present their analysis of the linked dataset at the March meeting and will make recommendations for using the data to build capitated budgets.

A methodology has been agreed with HSCIC to collect and allocate costs to GP prescribing data.

Joint assessments and care planning

One of the key social care priorities for 2016/17 is the integration of health and social care, and this includes planning for joined up approach to assessments and care planning. CCG areas are in varying stages of plan development, but all are in progress.

Local Action Plan for DTOC

DTOC plans are in development and are a key social care priority for 2016/17. Plans are in development within the CCG areas. For example in Swale - reducing DTOCs is an area of focus next year for Swale CCG. The Medway and Swale System Resilience Group are working with the Emergency Care Improvement Programme to identify good practice in reducing DTOCs.

There are a number of initiatives that are in progress to address DTOC which see an integrated approach across health and social care. Swale CCG is piloting a 'Home to Assess' model, where patients considered appropriate are discharged and assessed within 4 hours of discharge within their own home. Health and social care teams within the IDT at MFT work to the 'home is best' principle, discharging patients home with support as opposed to a step down community bed, where appropriate. This has resulted in a significant reduction in the demand for community beds in Swale.

East Kent CGG's, KCHFT, EKHUFT and KCC are currently piloting a 'Discharge to Assess' scheme which has already been successfully introduced in other parts of the country such as Sheffield, Manchester, Worchester, and Oxford.

Discharge to assess provides an opportunity for patients who are medically optimised to be transferred in a timely way from the busy acute hospital

environment to their own home with support and further assessment or to an appropriate community setting for ongoing assessment and rehabilitation.

Objectives:
1. Maximise people's capacity for independent living, increase the number of people able to remain living at home and reduce the number of people permanently admitted to long term care.
2. Support timely hospital discharge so that patients only stay until their acute medical episode is finished and then move to a more appropriate location for assessment of their future care needs.
3. Provide an environment which helps people meet their rehabilitation and reablement potential and to become as functionally independent as possible.

Integrated discharge teams have also been set up in all of the hospitals. In DVH and EKHUFT they have also introduced the care navigator role as part of the integrated discharge teams linking the support the voluntary sector can access to facilitate timely discharges from the acute hospitals.

Surge Resilience Groups and Executive Systems Boards have emerged in each Health and Social care economy to drive the whole system changes required to support the acute sector.

Investment in NHS commissioned out of hospital services
£26.2m is identified for out of hospital services, full details of this can be found in CCG Operational Plans (links in additional document section).

In Thanet this money will be invested into:
- GP step up beds
- The provision of equipment to support individuals in the community
- Development of integrated health and social care teams including integrated nursing teams and the development of ICT to support sharing of patient records
- Rehabilitation beds at Westbrook House.
- Support for carers

5. The Joint Approach Going Forward

Since the development of the plans for 15/16 significant work has taken place through the joint governance forums across Kent to engage the entire system, to help understand the impact on providers as integration develops, for example the East Kent Whole System Clinical Strategy. Further work is taking place alongside Districts within the devolution agenda and to explore how to make best use of the Disabled Facilities Grants. KCC social care and district councils are working together to explore ways of encouraging closer working arrangements to facilitate the pathway for a service user requiring a DFG. A paper was taken to the Districts chief executive group to request

project development and support for 2016/17 to work up a model for a new way of working which is most suitable and appropriate for Kent.

KCC are working closely with District Councils to share responsibility for areas of activity currently covered by social care capital grant which has been removed from social care and added to DFG funds this year, as existing commitment needs to be covered, and all work contributes to increasing the independence of people living with disabilities, facilitating them to remain living in their own homes, and decreasing their dependence on statutory services in the future.

Across all CCG areas detailed work has been carried out within the Making it Real agenda and Think Local Act Personal to further embed the use of I Statements and ensure meaningful involvement from patients, users and carers. Full details of this work is contained within the Integrated Care Pioneer Progress Reports.

A key concern raised has been on future capacity and workforce requirements. Therefore a Kent wide task and finish group has been set up to sit under the Kent Health and Wellbeing board. This will explore how to develop a more integrated support workforce, look at recruitment and retention and how we support the over 50 workforce. Kent will be hosting workforce events across each locality to promote careers in the Health and Social care sector and a draft Integrated workforce strategy is in development.

The Kent Health and Wellbeing Board continue to play a key strategic role in ensuring alignment across the variety of initiatives and monitoring of delivery. The Board has considered and endorsed the proposed planning footprint to support the delivery on the proposed STP.

6. Additional Documents

JSNA: http://www.kpho.org.uk/joint-strategic-needs-assessment
JHWBS: https://www.kent.gov.uk/__data/assets/pdf_file/0014/12407/Joint-Health-and-Wellbeing-Strategy.pdf
SKC CCG: http://www.southkentcoastccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Thanet CCG: www.thanetccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Canterbury CCG: http://www.canterburycoastalccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Ashford CCG: http://www.ashfordccg.nhs.uk/about-us/our-plans-reports-and-strategies/
West Kent CCG: http://www.westkentccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Dartford CCG: http://www.dartfordgraveshamswanleyccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Swale CCG: http://www.swaleccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Kent Integration Pioneer: http://www.kent.gov.uk/social-care-and-health/health/health-and-public-health-policies/kent-integration-pioneer