APPENDIX ONE

The Kent Better Care Fund 2016/17 Narrative

Contents:

Owner: The Kent Health and Wellbeing Board

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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

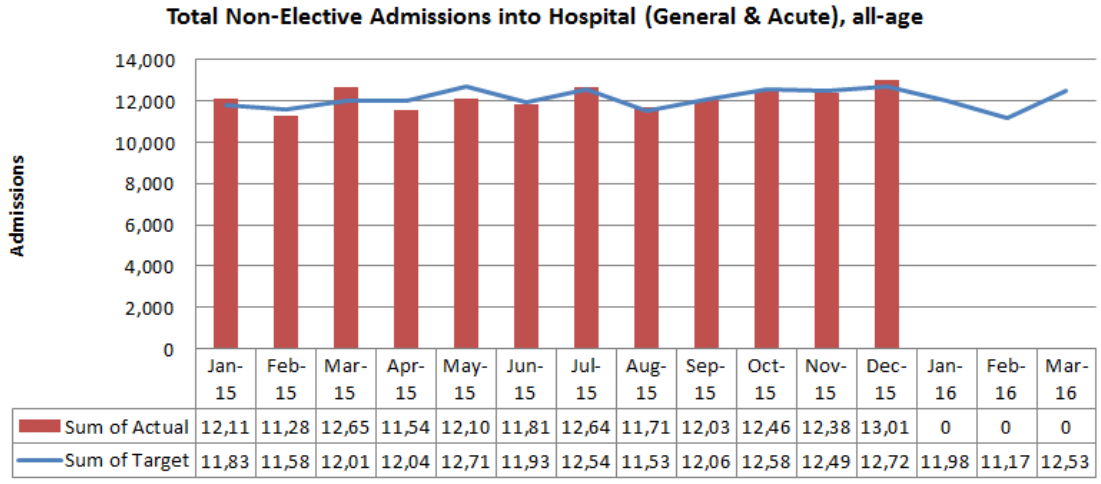
For those users of services this will make it clearer around:

- *"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/ 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

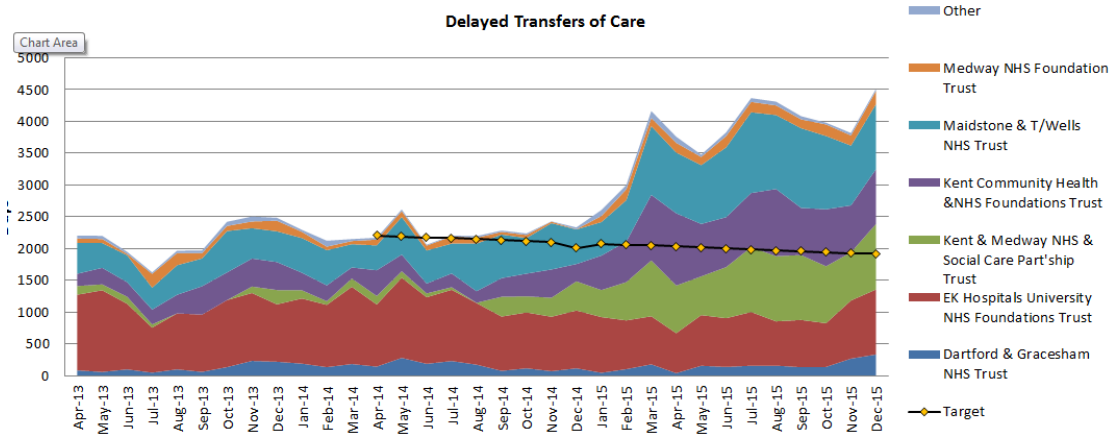
Kent has continued to use information provided through a Public Health led longitudinal study using risk stratified (based on a local version of the King's Fund tool) Kent whole population person level linked datasets to demonstrated variation in service utilisation (and costs) over time, across different 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 for NHS patients receiving acute care. Kent aims to maintain current levels of DTOCs system-wide (i.e. including non-acute such as mental health, palliative care or rehabilitation) and halt the current upward trend.



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.

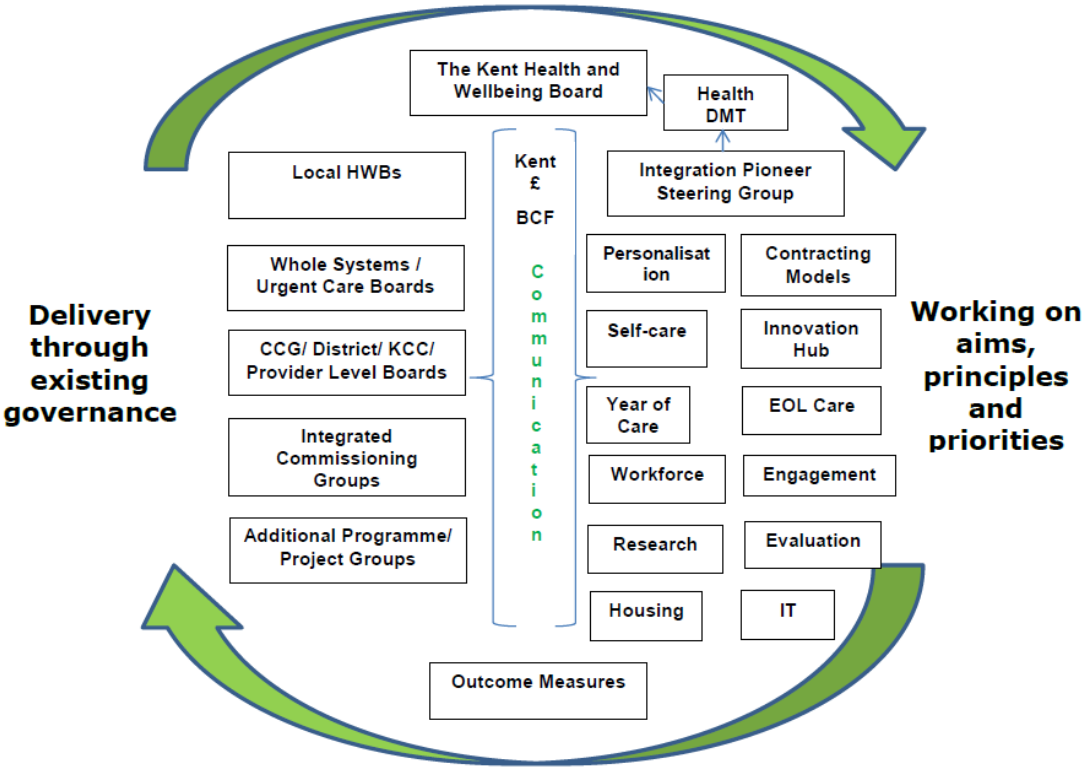
In Thanet the establishment of a detailed integrated working programme plan overseen by an 'Integrated Executive Programme Board' – co-chaired by KCC and the CCG. Integration is being driven at a local level with the development of strong town based (Margate, Ramsgate, Broadstairs and Quex) integrated 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. Governance and Management of the Better Care Fund

Kent's governance for delivering as an Integrated Care and Support Pioneer is set out below, the responsibility and management of the Better Care Fund will sit within this. Existing governance structures will ensure delivery and the Integration Pioneer Steering Group provide advice and guidance.

The risks and mitigations associated with the Better Care Fund are outlined in section 5 below.

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



4. 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 • 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

5. Risk Share

Risk sharing agreements and contingency plans for delivery of the Better Care Fund are outlined in the Section 75 agreement. Each Partner shall be responsible for their own risk under, or in connection with the Agreement. The Partners have agreed that if there are any overspends, then such overspends are at the risk of that partner and reported to the pooled fund manager. Provision for overspends are the responsibility of individual partners and are held outside of the pooled arrangement.

This response to risk and reward reflects the partner's current risk appetite. It has therefore been agreed to reflect risk at an Organisational Level. This will be reviewed over the course of the year at quarterly Finance and Performance Monitoring meetings.

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 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.	Workforce and training is a key objective of Kent's Integration Pioneer Programme. A programme of work is structured to explore the requirements of future workforce and implement changes to meet these requirements.

6. 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.

Numerous Schemes within Kent's Better Care Fund are dedicated to the maintenance of Social Care; £7.5m toward the provision of domiciliary care, £3m toward residential provision and £1.6m toward provision of Direct Payments to support service user's social care needs.
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.

Milestones:

- The Acute Workstream supports increased independence by reducing inappropriate referrals from hospital discharge into residential placements. The new ways of working are being fully rolled out across Kent and should be complete by the end of Summer 2016.

- In addition the Enablement Workstream which concentrates on increasing the number and quality of clients being enabled so they can remain independent and living within their own homes for longer, will also be fully rolled out by the Summer 2016.

- Further work will take place during 2016/17 to assess and design a further phase of adult social care transformation to deliver the vision of integration by 2020.

Metrics:

Kent aims to maintain the current proportion of people still at home 91 days after discharge at 85.9% or higher.

Residential Admissions are expected to drop as a result of funding against reablement, carers and domiciliary services.

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 and implementation of a 7 day community equipment service across Kent.

Since 1st November 2014 Kent County Council has been operating an 8am-8pm 7 day a week service, mainly supporting the Acute Hospital sites. The

extended access is being facilitated locally via a rota system including both Short Term Pathway staff and Adult Community Teams. This way of working was introduced following an organisational restructure and has now become core working hours. The extended access includes weekends and Bank Holidays excluding Christmas Day only and staff are operational on each Acute Hospital Site. The 8am-8pm is available according to business need with agreement from health partners. The 8pm may vary when comparing the Acute Hospital KCC teams, but this is reviewed and can/has changed according to need, and is being monitored to improve accessibility and performance.

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.

The CCGs are undertaking multiple projects and initiatives designed to meet the 7 day model required be in place by 1st April 2017 as part of the new GP contract. The work will be driven through engagement with the localities. Two area examples are laid out below.

South Kent Coast and Thanet

- **Enhance Primary Care** - Building on the Prime Ministers Challenge Fund (PMCF) pilot (8am-8pm/7days a week) which has provided the opportunity to look at different ways of working in general practice, and helped see how GP services could be designed from the way that patients experience GP services for the future, opportunities for patients to be seen at their local 'hub' by another GP or another appropriate health care professional (for example, pharmacist, paramedic practitioner, MIU nurse practitioner (out-reaching) or rapid response nurse).
- **Primary Care Home Model** - Primary Care Home Team which incorporates a practice team (integrated nursing team, ICT, primary care visitor co-ordinator, geriatrician, primary mental health worker, voluntary sector [e.g. Age UK] with the aim of keeping people well and enabling self-care), as well as social care workers, specialist nurses, paramedic practitioner and end of life care support from hospices, with the aim of serving a wider population and providing a point of access to care and services e.g. ambulatory care.
- **Personal Health Budgets** - Continue to deliver and improve the provision of Personal Health Budgets including continued allocation of commissioner resource to deliver Personal Health Budgets, including a review of progress to date and scoping of opportunities for improving processes and systems
- **KMPT Single Point of Access** - Single Point of Access soft launch of 24 hour 7 day week service (incl. Bank Holidays) across Kent and Medway for patients accessing KMPT services with urgent or emergency referral (KMPT
- **Project: Liaison Psychiatry -** The CCGs are working with mental health, children's mental health and acute hospital providers to improve access to Liaison psychiatry to meet the 2020 target of 24/7 provision. In 2016/17 the CCG plans to increase access to 12 hours, 7 days per week. An additional 3 consultants including CAMHS consultant psychiatrist have been agreed, with a substantive recruitment process

initiated.

Canterbury and Coastal

Encompass MCP, which incorporates 16 of 21 GP practices, is developing an integrated model of care to facilitate effective delivery of high quality, person centred and coordinated primary and community care. In 2016/17 the MCP will focus on developing integrated Community Hub Operating Centres(CHOCs) based on its Town Team localities of Whitstable, Faversham, Canterbury and Sandwich and Ash. The CHOCs will deliver integrated health and social care services across localities and will seek to reduce activity in the acute setting in respect of unscheduled attendances and admissions and facilitating timely discharges. The MCP will also continue its Paramedic Home Visiting programme linked to General Practice, which is resulting in a reduction in conveyance, and which will see Community Paramedics mapping into the CHOC integrated teams.

Where it is appropriate, the MCP will coordinate and align with EK wide schemes aimed at reducing acute activity, including unplanned admissions and delayed discharge. The MCP will also work with Public Health and CCG prevention programmes to support people to stay well and live independently in the community. This includes supporting specific developments within the Health Trainer programme in the Canterbury and Coastal CCG locality. The MCP is also investing in developing a social prescribing model within the CHOCs that will reduce social isolation and support people to optimise their health and wellbeing through a community asset based model.

There is also a development in Ashford as a 'fast follower' with clinical leadership from Ashford Clinical Providers (ACP) now a member of Vanguard (E**n**compass) MCP Steering Group.

Ashford Clinical Providers recognise that commissioning needs robust locality wide cost effective alternatives to allow shift from hospital to community built on the strengths of local Primary care. Shared early outcomes from key Vanguard projects have enabled ACP to refresh their plans and adopt a similar integrated hub model approach across three localities based on the following geography:

- Ashford South
- Ashford North
- Ashford Rural

The vision for the Herne Bay Integrated Care Centre is to commission "A resource for the community where primary and community care will work together to relieve pressure on the local health economy by providing a wide range of services closer to patient's homes", with the intention to base the centre at the Queen Victoria Memorial Hospital (QVMH).

The ICC will act as a hub where patients will be able to access a range of urgent and outreach services including access to diagnostics. This will include minor injury and illness, urology, DVT, wound and day case clinics. The service will be delivered in accordance with the 'Priority Three'.

The service will be nurse led with GP oversight provided by all four local

practices with support from the Community Network to ensure maximum interface between primary and community care.

Current services of this nature are not located locally to the population of Herne Bay, requiring travel to Canterbury, Margate or Whitstable with limited public transport options. Care will be overseen by local GPs to ensure the patients are known and to identify where core primary care services need strengthening to reduce the burden on other services. The ICC will provide advice including self-care and social care which can be wrapped around the patients' needs, will help to reduce the impact of any potential downgrading or changes to acute services and will assist in ensuring the viability and suitability of the community hospital in the context of a growing population need in the locality.

Milestones:

Qtr. 1:
Work towards the change in hours to 8am – 8pm (daily) – ensure that reduction in the inappropriate work that the nurses are doing has ceased.
KMPT Single Point of Access; launch of Urgent and Emergency Referrals pan Kent (4th April 2016).

Qtr. 2:
Primary Care Home; Implement multi-disciplinary locality teams.
KMPT Single Point of Access; Impact evaluation to occur in July 2016.

Qtr. 3:
Primary Care Home; Implement full integrated front door model at QEQM.
KMPT Single Point of Access; Phasing in of other localities for routine referrals.

Qtr. 4:
Enhanced Primary Care; Full implementation of technological solutions at hub level.
Evaluate all strands of the Primary Care Home.

Metrics:

Non Elective Admissions to Hospitals are expected to decrease as a result of seven day services being available to service users.

Seven day working should also facilitate discharge and help halt the increase of DToCs within Kent.

Kent also expects to maintain an 80% performance in the number of service users reporting that they have had enough support from local services or organisations to help manage their long term condition via access to seven day services.

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.

Within the Better Care Fund £750k has been allocated within West Kent to develop System Enabler Information Systems

Milestones:

- 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.

Metrics:

Better data sharing and the resulting improvements to holistic care planning should result in improved performance across the full set of BCF Metrics

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.
Milestones

Integrated Discharge Teams exist across the health and social economy of Kent and further work is planned to embed this into the community.

Milestones:

- Further development of shared care plan systems – Jan 2017

- Embed the MDT approach to patient information – March 2017
- Discharge to assess model – joint approach to assessment – ongoing pilots 16/17

Metrics:

Joint assessments and resulting improvements to holistic care planning should result in improved performance across the full set of BCF Metrics.

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. The plan is coordinated by the Health and Wellbeing Board and has streams in each of the three Health Economies in Kent.

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 CGGs, 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.

Thanet and South Kent Coast CCGs are implementing a three stage programme of DTOC reduction:

Implementing Safer Flow Bundle

- Implementation of Safer Flow Bundle in Community Hospitals has now commenced (KCHFT)
- Implementation of new staggered timetabled MDT board rounds at QEQM to enable IDT, Matron, Acute Therapy and Site Management attendance (EKHUFT)

Developing an effective Medical model

- Implementation of the first phase of re-launched acute medical model at QEQM on the 19th April to provide consistent senior medical decision making support to Ambulatory Care and the Clinical Decisions Unit. (EKHUFT)

Effective Site Management

- Run 5 month piloting of Head of Clinical Operations posts at WHH and QEQM and Site Senior Matron at K&C (EKHUFT)

West Kent has developed a transformation plan to tackle DToCs which mirrors plans in East:

Governance & Senior Leadership

- DToC reimbursement implementation to be delayed indefinitely following discussions at first COO meeting. Delayed transfers of care workshop and follow up workshops required to be clear on policy and procedure.
- MTW and KCHFT to implement Choice Policy following a review of current policies

Whole system capacity review

- Development of a directory of services to understand what services are available – both self-referral and clinician referrals
- KCC and CCG to further discuss Joint Commissioning arrangements, identify best practice, review progress to date, issues and actions to take forward. a programmed approach to creating Joint Commissioning arrangements and for applying those new arrangements to the services to support DToC.

Safer Bundle

- To commence a project to roll out best practice in Discharge Planning ward by ward, over the next six months. This would include, 8am consultant led board rounds seven days a week, a standardised whiteboard designed to set and monitor targets, discharge checklists used for every patient, clinical and functional criteria for discharge being recorded on each patient's record (as recommended previously by ECIST), rolling completion of discharge notices (EDN) by daytime staff.

Discharge to Assess

- Implementation of the discharge to assess model in WK

Dartford, Gravesend and Swanley CCG have a system recovery plan in development for 16/17.

Key projects which will address improvements to DToC are:

- Implementation of Discharge to Assess in DGS – to identify patients suitable to have assessment of care packages carried out in their home environment post discharge as opposed to this being done in hospital
- Implementation of national SAFER patient flow bundle, which includes effective management of patients to achieve their Expected Date of Discharge (EDD) and includes increased discharges before midday and at weekends, and weekly systematic review of patients with extended lengths of stay
- Review of the Integrated Discharge Team at DVH
- Review of CHC processes

Plans in Development:

In order to prevent hospital admissions and to provide a more efficient discharge process, reducing delayed transfers of care, KCC has reviewed services that have been effective in preventing admissions and reducing delays.

All proposed services have been tested and implemented in Kent, but not on a consistent basis or across the whole of Kent. It is believed that by implementing these services county-wide, Kent would start to build the evidence which in subsequent years can be built into the fully integrated pooled budgets as set out in the Sustainability and Transformation Plans.

It is proposed that funding is agreed for the overview of services below and that DTOC targets are agreed and monitored as part of the BCF and local planning and monitoring.

The Protection of Social Care funding is already targeted at prevention of admissions and improving delays, but because of the pressures on Local Authority budgets, increases in hospital activity and demographic pressures, this fund is already fully spent. A reduction or diversion of this fund would

have a negative impact on admissions and delays.

Some examples of these services include:

- Kent Enablement at Home OTs working in Acute Teams and across community hospitals within each locality.
- Physios to support integrated care centres
- Agency to support flexing beds in escalation
- Care Navigators
- Rural Care Packages
- Home from Hospital Support

KCC and CCGs already have integrated commissioning and provision for Learning Disabilities and Mental Health in place and arrangements for children are progressing. For Older people and Adults with Physical Disabilities the plan is to work towards full integration including pooled budgets and above services will be included. This will be part of the next stage of KCC's Transformation work and CCGs' Strategic and Transformation Planning which includes Vanguards, Integrated Care Organisations and other New Models of Care.

Milestones:

- The Accountable Officers and DMT hope to agree the investment in DTOC services and where the monitoring of the impact would take place before the end of Qtr. 1

- Implementation of Direction of Choice Policy (EKCOOs) – Qtr. 1

- Removal of prescribed discharge to assess pathways and introduced two pathways " home with support" and "safe assessment bed" (EKCOOs) – Qtr. 1

- Hot Ambulatory Care at WHH relocated and service delivered – Monday to Friday – Qtr. 1

- Detailed system recovery plan reviewed at the DGS System Resilience Group (SRG) – Qtr. 1

- Redesign pathway (East Kent Discharge to Assess pilot) signed off July 2016 – Qtr. 2

- Review of all DTOCS by EKCOOs – Qtr. 2

- QEQM and K&C accepted onto the NHS England's "New Care Models" rapid improvement programme (EKHUFT) – Qtr. 2

- Review and confirm substantive Site Management Model and senior out of hours roles (EKHUFT) – Qtr. 2

- Medical workforce plan to support re-launch of acute medical at WHH – Qtr. 3

Metrics:

Reduced length of stay for patients

DToC list reduced and less patients waiting for social care package of care.

Improved number of patients that need no further health or social care input after the assessment period

Increased patient experience

Kent anticipates that the above work streams will slow, and ultimately halt the increase in DToC numbers across Kent.

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).

The Better Care Fund contains many projects investing resource in this area, including £5.5m for the provision of Community Equipment and Telecare, and £4m toward support for carers.

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

Milestones:

- A project involving the commissioning of “Hilton Nursing Partners” is in progress throughout Kent. This nursing group provides a short 3-5 day recovery service in the service user’s home upon discharge from hospital. The project is to be expanded and in full roll-out by the end of Quarter 2 upon agreement by all CCG partners.

- High level milestones are provided within CCG operational plans and will link to the roadmaps identified within STPs.

- Key milestones will need to align with further development of areas such as the MCP, IACO and Mapping the Future, therefore full details of delivery dates are not yet available

Metrics:

Investment in NHS Commissioned out of Hospital Services should result in improved performance across the full set of BCF Metrics.

7. 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.

8. Kent Better Care Fund Plan Sign Off

The Kent Better Care Fund Plan will go before key members of the Kent Health and Wellbeing Board on Friday 29th April, in addition to electronic circulation.

The full Kent HWB will meet on 25th May for formal sign off.

9. 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