Kent Integration and Better Care Fund Plan 2017 – 2019

Owner: The Kent Health and Wellbeing Board

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Contents

1. Introduction ... 3
3. Progress to date ... 6
4. Evidence base and local priorities to support plan for integration ... 8
5. The Better Care Fund plan ... 10
6. Risk ... 12
7. National Conditions ... 14
8. Overview of funding contributions ... 16
9. Programme Governance ... 17
10. National Metrics ... 18
11. Delayed transfers of care (DTOC) plan ... 20
12. Kent Better Care Fund Plan Sign Off ... 21

1. Introduction

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). The Kent plan for 2016/17 built on these early developments to support the implementation of the Kent and Medway Sustainability and Transformation plans (STP) and ensure a fully integrated system by 2020.

The plan for 2017–19 is to support delivery of the STP and the Local Care Model through the identified schemes and supported by existing governance arrangements. It identifies the roadmap to move forward with the ambition for existing schemes to be fully integrated by 2019.

"*The Kent and Medway health and care system is seeking to deliver an integrated health and social care model that focuses on delivering high quality, outcome focused, person centred, coordinated care that is easy to access and enables people to stay well and live independently and for as long as possible in their home setting. More than that, the system will transform services to deliver proactive care, and ensure that support is focused on improving and promoting health and wellbeing, rather than care and support that is solely reactive to ill health and disease Core to the model is the philosophy of health and care services working together to promote and support independence, utilising statutory, voluntary and where appropriate the independent sector to deliver the right care, in the right place, at the right time*." Kent and Medway STP October 2016

(http://kentandmedway.nhs.uk/wp-content/uploads/2017/03/20161021-Kent-and-Medway-STP-draft-as-submitted-ii.pdf)

This plan has been confirmed and agreed by:

Peter Oakford, Chairman Kent Health and Wellbeing Board

Anu Singh, Corporate Director Adult Social Care

Patricia Davies, Accountable Officer Dartford Gravesham Swanley / Swale CCGs

Hazel Carpenter, Accountable Officer Thanet / South Kent Coast CCGs

Simon Perks, Accountable Officer Ashford / Canterbury CCGs

Ian Ayres, Accountable Officer, West Kent CCG

2. The Kent Vision for Integrated Care

The Kent vision is clearly outlined in the draft STP and the Better Care Fund plan is seen as a key driver in delivering the model of Local Care. This is a collective commitment to fundamentally transform how and where we will support people to keep well and live well.

We will help people to understand that hospitals aren't always the best place to receive care. Clinical evidence shows us that many people, particularly frail older people, are often better cared for closer to home. The model will build a vibrant social, voluntary and community sector to support people to look after their health and wellbeing, connect with others, manage their long-term conditions and stay independent. We have initially focused on the development of Local Care for frail older people with complex needs using an example service user 'Dorothy' to bring the model to life:

Dorothy will no longer need to repeat her story over and over again to different professionals – key workers will help to co-ordinate care and support and ensure that her wishes and goals are at the heart of her care and wellbeing planning - She will have one number to call when she needs help, advice or support. She will be safe in her home free from harm and hazards. If she needs to see a specialist/expert wherever possible this will be done close to home. If she needs help urgently she'll be able to access 'rapid response' at home via a skilled professional who understands Dorothy's case and can assess her needs to get her the right support. This will help to stabilise the situation and hopefully avoid Dorothy going to hospital If she does need to go into hospital, Dorothy will be supported to get home as quickly as possible with the appropriate support so she will recover faster Dorothy will be supported to stay independent in her own home for as long as possible.

This model of care will be delivered through a designated Multi-Disciplinary Team (MDT) which will bring together staff from the health, social care, and voluntary sectors. - We will create and expand new roles in care coordination and care provision, including multi-skilled 'Generic Health and Social Care Workers', and advanced multi-skilled practitioner roles. These new roles will help to fuse health and social care duties and competencies, help to address recruitment and retention challenges and create exciting new career opportunities.

Over time, this model will help to support primary care resilience such that GPs will be better supported to care for their local communities. We also will see a reduction in pressure on large acute hospitals, helping us to provide effective and sustainable hospitals services into the future.

2.1 The Kent Context and Case for Change

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.

The Kent and Medway Case for Change states:
"*We all want health and social care services that can meet our needs now and in the future. The NHS in Kent and Medway, Kent County Council and Medway Council do their best to offer safe, compassionate and high-quality care. However, we face new challenges that mean we need to change the way we work to improve care and get better value for the money we have available. As our population grows, and more people live with long-term conditions, the demands on our services are changing and increasing. Services are not necessarily designed for todays or future needs, and it is becoming harder to keep up with rising costs. What's more we aren't making the most of opportunities to improve health and wellbeing, prevent illness and support people to manage existing conditions and stay independent*."
(http://kentandmedway.nhs.uk/wp-content/uploads/2017/04/Kent-Medway-Case-for-Change-UPDATED-APRIL-17.pdf)

Kent is also part of the National Integrated Care Pioneer programme: a partnership between the 7 CCGs, Adult Social Care, Kent Community Health Foundation Trust, Kent and Medway Partnership Trust for Mental Health, Hospital Trusts in Kent and district councils. The partnership also includes the independent and voluntary sector and Healthwatch. The aim of the Integrated Care Pioneer programme is to make Health and Social Care services work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital or care homes.

This is supported by the development of The Design and Learning Centre for Clinical and Social Innovation which is focused on working to reduce frailty, develop safe new services and transform the health and social care workforce by promoting independence and self-care. The centre provides the opportunity to innovate together and work as a network rather than in isolation. The Design and Learning Centre ultimately sets out to facilitate new ways of working by co-designing and evaluating sustainable solutions to meet the changing needs of a growing population.

3. Progress to date

The Local Care model for older people with complex needs is built around eight core components:

- **Care planning and navigation** – People will be supported to develop a personalised care and wellbeing plan. Dedicated professionals from a variety of health and social care backgrounds will co-ordinate the care and support from the rest of the MDT and the wider health, social care and voluntary sector.
- **Supporting people to improve their health and wellbeing** – Supporting people and carers to improve and maintain health and wellbeing by building knowledge and changing behaviours through proactive prevention / engagement.
- **Healthy living environment** – Ensuring a healthy living environment to preserve long-term health & wellbeing (e.g. falls prevention, housing improvements and alterations).
- **Integrated health and social care multi-disciplinary team** – Providing person-centred, coordinated multi-disciplinary care services, wrapped around GP practices and community services providing care to people who have personalised care plans based on their needs.
- **Single point of access** – A number called by the person, the GP, community services and acute staff, or indeed any other professional, to support people with their care by gaining more efficient, coordinated access to services.
- **Rapid response** – The ability within an MDT to respond rapidly to people with complex needs who are experiencing urgent health or social care needs that left unattended would result in a hospital admission.
- **Discharge planning and reablement** – A pro-active, anticipatory service designed to target those people who are medically optimised for discharge, no longer requiring an inpatient bed, but still needing some level of care to prevent their health from deteriorating and to support their recovery.
- **Access to expert opinion and timely access to diagnostics** – The ability for primary care professionals to access a specialist opinion in the community setting.

Significant progress has been made to date in delivering not only the aims of Local Care but the objectives of previous Better Care Fund plans, this includes:

- A multispecialty community provider (MCP) vanguard called “Encompass” has been developed to serve a population of approximately 170,000 people across Whitstable, Faversham, Canterbury, Ash and Sandwich. This consists of a federation of 16 GP practices working in partnership with all sections of the health and care system, including voluntary sector and patient groups.

- In Thanet, a Primary Care Home has been established to start building an integrated, Accountable Care Organisation (ACO) to improve care for frail older people and reduce demand. An integrated nursing team has been established to provide an enhanced frailty pathway and an acute response team has been created to provide a range of treatment and personal care support to keep people out of hospital.

- An integrated commissioning team has been established jointly by Dartford, Gravesham and Swanley, with Kent County Council for Children, this includes joint governance arrangements and full time posts.

- Ashford is piloting integration of Intermediate Care, provided by the Kent Community Health Foundation Trust (KCHFT), and Enablement, provided by Kent County Council (KCC). Through this pilot, it is becoming clear that reviewing cases jointly is very helpful in achieving better outcomes for the users of the service. It is also clear that there is duplication and that a more efficient use of skills and staff time can be achieved. The plan is to roll this out initially to East Kent first and then to the whole of Kent.

- Case Managers in Thanet and South Kent Coast are attending monthly MDTs in GP practices to manage risk and jointly agree pro-active management of people's needs.

- An integrated rehabilitation service is currently being co-developed by KCC, KCHFT and Virgin Care as part of the current phase of Transformation. This will be community based to respond to people in their own homes and support hospital discharge for those who require rehabilitation and enablement. This will be linked to the Discharge to Assess "home first" models across the county. In previous phases of transformation KCC have worked with hospitals to get people back to their own homes following a hospital discharge, using the ethos "Own home is best bed". KCC are part of integrated discharge teams in all hospitals in Kent, where Health and Social care are working together to get people back to their own homes. This has enabled the health and social care system to co-produce Discharge to Assess and Home First models to support people to leave hospital in a timely manner. KCC senior support for new model of care, with a multi-disciplinary discharge team, is based on Esther and Buurtzorg models.

- An alliance agreement in Learning Disability between 7 CCGs and KCC for integrated provision.

- An integrated mental health service covers secondary care health and social care. Also CCG commissioned mental health primary care that is integrated with KCC social care, Live Well Kent strategic partners.

- A Kent and Medway Transforming Care Board – currently developing integrated commissioning for the Transforming Care programme.

4. Evidence base and local priorities to support plan for integration

The Better Care Fund plan continues to be aligned 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 also a key driver in the ambition outlined in the Kent and Medway STP, to put local people at the heart of services, helping people to stay well and independent in their own homes and communities and avoid being admitted to hospital. It sets out how we want to:

- improve the health and wellbeing of local people
- deliver high-quality, joined-up health and social care
- offer access to the right care and support in the right place, at the right time
- make sure NHS and social care staff are not under so much pressure that they can't deliver the caring ethos of the NHS and social care
- better meet people's needs within the funding we have available
- build health and care services that are sustainable for years to come.

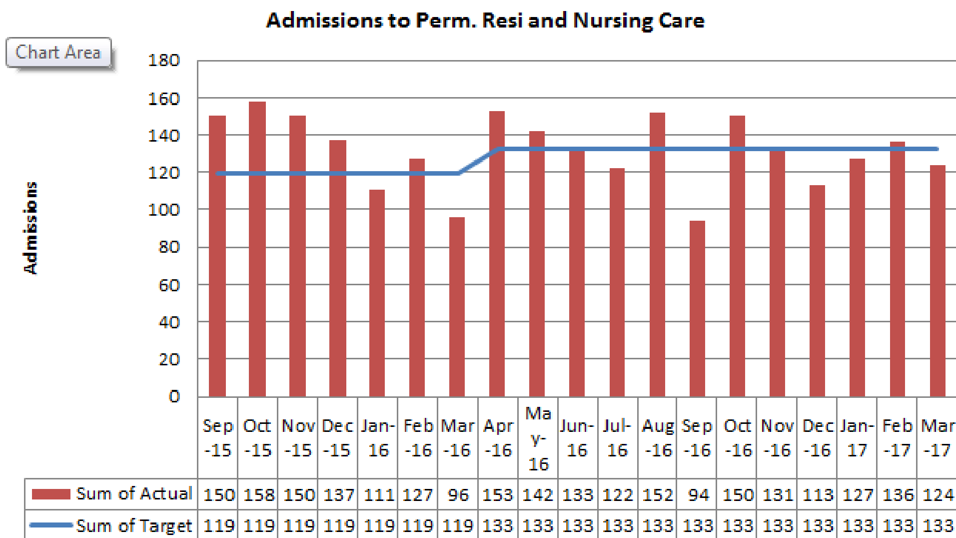
In 2016 Kent County Council published Your Life Your Wellbeing, which details the vision for Adult Social Care over the next 5 years. This is supported by a transformation programme aligned to the priorities in the STP and delivering elements of the Better Care Fund plan.

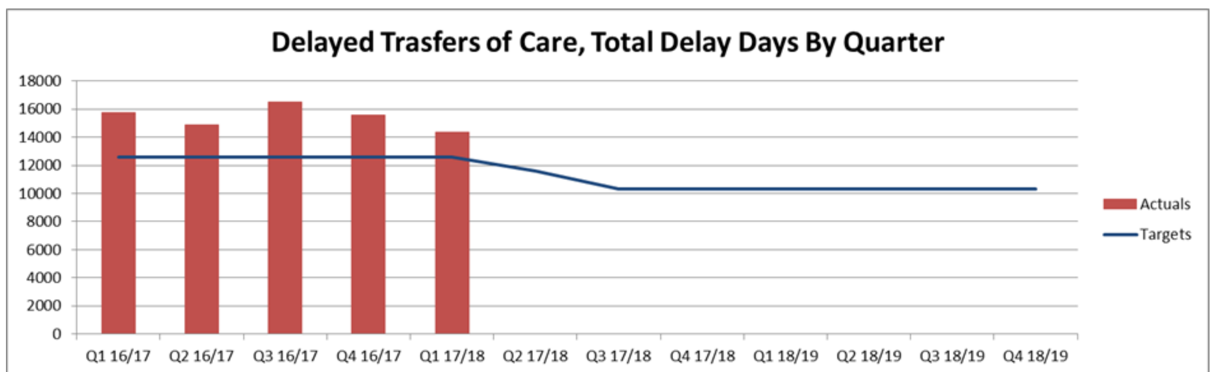
As part of the development for the 2017-19 BCF a review took place of existing schemes and their outcomes. This identified how schemes currently contribute to the national conditions, but also the Local Care Model.

Total Non-Elective Admissions into Hospital (General & Acute), all-age

Chart Area
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
Admissions

	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Sum of Actual	12,0	12,4	12,3	13,1	12,5	12,2	13,4	12,5	12,8	12,6	12,5	12,0	12,3	12,6	12,8	13,0	12,4	11,8	13,6
Sum of Target	12,0	12,5	12,4	12,7	11,9	11,1	12,5	12,5	12,5	12,5	12,8	12,8	12,8	12,6	12,6	12,6	12,6	12,6	12,6





This review has been used to inform the roadmap outlined in the plan and identify the key priority areas across Kent that align with local delivery:

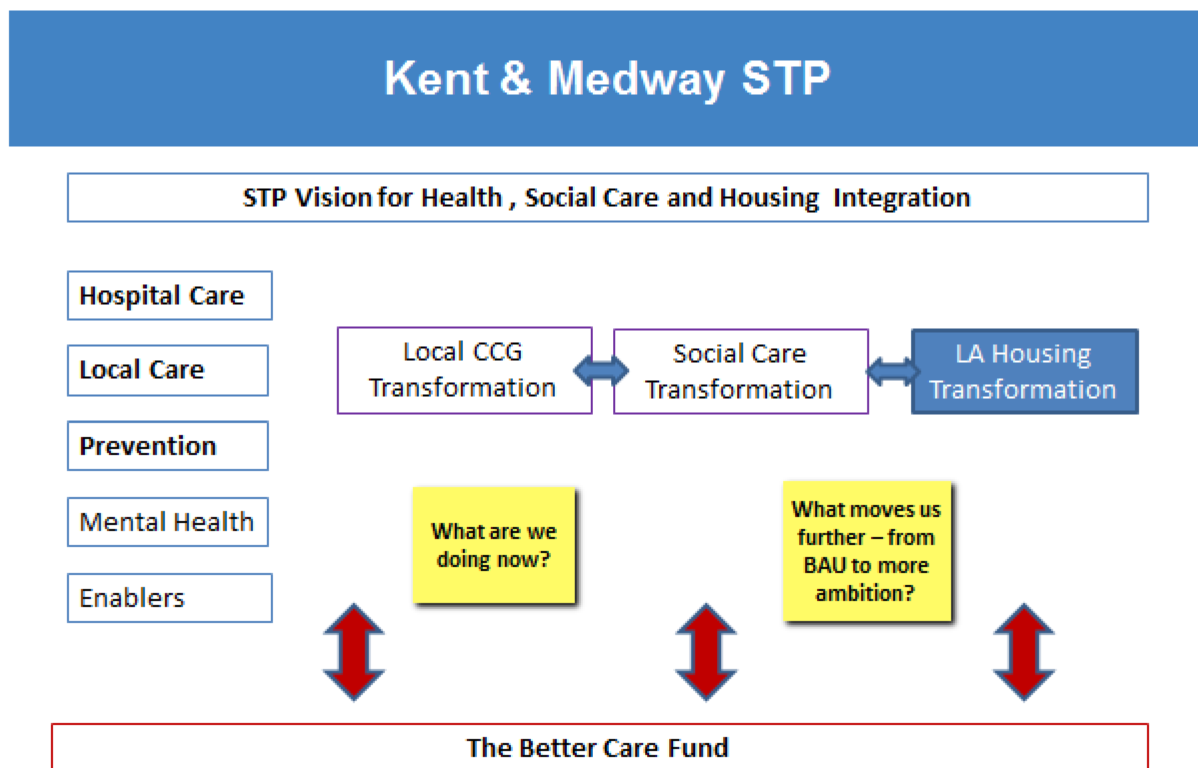
- Care Navigation
- Integrated Discharge Teams
- Discharge to Assess
- Joint Commissioning
- ICES
- Rapid Response / Reablement
- Intermediate Care Beds
- Carers Break
- Mental Health aftercare (Section 117)

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

- Joining up schemes and approaches across the STP footprint.
- The advantages of having a more integrated approach to commissioning and delivery. The road map identifies further opportunities to integrate functions to the benefit of both health and social care
- Development of the Care Navigation role to support people with non-medical needs and supporting integration with their communities.

5. The Better Care Fund plan

The Health and Wellbeing Board in January 2017 agreed the ambition of developing a BCF roadmap that supports delivery of the STP through ensuring alignment of key issues across Kent whilst supporting local delivery.



In broad terms the plans and how each of these areas will contribute to the required national conditions is outlined below. (The detail of spend for these schemes is in the attached planning template.)

The plan includes the aim to take existing areas of integrated work – such as ICES and intermediate care beds to incorporate them in to the BCF by 2019. Additional areas such as joint commissioning will not be delivered in 2017/18 but are ambitions for 2019, with the work required to design how these schemes will operate beginning now.

2017 – 2019 Schemes	National conditions supported by the scheme
Care Navigator	• NHS commissioned out of hospital services
IDT (hospital teams)	• Managing Transfers of Care
Discharge to Access	• Managing Transfers of Care
Joint Commissioning	• Plans jointly agreed
Integrated Community Equipment Service	• NHS commissioned out of hospital services

2017 – 2019 Schemes	National conditions supported by the scheme
Rapid Response / Reablement	• NHS commissioned out of hospital services
Intermediate Care Beds	• NHS commissioned out of hospital services
Carers Break (rolled from 16/17)	
OP Mental Health aftercare (Section 117)	• Managing Transfers of Care
Maintenance of Social Care	• Maintain provision of social care services
Disabled Facilities Grant	• NHS commissioned out of hospital services
Implementation of the Care Act	• Maintain provision of social care services
Carers support	• NHS commissioned out of hospital services
Delayed Transfers of Care – action plan	• NHS commissioned out of hospital services • Managing Transfers of Care

Further details of these schemes have been developed at a local level within scheme templates which outline strategic objectives, deliverables, linked metrics and risks and issues. For example within Care Navigation the objectives are:

To develop a joint Health and Social Care Navigation service based on learning from existing service of care navigation

- To develop a range of community based wellbeing services that will prevent or delay entry into formal health and social care systems by promoting individual wellbeing.
- To provide an easily accessible resource that both health and social care triage points can refer to.
- To refer people into community based resources.

With the outcomes of:

- Positive Patient Experience
- Increase in Patient Wellbeing
- Equity of Service
- Improved Integration of Community Services
- Reduction in Non-Elective Admissions in cohort

The partners in Kent have agreed that the additional social care funding will be used in line with the guidance issued:
- Sustainability of social care
- Market sustainability
- High Impact Changes in relation to Delayed Transfers of Care.

Use of the iBCF (across OP, LD, MH, PD) to improve social care market sustainability in care homes and community support includes wrap around support to care homes, leadership support, addressing shortfalls in the workforce, increasing capacity, identifying priority areas if risk of exiting the market and collectively working to improve quality across all client groups and access to loan equipment to support hospital discharge. It will also include investment in homecare and improving terms and conditions for the workforce and ensuring increases in wages direct to the worker. Alongside investment in other community support activity and voluntary sector support.

Money has also been agreed for training for the whole social care sector to target service gap and increased care home leadership training capacity facilitating discharges and follow up support for Home First, increasing flow.

The Disabled Facilities Grant is an important part of the BCF with the need to achieve improved independence, hospital discharge and the link with STP Local Care models such as community hubs. Joint Chief Executives agreed in March 2016 to a county wide review, resulting in recommendations for a transformation of the delivery of DFGs. The scope of the review was initially to work towards a more integrated model that could be implemented from 2018/19.

Further work is to take place in 2017/18 to develop this integrated model, but it has been agreed that the following can be included:

- DFGs
- Minor & Major Adaptations
- Handy Persons Schemes
- Hospital Discharge Schemes/support
- Telecare (assisted technology)
- Housing Assistance – low level inspection & referrals for repairs, heating and energy efficiency measures
- Advice Information & Support for accessing services outside the scope of the MDT/Hub

6. Risk

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.

Significant work has taken place across the development of the STP to ensure local transformation programmes align, therefore minimising risk to delivery. This includes the design and implementation of Your Life Your Wellbeing Phase 3 of Transformation for Adult Social Care. Understanding of the impacts of risk has been a key part of developing the 2017-19 BCF plan and is included in the planning templates used to inform this document.

The BCF Strategic Leads Group will have responsibility for monitoring risk and escalating issues as required to the Health and Wellbeing Board. However local level programmes will monitor, maintain and manage their own risks. Some key risks identified in the delivery plan are:

Risk	Mitigating Actions
Individual organisational timescales and pressures making system wider transformation difficult.	• Work collaboratively through the local governance and partnership arrangements.
Workforce issues with recruitment across all sectors	• Liaison with education providers required to support longer term delivery of workforce. • Integration of health and social care teams and use of technology to improve pathways and process releasing capacity.
Current national issues with availability of domiciliary care and reductions in the social care budgets.	• Additional social care funding and planning work with providers to create domiciliary care capacity. • New delivery models of domiciliary care explored (outcome based care) • Joint working with providers on workforce management.
Integrated Community Equipment: Failure to deliver equipment within the requested timescale may delay discharge or necessitate hospital admission or care placement unnecessarily. Failure to collect equipment in a timely manner may lead to clients and/or carers/families disposing of equipment therefore necessitating the purchase of replacement equipment. Failure to repair or service equipment within the scheduled frequency may put the user and/or carer at risk of injury.	• CCG reviews the performance indicators on a monthly basis as part of the contract and performance meetings, the quality of these indicators is scrutinised and wider system impact evaluated. • Kent wide operational and equipment review groups are in place to ensure patient pathways remain seamless and delays are reduced/addressed where necessary. • Good engagement with our partner organisations and senior provider leads which support areas of mitigation where appropriate.
Care Navigation: Lack of practice engagement leading to lower use of service Lack of consistency and equity across practices	• Concerted effort to ensure good understanding at co-design and planning phases, communication and engagement plan in place • Encourage GPs to be involved in developing the mode

7. National Conditions

7.1 National condition 1: jointly agreed plan

In January 2017 the Health and Wellbeing Board agreed the approach to developing the 2017-19 Better Care Fund plan. This included the creation of a BCF Strategic Leads Group to develop the plan and monitor its implementation.

The signatories to this Better Care Fund plan have agreed the approach outlined and further work has also taken place with Joint Chief Executives (as outlined in Section 6) on agreement for the Disabled Facilities Grant.

The partners in Kent have agreed that the additional social care funding will be used in line with the guidance issued:
- Sustainability of social care
- Market sustainability
- High Impact Changes in relation to Delayed Transfers of Care.

Kent County Council has consulted with NHS and other partners in relation to the iBCF proposals meeting with the Accountable Officers of the CCGs, all the Kent and Medway A&E Delivery and Improvement Boards (as requested by the CCGs) and these include NHS providers, the Kent Health and Wellbeing Board, social care provider forums and internal KCC member and officer committees.

7.2 National condition 2: social care maintenance

Significant work to transform social care services has taken place and work continues to deliver the Your Life Your Wellbeing strategy and implement the vision for Adult Social Care. This supports delivery of the Local Care Model within the STP and contributes significantly to the roadmap of increased integration by 2019.

Extensive work with the social care market has happened and KCC is issuing a new interim contract co-produced with providers as the first stage of market sustainability, moving in the next stage to a more Outcome Based Support contract. It is expected that this will improve the professionalisation of the workforce and increase recruitment and retention rates. Whilst addressed as two separate areas, both are linked and interdependent as, for instance, an effective Home Care service allows people to leave hospital quicker and safely.

£29.2m 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; £4.7m toward the provision of domiciliary care, £8.2m toward residential provision, £5.6m toward Enablement Services and £2.6m toward provision of Direct Payments to support service user's social care needs.

7.3 National condition 3: NHS commissioned out-of-hospital services

The BCF is designed to support the implementation of the Local Care Model Toolkit, with significant investment in out of hospital services. Full details of this can be found in CCG Operational Plans and the STP.

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

7.4 National Condition 4: Managing Transfers of Care

The High Impact Change model for managing transfers of care is being implemented as follows:

Early Discharge Planning: additional staffing to support social care activity in all hospitals at the front door for admission avoidance/integrated urgent care models and other staffing.

Systems to monitor Patient Flow: this will provide an integrated dashboard for monitoring activity and delays; it will also support a more effective panel process speeding up authorisations.

Integrated Discharge Team: additional staffing to support the Integrated Discharge Team pathway and OT Physio Support. All Acute Trusts have the intention to develop Integrated Discharge Teams and staff who will support the Home First pathways, but they are not all in place yet. This project will fully staff all the elements of the pathways and will make the IDTs and HF more effective across older people and adult mental health .

Home First/ Discharge to Assess / Trusted Assessors: additional investment in pathway, service commissioning to integrate the wider workforce, additional recruitment for enablement, Kent Recovery Service MH, technicians for adaptations and equipment across the sector. Home First is key to improving DTOC; this investment will provide a big increase in the HF capacity. It will also improve the follow up capacity of the enablement service and access to technicians for adaptations and equipment.

Seven Day Service: a single point of access to develop in line with Integrated Discharge Team/Home First pathways and additional professional mental health workers for the AMHP service.

Focus on Choice: working with Live Well Kent and KERS to do early engagement and link with individual in crisis to support them through admission and return home this should improve discharge to home rates for MH service users.

Improved integrated working with fewer discharges blocked through Choice issues.

Enhancing Health In Care Homes: increasing professional support (OT, Pharmacy) to care homes, reducing admissions from care homes and quicker

discharges. Additional dementia stepdown beds to improve flow for people with dementia and adult mental health.

8. Overview of funding contributions

Local Authority Contributions exc iBCF		
Disabled Facilities Grant (DFG)	2017/18 Gross Contribution	2018/19 Gross Contribution
Kent	£14,387,024	£15,645,644
Lower Tier DFG Breakdown (for applicable two tier authorities)		
Ashford	£775,304	£842,979
Canterbury	£1,017,727	£1,101,325
Dartford	£513,627	£558,301
Dover	£1,113,133	£1,203,366
Gravesham	£882,691	£961,866
Maidstone	£1,131,348	£1,230,870
Sevenoaks	£976,757	£1,064,336
Shepway	£1,138,882	£1,229,558
Swale	£2,182,185	£2,382,555
Thanet	£2,568,686	£2,794,932
Tonbridge and Malling	£1,007,235	£1,097,910
Tunbridge Wells	£1,079,451	£1,177,645
Total Minimum LA Contribution exc iBCF	**£14,387,024**	**£15,645,644**

Local Authority Additional Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Total Local Authority Contribution	**£14,387,024**	**£15,645,644**

iBCF Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Kent	£26,392,010	£35,018,901
Total iBCF Contribution	**£26,392,010**	**£35,018,901**

CCG Minimum Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
NHS Ashford CCG	£7,324,821	£7,463,993
NHS Canterbury and Coastal CCG	£12,861,063	£13,105,423
NHS Dartford, Gravesham and Swanley CCG	£15,566,069	£15,861,824
NHS South Kent Coast CCG	£13,451,140	£13,706,711
NHS Swale CCG	£6,936,651	£7,068,448
NHS Thanet CCG	£9,810,694	£9,997,097

NHS West Kent CCG	£27,870,714	£28,400,258
Total Minimum CCG Contribution	**£93,821,153**	**£95,603,755**

Additional CCG Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
NHS Swale CCG	£59,700	£59,700
NHS Dartford, Gravesham and Swanley CCG	£25,000	£25,000
Total Additional CCG Contribution	**£84,700**	**£84,700**

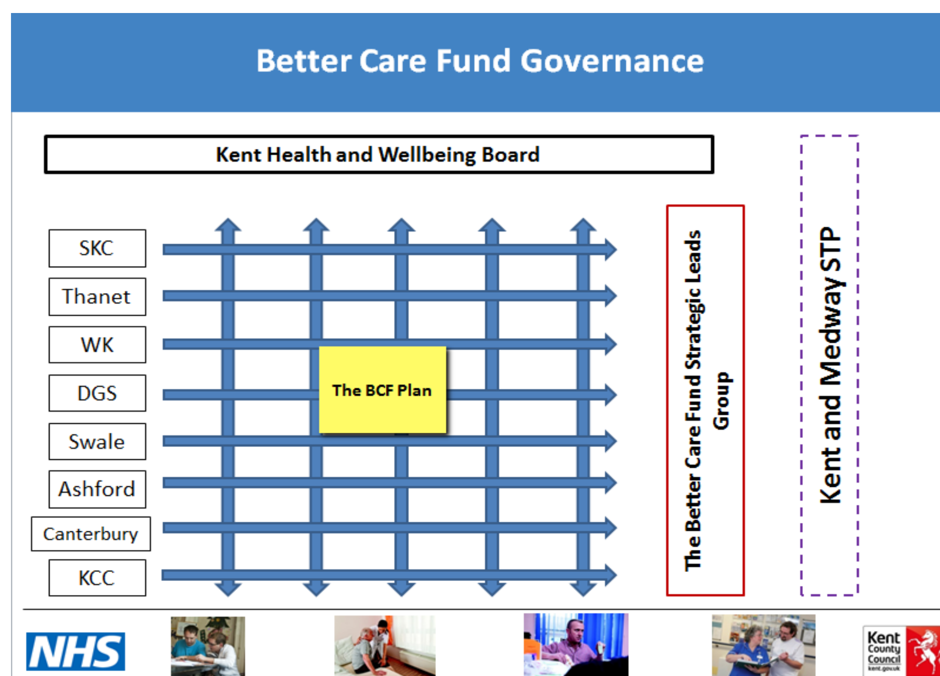
	2017/18	2018/19
Total BCF pooled budget	**£134,684,888**	**£146,353,000**

9. Programme Governance

The planning template identifies the detailed areas of spend for the Kent 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.

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.

To support the Board it was agreed to establish a new group of BCF Strategic Leads, comprising representatives from all CCGs and KCC. This group will meet bi-monthly to monitor delivery and implementation of the road map for 2019. This group will be supported by local implementation arrangements and existing STP governance.



10. National Metrics

Non Elective Admissions

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	**Total 17/18**	**Total 18/19**
HWB Non-Elective Admission Plan* Totals	**40,002**	**40,400**	**40,793**	**39,768**	**39,241**	**39,629**	**40,043**	**39,036**	**160,962**	**157,950**

Residential Admissions

The overall residential figure is reducing; the plan is to sustain this throughout 17/18 and 18/19.

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	594.8	519.8	510.2	500.2
	Numerator	1,786	1,595	1,595	1,595
	Denominator	300,274	306,850	312,626	318,873

Reablement

Performance will begin to see the impact of Discharge to Assess programmes therefore the aim is to maintain the target at 85.9%. Note: The performance of this indicator is measured once a year, for people discharged within a specific 3 month period – this is as per the statutory return guidance. This means we will only be able to refresh the 16/17 position after March 2018.

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	83.4%	85.9%	85.9%	85.9%
	Numerator	1,354	1,351	1,351	1,351
	Denominator	1,624	1,573	1,573	1,573

Delayed Transfers of Care

For this indicator we have replicated the national expectation target from the Department of Health that we are aiming to reach as of September 2017, with a plan to continue the performance into the last quarter of 17/18 and throughout 18/19.

		16-17 Actuals				17-18 plans				18-19 plans			
		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	1304.4	1231.7	1368.1	1279.7	1179.7	952.7	848.9	841.3	841.3	841.3	841.3	834.1
	Numerator (total)	15,739	14,862	16,508	15,591	14,373	11,607	10,342	10,342	10,342	10,342	10,342	10,342
	Denominator	1,206,598	1,206,598	1,206,598	1,218,316	1,218,316	1,218,316	1,218,316	1,229,352	1,229,352	1,229,352	1,229,352	1,239,886

11. Delayed transfers of care (DTOC) plan

The DTOC plan is coordinated by the Health and Wellbeing Board and has Home First work streams in each of the four Health Economies across Kent (West, East, North and Swale). Partnership working takes place through the A&E Delivery Boards and associated work streams, working to the A&E improvement plans, linking with the developing STP in particular Hospital Care and Local Care. This includes Adult Social Care presenting High Impact areas at the A&E delivery boards to be considered alongside the A&E five priorities.

Examples within the action plan include:

- KCC hospital teams identify people who are not yet ready for discharge and track their treatment whilst in the Acute setting to support timely social care engagement at the point of medical optimisation. In most cases this is as part of an integrated discharge team.

- All Integrated Discharge Teams have voluntary sector presence and link to the community services.

- Home First and Discharge to Assess models are being developed across Kent supported by Governance linked to the A&E Delivery Boards. Adult Social care has aligned the Home First model with the Your Life Your Wellbeing Transformation Programme.

- MDTs, task and finish groups, health workshops e.g. Home First, Frailty Model, Stroke Services are attended by health and social care.

- Appropriate use of care navigators, telecare and the Esther and Buurtzorg models. Care Navigators are on site in the majority of the Acute Hospitals and active members of the IDT teams.

- Appropriate social care involvement in rapid improvement events, perfect discharge weeks, and locality work such as ART, Vanguard.

- KCC have invested in performance capacity to develop a social care urgent care dashboard approved by A&E delivery boards and submitted to form part of integrated dashboards.

- KCC work with transforming care in development of SHREWD capability for social care, which is used across Kent as an operational tool.

- KCC are part of the SE ADASS DTOC reporting framework.

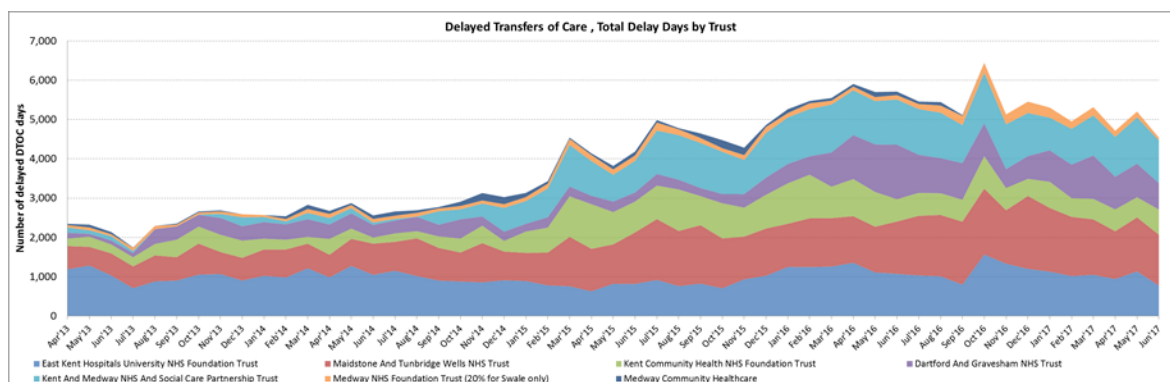
- KCC have a senior manager with responsibility for urgent care, supported by a county service manager operational lead. Transfers of Care are monitored daily and there is an escalation process in place. Where DTOC pressures occur there is a commissioning escalation process in place to resolve delays. As part of the iBCF reporting each hospital team leader has a DTOC target in terms of bed days and DTOC numbers.

- A Trusted Assessor Model is in place across social care where by Case Officers and Case Managers have been trained as community equipment assessors and assisted digital technology.

- KCC along with health partners are signed up to the wider trusted assessor role and will progress this as part of Home First when the tool kit / further guidance is issued. In East Kent and North Kent work has commenced with ECIP to start this.

- There are 4 integrated care centres across Kent. These units support admission avoidance and discharges from hospital and are included in the BCF plan for 17-19.

Recent data shows some improvement in DTOC, with local plans and targets being set to meet the national targets set for delayed transfers of care and sustain these in the second part of 17/18 and throughout 18/19. The development of an integrated urgent care dashboard will support the ability to measure impact of the action plan.



12. Kent Better Care Fund Plan Sign Off

The Kent Health and Wellbeing Board discussed the Better Care Fund Plan on 14 June 2017 and due to timescales delegated responsibility for formal sign off to the Chairman.

However the Kent Better Care Fund Plan will go before the Kent Health and Wellbeing Board on 20 September 2017, in addition to electronic circulation.