Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Kent County Council**
Clinical Commissioning Groups	**NHS Thanet CCG**
Boundary Differences	
Date agreed at Health and Well-Being Board:	**12 February (1st draft)**
Date submitted:	**3 February (1st Draft for 12 Feb Kent HWB)**
Minimum required value of ITF pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Thanet Clinical Commissioning Group
By	Hazel Carpenter
Position	Accountable Officer
Date	3rd February 2014

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

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

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Thanet CCG has already begun the work of transformational system change in collaboration with its major providers in both health and social care. This has resulted in an East Kent strategic plan that sets out the vision for a desired heakth and care system in 2018/19. This includes outcomes for people; a clear financial sustainability model; improvement interventions to achieve the desired outcomes and system along with the governance that will oversee the delivery of the plans and the key values and principles required to underpin the system wide working to deliver the vision.

The four East Kent CCGs, on establishment, recognised the need to work together at a strategic level thus establishing the East Kent Federation and associated Whole System Board and related infrastructure. The Whole System Board agreed to take forward a collaborative approach to the development and delivery of a strategic plan establishing the necessary local service change to enable the local health and social care to ***best meet the needs of local people, delivering the right experience and outcomes in a way that is sustainable into the future.***

There is high-level multi-agency agreement in the direction of travel set out in the national vision. For services to integrate wrapping around the most vulnerable to enable them to remain in their own home for as long as possible supported by a package of care and support focused on their personal health and wellbeing ambitions. This will lead to a broader and potentially more innovative delivery of health and care out of hospital.

The local Thanet Integrated Commissioning Group (ICG) has been central to the development of the Integration agenda and specifically the Better Care Fund Plan. Its membership includes representation from CCG Commissioners, Local Authorities, service providers and stakeholders working to help shape the range of schemes and proposals. Work is also underway with our major providers to explore transformational system wide change through integration opportunities.

The East Kent Federation vision has been developed and shared at the East Kent Whole Systems Board whose membership includes local providers. Our local plans have been informed and are aligned to this vision.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

A number of Thanet commissioning schemes included in its operational plans for 2014

are included in the Better Care Fund Plan. These were developed through the CCGs stakeholder engagement activities led by its Communication and Engagement Committee and outlined in its local community and engagement strategy. These include:

- A number of Public and Voluntary Sector Events under the banner of 'A call to action'
- Engagement with service users via Thanet Health Network
- A number of engagement events with individual Practice Patient Groups
- Locality Meetings – GP planning

Further patient, service user and public engagement activities will be developed through 2014 as part of the work of the Integrated Commissioning Group and will, with engagement with all stakeholders form a system wide/multi-agency perspective. This will inform further development of the Better Care Plan into 2015/16

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
Developing the East Kent Strategic Plan 2014-19 – East Kent Federation	
Thanet Clinical Commissioning Group Strategic – *Working towards a healthier Thanet 2013-2018*	

2) VISION AND SCHEMES

a) Vision for health and care services
Please describe the vision for health and social care services for this community for 2018/19.

Thanet CCG is committed to transforming the health of people living and working in Thanet, we will work with local people, communities and our partners to deliver high quality services that are patient centred, safe and innovative. We want all of our local communities to be ambitious about their own health and to challenge the best possible care in the best possible environments with our resources.

Our vision is to provide care that crosses organisational boundaries and best serves the needs of the population we serve. This is outlined both in our strategic planning and our developing work on integration. Our ambition is to achieve a health economy that is both fit for purpose and sustainable for the future.

This vision will take forward a localised strategy in acknowledgement that in order to deliver much larger system change it will be necessary to work across an East Kent footprint. 2014-15 will be the start of this process and an East Kent wide strategy will be developed. The integration agenda will be at the centre of this work and the Better Care Fund will be an enabler of many of these initiatives

To achieve this vision we will:

- Develop services collaboratively across all service partners
- Ensure services are clinical led (supported by professional management)
- Ensure service development is informed by patients describing how services can be integrated around them to meet their needs
- Informed by public debate on a sustainable NHS service model within the wider community
- Ensure that the individual is at the centre of their care. Delivering the right care, at the right time, by the right person
- Support individuals in maximizing their own independence to take more responsibility for their own health and wellbeing
- Support people in service delivery in their own homes and communities
- Reduce acute hospital pressure by ensuring that appropriate services are available in the community
- Achieve the best possible outcome within the available resource and services
- Develop and provide integrated services where this is the optimum service delivery model of care

This vision will be achieved by providing integrated services through integrated teams that are wholly designed around patient needs. It will achieve differences in provision and improvements to patient and service users by:

- Reduced treatment of patients in hospital where it is appropriate to provide care within the community, particularly for the frail elderly
- Ensure GPs can act as the lead responsible clinician in the management of the most needy patients ensuring optimum care at the right time by the most appropriate intervention
- Better use of each "Health Pound" on behalf of those patients and service users
- Hospital Consultants working across the hospital-primary care "divide" to;
    - Manage the care of individual patients
    - Train Primary and Community Care (out of hospital) clinicians in best practice
    - Provide advice to individual clinicians about the management of their patients

It is inherent within these plans that patients, service users and carers can navigate quickly and easily through the services they need, being offered by the right service provision, at the right time, in the right location.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Our overall aims and objectives have been developed and published in our overarching five year Strategic Plan, which itself draws on joint work of the East Kent Federation of CCGs. The following highlights the elements of these plans that are supported by an integrated approach and in particular are applicable to the Better Care Fund:

1. Securing years of life for the people with treatable mental and physical health conditions
2. Improving the health related quality of life for people with one or more long term conditions, including mental health conditions
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
4. Increasing the proportion of older people spend living independently at home following discharge form hospital
5. Increasing the number of people having positive experience of hospital care
6. Increasing the number of people with mental and physical health conditions having positive experience of care outside hospital, in general practice and in the

community

7. Reduction in funding for hospital care for services that can be more effectively provided in a community setting

We are already delivering a number of these service changes and improvements across the health and social care system. These are outlined in section c).

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Alignment with local JSNA and local commissioning plans

The following schemes have been aligned with the CCGs top health priorities derived from the local Joint Strategic Needs Assessment. In addition, they will be further developed as part of the CCG strategic commissioning intentions and in negotiation with major providers, local authorities and key stakeholders. We will work with the Thanet Integrated Commissioning Group, the already established multi-agency forum, in planning the Integration agenda and specifically the Better Care proposals and activity.

Integration – Thanet Current Schemes 2014/15

Delayed Transfers of Care

- Purchase of step up step down beds (GP step up bed project)
- Loan store

Emergency Admissions

- Additional Emergency Care Practitioners (GPs in A&E)
- Mental Health provision in Emergency Departments
- Multi Disciplinary Team (MDT) in reach to care homes
- Improved pathways for Counselling Services
- Universal Care Teams/Cluster Team Development

Effectiveness of Reablement

- Community Services Review including intermediate care and community hospital beds

Admissions to Residential & Nursing Homes

- Step up and step down beds (GP Step up bed project)
- Multi Disciplinary Team (MDT) in reach to care homes
- Carers – Rapid Response
- Continuing Healthcare, funded nursing care and out of hospital area placements review
- Additional capacity in care home as step up bed pilot
- Westbrook - review current provision to ensure efficient use of bed base

Patient & Service User Experience

- Ensure an increase in patients reporting a positive experience of care as reported through the friends and family test

Children Services

- Adoption
- Looked after children
- Post sexual abuse

Admission Avoidance

- Falls service Intermediate care
- Care navigators
- Social enterprise scheme to support dementia
- Personal health budgets
- 7 day working in locality teams
- Social transport

Integration – Thanet Current and Proposed Better Care Fund Schemes 2015/16

Proposed service areas that are identified as local priority schemes for the Better Care Fund through 2014 and into 2015/16 are shown below:

1. Integrated Teams and Reablement

The team will be available 24 hours a day and seven days a week, contactable through a single access point. The team will provide a rapid response to patients at high risk of hospital admission and coordinate intermediate care and support in the community, including the use of community beds. The team will also develop a robust integrated discharge process and coordinate post-discharge support in the community. Patients will know who to contact in the team whenever they need advice or support.

Scheme Requirements:

a. **Admission avoidance**

- Integrated pathway to coordinate referral management, admissions avoidance and care coordination across health and social care, supported by single access points
- Integrated assessments to ensure responsive onward referral to either rapid response services or intermediate care services ensuring transfer to most appropriate care setting (including patients own home);
- Intermediate care provision to be provided at patients own home wherever possible by professional carers or by a multidisciplinary team of therapists and nurses;
- The team will additionally enable response to patients in A&E within 2-4 hours of referral and initiate admission avoidance intervention.
- The team will integrate with paramedic practitioners to support care homes to assess, diagnose and treat patients as an alternative to non-elective admission via A&E.

Outcomes

- *Reduced hospital admissions*
- *Fully integrated team responding appropriately to the patient's needs*

Metrics

- *Single access point into the team known to all patients with long term conditions*
- *Measurement of ability to obtain timely support*
- *% of care provision undertaken at patient's own home*
- *Response to known patients presenting to A&E within 2-4 hours of referral*

- *% patients with long term conditions known to the team*
- *% of admissions avoided from A&E*

b. Integrated rapid response team to support acute discharge and prevent readmission

- Enhanced Rapid Response teams supporting admissions avoidance as part of intermediate care provision as well as respond directly to A&E referrals
- The team will develop a robust integrated discharge referral service to support the patient in the first 5-7 days post discharge, by integrating with the hospital discharge planning processes and coordinating post-discharge support in the community. Medicines use will also be assessed in the first 5-7 days post discharge as this is a major cause of readmission.
- The teams will include medicine management support as well as medical leadership and input from hospital consultants to enable continuous support at home.
- The teams will integrate with the Dementia Crisis Service which can receive referrals 24/7 providing support 24/7 to patients with Dementia and carers of people with Dementia to prevent hospital or care home admissions

Outcomes

- *Reduced hospital readmissions*
- *Fully integrated team responding appropriately to the patient's needs*
- *Robust planned discharge process*

Metrics

- *% of eligible patients receiving support 5-7 days post discharge*
- *% of eligible patients receiving a medicines review 5-7 days post discharge*
- *% of readmissions of patients seen by the team*
- *Measure of response times*
- *% admissions & readmissions of patients with dementia*
- *Patient satisfaction*
- *Workforce measurements*

c. Flexible use of community beds and Westbrook House

- Care home beds (previously GP step-up beds) to be used as step-up beds for patients requiring a short-term intervention that would prevent them being admitted to secondary care. These beds will be used flexibly to effectively respond to changes in demand and may also be used as step-down beds to enable maximum occupancy.
- Westbrook house will be further developed as an enhanced step down facility to support patients for 6-8 weeks post discharge so that they can be returned, where possible, to their own bed and avoid social care placement

or re-admission. The Westbrook House team will be supported by a dedicated multi-disciplinary team, including therapists, social care and primary care input, to ensure timely patient flows.

Outcomes

- *Reduced hospital admissions*
- *Reduced hospital readmissions*
- *Avoidance of long term social care placements*

Metrics

- *% occupancy of step-up beds*
- *% occupancy of Westbrook House (Victoria Unit)*
- *% of readmissions of patients seen by the team*
- *% patients returning to their own home*
- *Measure of response times*
- *Patient satisfaction*

d. Falls prevention

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

SCHEME REQUIREMENTS:

Development of a local specialist falls and fracture prevention service

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

Local integrated falls prevention pathways

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

2. <u>Enhance Integrated Community Teams and Care Coordination</u>

This model builds community care teams wrapped around the patient at the centre to support and pro-actively manage their needs. The teams will be further enhanced to

ensure integrated working between GP practice, community and social care with specialist input from hospital, mental health and community services as required in order to keep people in their own homes. The teams will be aligned to every GP practice, will undertake Multi-disciplinary Team meetings and will include designated care coordinators for all patients.

Scheme Requirements:

a. **Risk Profiling to enable proactive care of patients who are at both high and low risk of hospital admission to deliver more coordinated patient care in the community**
   - Aligned to every GP practice the Community Integrated Care Teams will be available 24 hours a day seven days a week and will coordinate integrated proactive care management of patients through a multi-disciplinary approach with patient involvement at every stage of the process including the development and access of anticipatory care planning to ensure patient centred care and shared decision making;
   - The Community Integrated Care Teams function as integrated teams and provide continuity of care for patients who have been referred for support in the community and form the main structure in providing post hospital discharge care and some pre-admission interventions as well as seamless coordination and delivery of End of Life care;
   - Access into and out of the Care Teams will be coordinated through a clinically supported single access points. Patients who require assistance by more than one professional will receive coordinated integrated assessments;
   - Each Care Team will include input from the wider community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, and Social Care Managers as part of the multi-disciplinary approach;
   - The community services nursing model will ensure continuity of care by training the core team as "universal nurses" who will manage the majority of individual patient nursing needs, ensuring that specialist input is appropriate and timely
   - The teams will support patients with complex needs to better manage their health to live independent lives in the community, including supporting and educating patients with their disease management by using technology, for as long as possible empowering them to take overall responsibility for managing their own health;

Outcomes
- *Reduced hospital admissions*
- *Reduced hospital readmissions*
- *Avoidance of social care placements*

Metrics
- *% patients with a named care-coordinator*

- *GP practice and patient satisfaction*
- *% of admissions of patients seen by the team*
- *% patients needing coordinated integrated assessments*
- *Measure of response times and availability*
- *% patients using assistive technology*

b. Specialists to integrate into community based generalist roles

- The enhanced Community Integrated Care Team model requires specialist input from acute in the community to enable the management of care for more patients in the community for a range of specialisms including the care of the over 75s, this will include undertaking clinics and reviews of patients in or close to their own homes rather than in hospital. This could include actual and remote approaches supported through the use of technology.

Outcomes

- *Appropriate use of specialists out of hospital*
- *Reduced hospital admissions*
- *Avoidance of social care placements*

Metrics

- *Time spent on specialist caseload*
- *Training to universal team from specialists*
- *% of patients able to access hospital care in the community*
- *% of admissions of patients seen by the team*
- *% patients using assistive technology*

3. <u>Enhanced Primary Care</u>

Integrated community models of care centred on GP practices requires significant change in primary care working patterns. Different models need to be developed to ensure the right levels of support and capacity is available within general practice. This will include a hub of practices in every community to improve access to a full range of local health and social care services to support the move from a medical focused model of care and shifting towards a health and well-being focus.

Scheme Requirements:

a. Develop primary care based services with improved access and integrated with other community and specialist services

- GP practices to be clustered in hubs and configured in a way that enables different access opportunities for patients to include open access and access to other practices in the hub to improve responsiveness of service provision;
- Develop an approach which increases opportunities for patients to have their

wider health and well-being needs supported by primary care. This will require stronger integration with the integrated community care teams as well as stronger links with and signposting to the voluntary sector;

- Integrated primary care provision will have greater support from specialist hospital teams and stronger links with rapid response services to enable patients to remain out of hospital.

Outcomes

- *Improved ability for patients able to access primary and out of hospital care*
- *Improved responsiveness of service provision*
- *More patients seen by the right person in the right place*
- *Reduced hospital admissions*

Metrics

- *Access to primary care*
- *Patient satisfaction*
- *% of patients able to access hospital care in the community*

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

- Professionals in primary care will promote the use of integrated personal health budgets for patients with long term conditions and mental health needs to increase patient choice and control to meet their health and social care needs in different ways;
- Primary care and the Integrated Care Teams will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the community;
- The Integrated Care Teams will educate patients about preventative services such as weight management and alcohol services as part of the multidisciplinary assessment;
- Patients will be supported by the Integrated Care Teams and primary care to inform and take ownership of their care plans this includes electronic sharing of care records with the patient and between health and social care professionals;
- Improved signposting and education will be available to patients through care coordinators and Health Trainers to ensure patients are given information about other opportunities to support them in the community, including the voluntary sector, and community pharmacies.

Outcomes

- *Patients informed and empowered*
- *Improved health outcomes*
- *Reduced hospital admissions*
- *Avoidance of social care placements*

Metrics

- *% patients with a self-care plan*
- *% patients sharing electronic records*
- *Measurement of ease of all health and social care professionals to access patient records*
- *GP % eligible patients with a personal health budget*
- *practice and patient satisfaction*
- *% of patients using the voluntary sector*
- *Measure of response times and availability*
- *% patients using assistive technology*

4. Enhanced Support to Care Homes

Scheme Requirements:

In particular, we want to introduction of enhanced primary care support to care homes by aligning each home to a single practice, with clear requirements for the practice to assess and review residents and to ensure care management plans (anticipatory plans) are in place.

We intend to commission high quality End of Life Care (focus on Advance Care Planning) for patients whether they live in their own homes or in care homes.

Outcomes

- *Reduced hospital admissions from care homes*
- *Reduced hospital attendances for care home residents*
- *Reduced use of emergency services (SECAmb and IC24) by care homes*
- *Care homes feel better supported by general practice*
- *Improved skills and confidence of care home staff particularly around End of Life Care*
- *Increase in percentage of people dying in their preferred place*
- *Increased use of Share My Care (or any other agreed mechanism for sharing appropriate patient information), particularly for End of Life patients*

Metrics

- *Care home residents registered with an aligned practice (aiming for 80% by 6 months).*
- *Assessments of new residents*
- *GP visits to care homes (with purpose and number of residents seen/reviewed)*
- *Virtual consultations*
- *Care management plans completed for all residents who have at least one long term condition or who are frail*
- *Advanced care plans completed and kept up to date for all residents and patients thought to be in the final year of life*
- *Multidisciplinary meetings held*
- *Numbers of:*
    - *hospital admissions from care homes*

- *attendances at A&E from care homes*
- *emergency ambulance call-outs*
- *calls to Out of Hours service*

5. **Mental Health**

Scheme Requirements:

Improving the integration, service quality and outcomes for people with mental ill-health, based on recovery principles and to ensure health and social care needs and care package are regularly reviewed. This will include booking annual medication review and that patients get access to the right mental health service, in a timely manner. To increase the current capacity of the Primary Care Mental Health Specialists Pilot in Thanet to improve the identification and management of adult mental health conditions in primary care, including where this is secondary to a physical long term health condition.

Outcomes

- *Care received in primary/community setting*

Metrics

- *Reduced number of patients cared for in a secondary care setting through a shift to primary care management*

6. Dementia

Scheme Requirements:

Thanet CCG aims to improve the rates of diagnosis of dementia to 67% by March 2015. It is intended to establish a memory assessment service (KMPT) which will have close links to primary care, social care and other support services. Support for carers is a priority; all carers will be offered a carer's assessment.

Outcomes

- *Improved diagnosis rates*

Metrics

- *Referral rates to the memory assessment service*
- *Diagnosis rates*
- *Carer's assessments carried out and support packages agreed*

7. End of Life Care

Scheme Requirements:

A major opportunity to address some of the key issues for EOLC is through adoption of the new Long Term Conditions Agenda that incorporates the themes of risk-stratification,

integrated teams and self-care. The vision is for a unified data hub that integrates activity across all health and social care and a fully functional system which will enable early identification for those at risk of death, enable more accurate EOLC planning across a population and ensure health and social care are better coordinated and integrated with each other. End of Life Care (EOLC) should support people to remain independent where possible, allowing the final stages of life to be as comfortable as possible. The preferred location of death should be discussed with family and carers, with the choice being adhered to wherever possible. Many people do not wish to die in hospital and would prefer to die at home, but often this does not happen. Two-thirds of people would prefer to die at home, but in practice only about one-third of individuals actually do.

Outcomes

- *To enable end of life care in patients own home*

Metrics

- *To reduce the number of secondary care admissions for patients receiving end of life care*

Success factors and Outcome Measures

A number of outcomes measures have been determined for each of the schemes. These will be further fine-tuned in developing the CCG strategic commissioning intentions and in negation with major providers and key stakeholders.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The plans align with the delivery of Thanet CCGs 5 year strategy, as outlined. The majority of the NHS savings will be realised by the reduced emergency attendances and admissions and a reduction in length of stays within the acute setting and therefore there will be a reduced investment in secondary care.

The plans will not have a negative impact on the CCGs constitutional targets as set out in the Everyone Counts: Planning for Patients 2014/15-2018/19. The plans will support the delivery of some of these targets, in particular the A&E waiting times and the proportion of older people at home 91 days after discharge from hospital into Reablement/rehabilitation services.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Better Care Fund Management

The management, monitoring and delivery of the schemes will be supported by the Thanet Integrated Commissioning Group which will report progress to the Thanet Health and Well Being Board.

Measuring Delivery

The Better Care Fund schemes and metrics will be included within the body of the Integrated Quality and Performance Report which is a standing agenda item on the Operational Leadership Team. The Operational Leadership Team feeds into the CCG's risk register and any risk to delivery or expected outcomes will be included via output from the committee.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

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

Please explain how local social care services will be protected within your plans.

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

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

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

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

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

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

In Thanet the Universal Care Team is the main structure for providing post hospital care for any reason and some pre-admission intervention in the community.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The prime identifier across health and social care in Kent is the NHS number.

NHS

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

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

Social Care

A proportion of NHS numbers are held within KCC's Adult Social Care System SWIFT. Monthly batches of client records are sent to the NHS matching service (MACS) and if they can match to a single record on their system they return the NHS number which is uploaded into SWIFT.
The NHS number is predominately used to facilitate the matching of data sets for Year of Care and Risk Stratification, not for correspondence or to undertake client checks, the numbers are too low. We would use name: address and date of birth as the key identifiers at present. Further work will be required to ensure NHS number is used across all correspondence.
KCC achieved approx. 80% matching of records to NHS numbers when we started, improvement to this percentage would need significant additional resource.
The MACS service is due to close at some point (no date given yet) so KCC are in the process of transferring to the Personal Demographics Service (PDS).

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

N/A

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Thanet, along with all other East Kent CCGs, is committed to using the Medical Interoperability Gateway (MIG) as its preferred solution to interoperability. This is provided by a joint venture between EMIS and INPS Vision, in a company called Healthcare Gateway. Not only will this be within the CCG's Information Technology Strategy, ensuring all new systems utilise this technology, contracts with providers will also require a commitment of their agreement to utilise the MIG. Data sharing (with GPs as the data controllers) have been developed as have governance protocols for the viewing of patient identifiable data and patient consent. In the main consent will be requested at the point of treatment, but protocols are in place for patients who are

physically unable to give consent i.e. unconscious.

The project first stage is the integrated use with EKHUFT's A&E and pharmacy departments, stages 2 and 3 will widen this to other providers, as well as allow viewing of provider data at the GP practice site.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

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

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Risk Profiling

Thanet CCG has been running a Risk Stratification Tool which almost all practices are participating in. This involves multi disciplinary integrated team meetings for risk stratified patients with multiple co-morbidities. The aim is to improve patient's self-management, their quality of life, medicines compliance and reduce A&E and associated hospital admissions.

Through risk stratification the patients at highest risk of hospital admission and then works its way through the lower risk patients. This means that the amount of clinical time and intervention decreases with lower risk patients and there is an expectation that such intervention will go some way to preventing these lower risk patients from deteriorating as fast thus prolonging their health and quality of life over the long term.

Risk Stratification is delivered by a multi-disciplinary health and social care team undertaking joint assessments, clinically led by a GP, and jointly agreeing anticipatory care plans for every patients going through the programme. The GP remains the accountable professional for their patients.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability.	High	Each responsible organisation to develop a detailed workforce plan to support delivery of each scheme.
Different skills and training required across multiple professionals and organisations.	High	Training and skills requirements for each scheme to be linked to workforce plan to support the delivery.
Governance of the plans and the delivery of a fully integrated health and social care system should be clinically led and clearly defined.	High	CCG Primary Care Strategy to set out an agreed approach, which could include an Integrated Care Organisation, for overall governance of the plans.
Communication – need to ensure robust communication with the public and across organisations to ensure people know how to access services within the integrated system to ensure services are used appropriately	High	Robust communication plan to be developed to support delivery of each scheme.
IT systems across services not integrated and therefore do not enable shared care plans between organisations and support integrated outcome measurement and monitoring.	High	Integrated system to support sharing of care plans to be developed as a priority. Integrated performance monitoring and reporting to be enhanced to take into account all schemes.
Transition of service capacity changes to be planned and implemented in stages to prevent destabilising the system.	High	Detailed modelling required to fully understand impact on acute capacity and requirements of community capacity to inform transition over a defined period of time including investment and dis-investment requirements.
The investment required into primary care for the full benefits of the plan falls outside the remit of the pooled budget and sits with NHS England.	High	To be discussed with NHS England.
Cultural change – significant shift in how systems need to work in the future requirement large culture change	High	Ensure whole health and social care system has shared vision and values to

		enable the delivery of required changes. Communication with organisations, staff and service users to be included in communication plan.
Regulatory and legislative environment – current arrangements not always looking at how the overall system works	High	Provide feedback to NHS England on this issue via the Kent Pioneer Programme.