Appendix C - Examples of Integrated Delivery

Home First

Home First is transforming patient care in Kent by facilitating hundreds of patients to receive treatment at home who would normally have needed to stay in hospital. This initiative promotes collaboration between Kent NHS hospital trusts, KCC, and voluntary and community sector partners. Hospital staff coordinate closely with community and care colleagues to plan for patients return home ensuring personalised care plans are in place. Patients are seen at home within hours and receive an assessment by a Home First Team. Patients with complex needs undergo robust assessments, before coming to a decision with them and their families, to determine appropriate care. Where possible, the teams also assess patients in the community and provide appropriate care to avoid people going into hospitals at all.

Development of Integrated Neighbourhood Teams

As described in the main body of the report, Integrated Neighbourhood Teams are in development and progress varies across the County as models are explored.

In East Kent the Health and Care Partnership is currently working with 4 Primary Care Networks and the Voluntary and Community sector, as Integrated Neighbourhood Teams (INTs) early adopter sites. They are looking at tools to identify those most at risk of needing social care or who are likely to experience worsening health outcomes. This is known as risk stratification and will help identify those people who will benefit from remote monitoring and early identification of deterioration to provide additional support. This is a formal program working alongside John Hopkins University and will be invaluable in informing how INTS develop across the County.

There are many examples of how pockets of this integrated approach are emerging across West Kent as we prepare for INTs:

- Core frailty team with shared case management and shared System use working well in Tonbridge PCN area
- Mental Health multi-disciplinary complex mental health needs working well in Weald
- Sevenoaks area established a Health and Well Being huddle approach to link the wider H&WB offer and organisations to the core Primary Care Networks/ Integrated Neighbourhood Teams
- Maidstone PCNs have worked together on a joint service provided by VCS for people with complex mental health related needs across all their PCNs
- Maidstone Central developed an integrated model for children's mental health support (yet to be fully mobilised)
- Wider health and wellbeing targeted support provided for a range of communities/groups experiencing health inequalities in Maidstone
- Joint work on coproduction and engagement with local residents at a neighbourhood level and as part of INT developments
- Developing shared approach to Workforce and Estates as part of the HCP developments in this area
- Active WK digital and data group developing a shared approach to – digital transformation, systems and data access and use

Integrating support to help people with health conditions into work
Kent and Medway ICS have submitted a bid to be a vanguard area for the WorkWell program, integrating local employment and health support for disabled people and those with health conditions to start, remain and succeed in work. Regardless of the bid's outcome, System Leaders have agreed to create a Work and Health Strategy for Kent and Medway, aligning the shared health and economic aims of the ICP and Kent and Medway Economic Framework. This strategy will set out how work and health support will be integrated so people can receive holistic support which might include a consistent work and health coaching offer and a range of specific support such as physiotherapy, mental health support, employability advice and support for employers.

East Kent Hospital Discharge Pathways
This initiative is a partnership between Kent Community Health NHS Foundation Trust (KCHFT), Kent County Council, and East Kent Hospitals University NHS Foundation Trust as part of East Kent's provider collaborative. During winter, two new wards in East Kent provided up to 30 rehabilitation and reablement beds. The first 15-bed ward opened in December at Westbrook House in Margate, followed by an additional 15 beds at West View in Tenterden in January. These beds will operate until April as we transition to a more integrated model of care.

Better Care Fund
Funding from the Better Care Fund (BCF) has facilitated the establishment of 'Transfer of Care Hubs' countywide, enhancing collaborative efforts across acute, community health, social care, and voluntary sectors in discharge planning. The BCF has further supported the implementation of a 'Physio/Occupational Therapy (OT) In-Reach and Drop and Stop Service', expediting discharges and facilitating more physio/OT assessments in patients' homes.

Commissioning Academy
We have set an ambitious joint plan to develop leadership capability across our commissioning teams, with a true focus on achieving outcomes, developing skills in partnership working at all levels including place, localities, and communities. The Commissioning Academy is designed to give participants the tools, techniques, and confidence to approach the most challenging issues facing communities in a collaborative, creative, and evidence-driven way. The Academy is accredited by the Cabinet Office and was launched in 2012. Our HR/OD Division were given permission to hold two KCC/Kent Commissioning Academies during 2024, with the first cohort commencing in January and the second starting in April. It is a 9-month programme focused on joint working, building better trusted relationships, resulting in improved and greater joint commissioning. Both cohorts have a mixture of KCC Commissioners, ICB, NHS and Medway participants.

Alongside the academy, we have established a Community of Commissioning Professionals, first event will be held at the end of April, with the aim to improve how we all work effectively together as a System, creating a network across directorates, services, partners, and communities. This is critical to achieving long-term efficiencies in public service, and – most critically – to reducing demand for statutory provision through enabling early support. This forum will bring together all commissioners from within Kent County Council and hopefully with partners in the ICB to share best

practice and to embed the disciplines of excellent commissioning. This collaboration hub of innovation will accelerate progress to achieve our ambitions around improved integration and joined up commissioning.

Supporting people with learning disabilities and autism

The Kent and Medway Learning Disability and Autism Delivery Partnership is a joint working arrangement between KCC, Medway Council and NHS Kent and Medway with a fully integrated programme team that brings together support and resources for the benefit of neurodivergent people in Kent and Medway. The Partnership is developing a system-wide strategy for learning disability and autism to improve outcomes and reduce inequalities in this population. This will include progressing joint commissioning of accommodation and jointly re-procuring services.

One of the ways partners are working together is through the Kent and Medway Dynamic Support Arrangements for children and young people with learning disabilities and/or autism who exhibit behaviours of distress and challenge that leave them at risk of current placement breakdown, admission to specialist hospital and detention or prosecution. The arrangements include an electronic record (launching imminently) to track and stratify children with complex needs, the Dynamic Support Service that provides highly expert independent advice to the system on meeting the complex needs of the young people identified so that better outcomes can be achieved for them, and multiagency review sessions to improve outcomes for young people in the most complex or stuck situations. The support includes Peer Associates to work with and advocate for young people and their families, which is provided in partnership with voluntary sector organisation Involve, Kent.

The impact on reducing Tier 4 (highest need) hospitalisation and length of stay has been dramatic. Typically now there are only one or two young people occupying Tier 4 beds, usually staying for only a few months, compared with the position in 2020 where over 20 young people were typically in Tier 4 beds at any given time, sometimes for many years. This reduction in high need hospitalisation has freed up resources including regional NHS funding that can be used to further support neurodivergent people in Kent and Medway. This has included the provision of a new residential facility for young people with complex needs where they can receive support instead of being admitted to hospital, and more capacity to focus on supporting neurodivergent adults with complex needs to be able to leave acute hospital settings. The Dynamic Support Service is funded by NHS Kent and Medway who have appointed KCC to commission and run it, demonstrating the strength of integrated working that is not always seen in other parts of the country. Building on this success, the service is starting to work with the criminal justice system to prevent young neurodivergent people with complex needs from being detained and will be providing earlier intervention around emotionally-based school avoidance to try to prevent escalation of needs.

Technology Enhanced Lives

In November 2023, KCC launched its co-designed Technology Enhanced Lives service. Devices such as movement sensors, smart watches, wearables, falls prevention devices and other technologies will allow people to remain independent for longer and better manage risk when previously they may have needed additional help, for example home care or moving to a care home. There is an opportunity to use data generated from the Technologies to enable us to move from reactive to preventative

approach. There are system wide benefits, such as working with Health to reduce hospital admissions and improve hospital discharge. Technology Enhanced Lives offers a short-term service, free for up to 10 weeks to support people to return to their previous levels of safety and independence following hospital discharge.

Hospital Technology Facilitators

Funding from NHS England has allowed social care, social prescribing providers and health to test Hospital Technology Facilitators from July 2023 - March 2024. The aim to provide technology assessments to maximise the use of technology to support hospital discharge and relieve pressures on the health and care sector and provide more cost effective and meaningful outcomes. 300 people were supported to return home with technology. Initially there was demand for hydration cups, movement sensors, and dementia clocks, however from December 2023 there was a shift with technologies being more focused on supporting informal carers. This has been independently evaluated and will inform next steps.

Case Study – Derek

Derek is in his eighties and has early on set Dementia. Derek lives with his wife who supports him as his informal carer and has a son who lives close by. Derek has started to frequently wander without purpose in the day and of a night. Derek and his wife sleep in different rooms however his wife is now struggling to sleep due to worrying about Derek wandering and leaving the house. Derek was admitted to hospital from a fall after he was found in the early hours of the morning in the front garden by a neighbour.

Derek was referred to the Hospital Technology Facilitator by the Occupational Therapist in the hospital. Through conversations with Derek and his wife it was apparent that Derek's wife was struggling to manage her caring role for her husband and the lack of sleep was impacting her ability to support him during the day.

The Hospital Technology Facilitator discussed the use of technology to support her to maintain her caring role for Derek.

To help support Derek's wife's caring role a PIR movement sensor was given to support her with getting quality sleep and reduce the risk of carer burnout. The movement sensor was placed downstairs by the front door and would alert Derek's wife in the event of him getting up during the night.

This enabled his wife to get quality sleep and was the least restrictive solution to locking doors. In the event Derek tried to leave the property his wife would be notified through the pager alarm and would be able to assist, reassure and support him accordingly.

Derek was discharged with the equipment with their son agreeing to set this up within his parents' home. At the point of the two week check, Derek's son commented on the difference the technology had made to his parents lives and that his mother is now able to have quality sleep whilst continuing to support Derek. He also commented on how simple the device was to set up.

Integrated Digital Transformation
To oversee a three-year programme funded by Department of Health and Social Care, the ICS has created an Integrated Digital Transformation Board and Plan. Some of the activities that have been funded include:

Feebris
This is a digitally enabled programme for proactive risk assessment and detection of deterioration of people in 30 care homes. The platform is hardware agnostic, connecting to a range of sensors, and uses AI to ensure the quality of information captured and automate the detection of risks, this empowers proactive management of risks such as falls and deterioration therefore reducing hospital admissions. At present the digital tool is monitoring 800 people.

Digital Social Care Records
Care providers are supported to put in place Digital Social Care records which will improve work process for the provider by moving from paper based to digital and improving the quality of information.

Digital Front Door
Working with people who draw on care and support and partners we co-developed an information, advice and guidance platform and a range of digital self-help tools. This will help with prevent, reduce and delay by improving information and connecting people with the right support and services at the right time. During the autumn and winter 2023 there was a digital roadshow in partnership with Digital Kent across communities to raise the profile of these digital tools to communities and partners and help address digital inclusion. Work continues with health to further develop opportunities that will help with prevent, reduce and delay.

Infant Feeding and Perinatal Mental Health
Two strategies are in development relating to the best start in life and led by Public Health.

The co-development of a 5-Year Infant Feeding Strategy, will set out ways to support families, by reducing barriers to breastfeeding, including in public spaces, and helping mums and their family learn about infant feeding choices before their new baby arrives. This already includes the co-creation of animated films on responsive bottle feeding for the workforce and breastfeeding in the first days, weeks and months, and a process to offer the provision of maternity wear and some associated infant feeding resources to those living in the most deprived wards in Kent.

The Perinatal Mental Health Strategy will represent a significant commitment to supporting babies and their families in Kent that need 'mild-to-moderate' support, with an estimated 6,663 parents and carers that could benefit every year from this support. Co-produced with colleagues across the health and care sector in Kent, it encourages working together across the professional networks that exist to support babies, parents, and carers, setting out how we can improve perinatal mental health by focusing on early intervention and prevention. An example of good practice includes the Kent Community Health NHS Foundation Trust's Health Visiting Service which implements an early intervention intensive visiting service for families facing various vulnerabilities, including mental health issues.

Optimising Weight Management Services

A Task and Finish group has been stablished between KCC Public Health and the ICB, with the aim to establish a sustainable weight management strategy across Kent, providing an accessible, equitable, and evidence-based support and standardised approach with a robust referral system. This also aims to empower individuals to take control of their health, achieve and maintain a healthy weight, and improve overall well-being.

Collaboration with the broadest range of partners across the System is crucial, as commissioned services alone may not reach enough people to address the problem of excess weight.