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	**<Name of Local Authority>**
Clinical Commissioning Groups	**Dartford, Gravesham and Swanley (DGS)**
	Swale
	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
Boundary Differences	DGS: While the local authorities of Dartford and Gravesham are co-terminus with the CCG boundaries, the Swanley area falls within the boundary for Sevenoaks District Council, with approximately 42% of the Sevenoaks district population within the DGS CCG boundary. Swale: Swale CCG represents approximately two thirds (78%) of the population of Swale borough council. local (CCG) health and wellbeing boards, as well as review by the Kent health and wellbeing board will ensure any gaps or issues are identified and minimised.
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
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	Dartford, Gravesham and Swanley CCG
By	Patricia Davies
Position	Accountable Officer
Date	<date>

Signed on behalf of the Clinical Commissioning Group	Swale CCG
By	Patricia Davies
Position	Accountable Officer
Date	<date>

<Insert extra rows for additional CCGs as required>

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

<Insert extra rows for additional Councils as required>

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

<Insert extra rows for additional Health and Wellbeing Boards as required>

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

The proposed plans are underpinned by work already in progress within North Kent (including with Medway CCG and Medway Council) to review and understand the current health and social care landscape and develop the local vision and sustainable plans for the future. As such health and social care commissioners, and health providers have been part of two Kings Fund facilitated workshops to review audit data from acute and community hospitals and agree key actions aimed at ensuring that people are treated within the most appropriate care setting for their needs. Workshops were held on 19th (DGS area) and 22nd (Swale / Medway area) November 2013 and the second stage workshops are planned for the 6th and 18th February.

In addition workshops to review these proposals have been held on a kent wide basis

(16th January) and North Kent (29th January) basis, which included health and social care commissioners and health providers.

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

These plans are i) aligned with the CCG commissioning plans; which are informed by stakeholder engagement – this is in the form of workshops which are open to members of the public, voluntary groups, local authority representatives, and health providers. Details of workshops held by each CCG can be provided. ii) Informed by patient engagement on a review of community services that took place in 2013. Information on the results of this engagement can be provided *Details re whole plan stakeholder engagement to be added.*

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**
Project plans in development	
Draft CCG Strategies 2014 to 2019	
Draft CCG Operating Plans 2014-2016	
Better Care Fund Vision document	

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.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

2.1 Our vision for whole system integrated care is based on what people have told us is most important to them (see appendix X). Through patient and service user workshops, interviews and surveys across Dartford Gravesham Swanley and Swale we know that what people want is choice and control, and for their care to be planned with people working together to help them reach their goals of living longer and living well. They want their care to be delivered by people and organisations who show dignity, compassion and respect at all times.

2.2 We recognise that realising this vision will mean significant change across the whole of our current health and care provider landscape. Whilst our GPs will play a pivotal role within this, all providers of health and care services will need to change how they work, and particularly how they interact with patients and each other. The CCGs and local authority commissioners who make up the North Kent Health and Social Care economy are committed to working together to create a marketplace, and to effect the required behavioural and attitudinal change in the acute sector, to ensure that this happens at scale and at pace.

2.3 We aim to provide care and support to the people of North Kent (Swale and DGS) in their homes and in their communities. We want to achieve a health economy that is sustainable for the future. Our vision is of primary, community, mental health and acute care services working seamlessly together , with local authority, voluntary, and other independent sector, organisations, to deliver improvements in both health and well-being for local people and communities.

2.4 We will:

1. Keep people at the heart of everything we do, ensuring they are involved and listened to in the development of our plans
2. Maximise independence by providing more integrated support at home and in the community and by empowering people to manage their own health and well-being
3. Ensure the health and social care system works better for people, with a focus on delivering the right care, right time, right place, providing seamless, integrated care for patients, particularly those with complex needs
4. Safeguard vital services, prioritising people with the greatest health needs and ensuring that there is clinical evidence behind every decision.
5. Get the best possible outcomes within the resources we have available; delivering integrate services wherever possible to avoid duplication

3.0 <u>Our vision - What this will mean for our health and social care services</u>

3.1 Effects on services

We think it is important to be clear about what this will mean, especially because this is not new investment in the system, but a re-organisation of existing funding and services. There is likely to be an increase in the support available in the community through an investment in early intervention, and by managing demand in this way, a decrease in the need for more

intensive social care support or health support at acute level, with corresponding changes in acute services. We will be working towards single health and social care assessments that will require a much closer level of integration between primary health (GPs), community health (e.g. district nursing, physiotherapy), mental health (e.g. primary care mental health workers, dementia nurses), social care (support to live independently), and local authority (housing, benefit services) so that these services can identify, support and intervene much earlier to prevent a crisis occurring or someone feeling they are unable to access the support they need.

This will require a different way of working from our service providers and will require us to develop an infrastructure that will allow both the voluntary and community sectors to play a greater role of supporting people more effectively in their communities. If we are successful, funding for unplanned admissions to hospital will be reduced because people will not need to go to hospital in the same numbers as they do at the moment, and lengths of stay will be shorter.

This is easy to say and hard to do. Recognising that the way that change is done is as important as the change that is aimed at, the next four principles set out 'rules' we are proposing to govern what we do to achieve this vision.

b) Aims and objectives

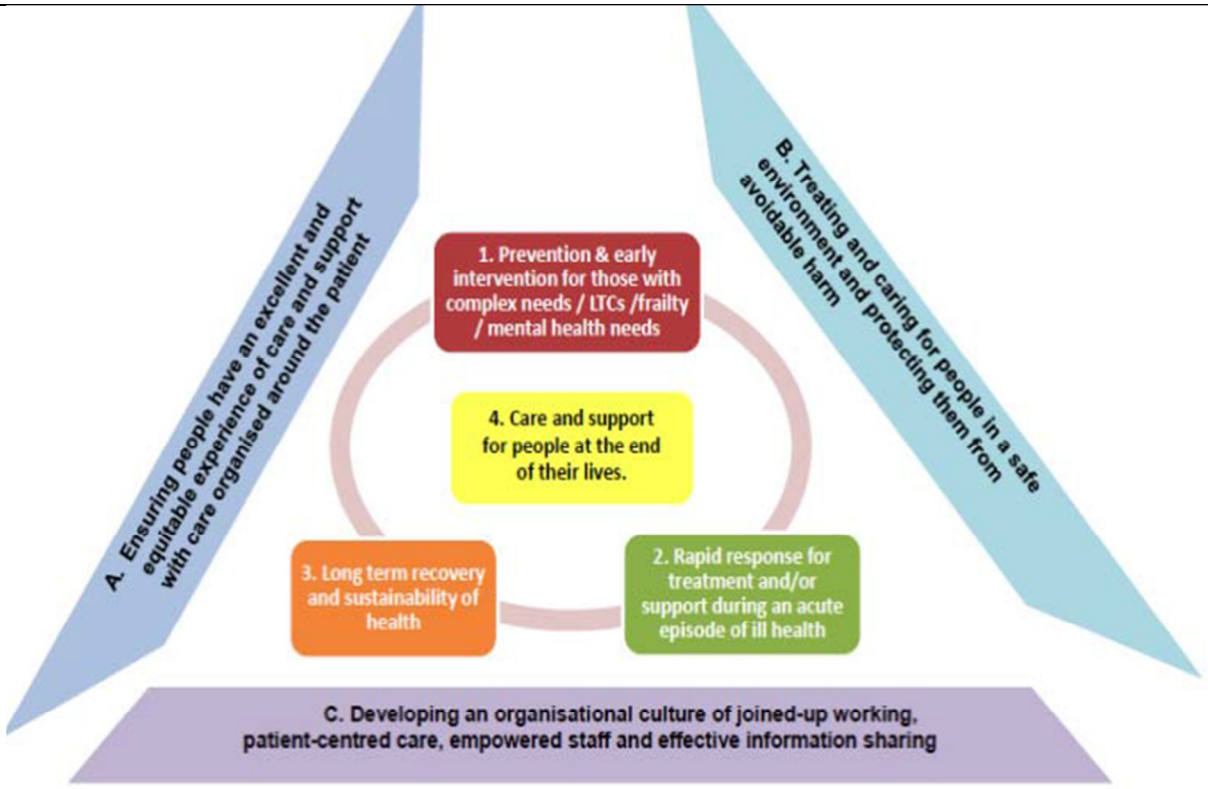
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- 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?

3.2 Measuring success

We will measure our success primarily by analysis of demand for acute health services (such as emergency bed days) and formal social care services (such as a paid agency carer supporting someone at home, or someone moving into residential or nursing care home), using current levels of demand as a baseline (and allowing for the impact of demographic change so the 'baseline' keeps pace with population change and growth). We will build on the Outcomes Framework which has been developed to support the CCG. This has a major focus on patient and carer experience, and triangulating data from several sources to measure outcomes. The Outcomes Framework structure is shown in the diagram below

NHS Outcomes Framework Domains



We will also use other measures that show us whether the system is effective, such as delayed transfers of care, the effectiveness of short-term recovery-focused services like reablement, and patient and user experience of services. We will therefore seek to deliver services that have a positive impact as measured by these measures.

3.3 This strategy is based on 3 core principles:

i. People will be empowered to direct their care and support, and to receive the care they need in their homes or local community.

ii. GPs will be at the centre of organising and coordinating people's care.

iii. Our systems will enable and not hinder the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system

To achieve this we are engaging with local health and care providers, and associated public, private and voluntary and community sector groups, to “co-design” models of care that will engage with and meet people’s aspirations and needs. The following sections provide a summary of what this will mean, in practice, and the specific BCF investment areas for the next 2 years that will deliver on our aims and objectives.

3.4 Open, Honest and evidence-based

It is recognised that the basis of the funding for the Better Care Fund is money that is already committed to health and social care services of many different types. Some services will need to change to support the aim set out above, others will need stability. Discussions should be open, honest and evidence-based in order to make sure we use the money in the best way.

3.5 Early intervention and supporting independence

The plans set out in the Better Care Fund should align with existing or developing strategies, such as the CCGs, Kent County Council and Local Authority Strategic Plans, including the Kent Health and Well-being Strategy, Pioneer plan and Health Inequality plans. A key principle of all of these strategies is that people experience the best outcomes when they are able to live independently at home, and supporting them to do so will be a theme throughout all proposals in the Integration Plan. There will be other important themes, including coherence and integration of services, the importance of identifying vulnerability and acting to prevent deterioration, ensuring professional judgement is valued and free to be flexible, and that services are person-centred.

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

4.0 A Proposed Model

4.1 We are proposing to develop the model over the next five years recognising the work that has been done over the last year. Evidence suggests that successful models of integration are both vertical and horizontal and require therefore time, system leadership and education to emerge and develop fully. This should not be under-estimated. Successful models for example Torbay, Trafford and Canterbury (New Zealand)all demonstrate success over a gradual period, based around iterative service improvement that constantly evaluates and adapts the model to achieve the greatest success and outcomes. We understand the need for pace and the financial climate dictates that the system needs to change in the short, medium as well as the longer term. There is a commitment from the whole system, to deliver quick wins now, to release funds and create operational head-room to provide the foundations for the next stage towards full integration. We will design and commission new system-wide models of care that ensure the financial sustainability of health and social care services; a proactive, rather than a reactive model that means the avoidance of emergency hospital and care home admissions. We will build on our current plans with providers, KCC and North Kent District Councils, to deliver the critical transformational changes required to deliver the key priorities identified by our public and patients. These will include;

f) **A united approach to advice and information on community and public sector services.** This will include developing robust and reliable sources of advice and support for older people before they become frail or need to access the statutory system; and providing universal information and advice about services from all partner agencies, which should be quick to access, clear, friendly and personalised. This will include developing access to transport for vulnerable people who need it to prevent social isolation and access to medical appointments.

- **Integrated Primary Care Teams - GPs will be at the centre of organising and coordinating people's care.** We will invest in primary care, through the reconfiguration of enhanced services and the secondary to primary care shift / shared-care and funding arrangements with other providers. We will ensure that patients can get GP help and support in a timely way and via a range of channels, including email and telephone-based

services. The GP will remain accountable for patient care, but with increasing support from other health and social care staff to co-ordinate and improve the quality of that care and the outcomes for the individuals involved.

We will deliver on the new provisions of GMS, including named GP for patients aged 75 and over, member practices determining the model for out-of-hours services, which should be integrated and as seamless as possible with main stream primary and community services. Flexible provision over 7 days will be accompanied by greater integration with mental health services, and a closer relationship with pharmacy and voluntary services. Our GP practices will collaborate in networks focused on populations between 10,000 and 20,000 within given geographies, with community, social care, mental health and specialist services, organised to work effectively with these networks. A core focus will be on providing joined-up support for those individuals with long-term conditions and complex health needs.

We expect the core team that will function around the GP network to be as follows:

- Generalist District Nursing Service (see specification attached). This will include District Nursing sisters who will act as case holders and managers working with and delegating work to their team of registered staff nurses, health care assistance / re-ablement workers, using peripatetic skills across therapy, nursing and social care.
- Named Social Care Workers (inclusive of enablement and re-ablement)
- Primary Care Mental Health Practitioner (see job specification attached)
- Primary Care Dementia Practitioner (see job specification attached)
- Primary Care Health Visitor linked to vulnerable adults using public health skills (NHS England responsibility)
- Health Trainers and Health prevention workers
- We would expect District Nurses would provide end of life care but access hospice and palliative care specialists (on discussion with GP and the MDT as required)

The core team would have strong working links with community support services using third sector providers such as the voluntary sector and District Councils to ensure full packages of care are provided to meet the needs of the patient, carers and the wider community.

We would expect the acute sector and specialist clinicians to work increasingly flexibly, within and outside of the hospital boundaries, supporting GPs to manage complex needs in a “whole person” way. In particular we see acute geriatricians, respiratory consultants and diabetiologists supporting risk stratification and maintenance management as required. Assistive technology, telecare and telemedicine will be more effectively used to support patients to be independent.

g) **Investment in community capacity as described above, to enable people to meet their needs with support in their local community.** The integrated primary care teams will be based around the General Practice networks and focused on the needs of patients. They will deliver robust rapid response where this is appropriate, long term condition management, geriatrician, mental health and social care support. They will actively support GP practices to identifying people who are at risk of admission to hospital or residential / nursing home care where indications are that, with some immediate intensive input and support, such admissions can be avoided. They will work seamlessly with the Acute Hospital and social care, through the integrated discharge team, to ensure that patients receive the treatment they need and are rapidly discharged with health and social care support to return back to independent living. Assistive technology, telecare and telemedicine will be more effectively used to support patients to be independent and they will be actively utilised in care homes with support to enable patients to be managed when

in acute crisis.

Rapid Response services 24/7

Local Referral Unit / Crisis response (Community Based) – This will focus on admission avoidance and where possible attendance avoidance, where patients either known to the system or unknown, have reached crisis point. It is anticipated that through more robust integrated community work, that the number of patients unknown will be reduced. However, it is accepted that patients ill have long term and enduring conditions that will require rapid response at times of acute need. Similarly, people without long term conditions, may require time-limited support to prevent exacerbation of an acute health or social care episode. This team will be centralized to cover a greater geographical area than for GP networks, to ensure effective use of skills and resources. However, there will be strong links between the Local Referral Units and networks. For example, acceptance of each other's assessments and referrals.

There will also be an improved approach to crisis management and recovery. Supporting rapid escalation and action when a crisis occurs in the life of an older person; this is likely to involve a coordinated response from all agencies working in multi-disciplinary teams, 7 days a week, to provide intensive support in the short term and encompassing services such as respite care and supportive discharge planning. Support should focus on ensuring that when the crisis is over older people and their carers remain as independent as possible and avoid short term crises triggering a deterioration which leads to long term health or social care need.

The team will comprise:

- Duty Social worker / case managers
- Nursing Staff
- Therapy staff (minimum OT and Physiotherapy plus technicians and re-ablement workers)
- Access to domiciliary care to provide 24/7 support as required
- Crisis Mental Health Teams (including functional and Dementia)
- Clinical assessment utilizing specialist nurses, paramedic practitioners and roving GPs

- **Integrated Discharge Team (Hospital in-reach and links to LRU for early supportive discharge and admission avoidance. 7 days per week (8am – 10pm) –** (See attached specification and Heads of agreement)
-
- **Community Hospital Re-design and Estate reconfiguration using evidence for the Oaks Group and Kings Fund.** It is accepted that the current community hospital resource is not fit for purpose or utilized appropriately. Re-profiling of beds and criteria is required, in line with the Kings Fund work which includes the definition of medical cover required to support any non-acute bed based facility. Community Hospital services will become integrated health and social care centres that will enable patients to receive the appropriate rapid support that they need.

  A joint accommodation strategy and implementation plan is required, with appropriate range of accommodation available. This needs to include, care for vulnerable adults needing accommodation and care input, including those with dementia, learning or other disability or with mental health needs unable to remain in their home such as extra care housing. Extra care provides the security of having your own home as well as the availability of having care on site. This will include health and social care centres running

within community hospitals.

h) **Coordinated and intelligence-led early identification and early intervention.** Implementing community record and information sharing between the range of organisations supporting individuals at risk of requiring more support in the future. Ensuring that the workforce are able to feed back as much intelligence as possible as to the needs of the service users they are supporting and how service delivery and deployment of available resources can be improved.

6.0 How will we know if we have achieved our vision?

6.1 GPs, community health workers, social workers, housing workers and other professionals in the health and social care system should expect and will work more closely together with the express intention of supporting the patient or service user to require as little support as possible to live independently. This is likely to involve a single assessment process, a joint care plan, and system-wide common ways of identifying risk and measuring outcomes. There will be trust between organisations to help the patient or service user make good decisions about what support they need next, and all agencies will work cooperatively and understand that getting things right for the patient or service user is in everyone's interests. They should have wide room for professional judgment, and wherever possible make preventative interventions to stop deterioration, even if that intervention is more expensive in the short term. They will be able to access more information about the patient or service users support from other agencies, and they will make time for working together.

6.2 Hospital staff will expect to see proportionately fewer frail and elderly patients. This does not mean that these service will not be required. The skills of key physicians and, in particularly geriatricians, will extend into the community. This is supported by the recent report published by the royal college of physicians, which recognises the value of such skills within the community. Hospitals need to recognise that delivery of care is not and should not be confined to beds within an institution, but delivered in a number if settings to support and maintain independence. We should, therefore, see a reduction in the number of unplanned admissions of other adults with social care needs. They will work closely with professionals who are based in community services, whether that is medical, social, housing or voluntary. They will have access to more information about patients, including non-medical involvements by other services, and they will use this information to help them make good decisions with patients about the most appropriate care for them. Sometimes, this might mean not treating people in hospital, and community based services will be easier to access and take on complex cases.

6.3 Primary and community care services will be working closer together, along with voluntary organisations and other independent sector organisations.

6.4 People will get the 'right care, in the right place at the right time by the right person'. We will measure the success of this by measuring if there has been a reduction in the time people currently spend waiting for a service.

6.5 Pressure on the acute hospitals will reduced, we will see fewer acute emergency / non elective admissions and reduced length of stay.

6.6 We will see more people remaining in their own homes and a reduction in care home admissions, and people will be living more independently following re-ablement and / or intermediate care, taking into account the increase in population. We will see;

3) People and particularly those patients with long term conditions accessing support and information to manage their own health and social care to proactively prevent

deterioration of their condition

4) Carers supported and they will have access to services that enable them to manage their own health.
5) Feedback from people with long term conditions demonstrating that they feel more enabled to manage their health
6) Ill Patients having improved experience and feeling supported to manage their health and social care.
7) Easier access to information, advice and guidance will be available.
8) Increase in the early diagnosis and intervention for the highest impact conditions identified within the health inequalities documents, CVD, diabetes and dementia being the highest.

6.7 Given the growth in NK population in general and in particular within the elderly (over 85) cohort we will and should see a growth in activity in some areas to provide active intervention earlier on. We should, therefore, see a reduction in non-elective care that often results in expensive reactive care. By intervening earlier we provide the individual with the greatest opportunity of self-management and therefore reduced long term multiple care inappropriate to need.

6.8 This paper sets out a vision for use of the Better Care Fund, to bring together all of the public agencies that provide health and social care support, especially for older people, to co-ordinate services such as health, social care and housing, to maximise individuals' access to information, advice and support in their communities, helping them to live as independently as possible in the most appropriate setting.

6.9 The vision sets out a range of principles that we think are important to how we will use the Better Care Fund in North Kent. The King's Fund emphasises that it is important to find common cause care matters, and put together a persuasive vision to describe what integrated care will achieve. We would like this paper to start this conversation.

6.10 We have not set out any specific projects in detail. There are many other projects already up and running that need to be progressed and monitored to ensure that they deliver the transformational changes required. This paper sets out the vision and principles that we believe are important to deliver an integrated system that provides the right care for patients within the extremely tough economic environment.

7.0 Suggested Metrics for development?

- **Reduction of emergency admission by minimum of 15% from a 2012/13 baseline** (significant progress in 14/15 – link to the Oaks group Non-qualified admissions of reduction by 10-15%). The expectation is that there will be a significant decrease in patients attending and being admitted non electively for specifically HF, CVD, COPD, diabetes, which are the areas for highest inequalities.

- **Increase in the number of patients discharged from A&E with support** and reduction in the number of patients re-attending. (80% w/e 12th Jan)

- **Reduction in Length of Stay per speciality** to within a minimum of HRG trim point per condtion.

- **Primary care – 80% over 75yr and those with complex needs have an accountable GP** and have been reviewed to understand their needs and packages of care (funding for practices plans of £5/head for each practice. Clear specification for the management of patients in care Homes.

- **Patient experience** – identifying that patient accessing greater support that manages

their condition

- **Increasing the number of patients who die in their place of choice.** Increasing the number of patients to 90% who are at the end of life stage to be on the end of life care register and have agreed plan in place with all relevant providers of their care.

- **Increasing the % of patients diagnosed with dementia from 50% to 65%** with 90% having an agreed treatment plan in place and enacted with appropriate professionals and voluntary sector support.

- **Increase in the number of patients receiving planned care for HF, CVD, COPD, diabetes**. (Note in order to support the reduction in the more expensive non-elective admissions.)

- **Integrated Primary Care Teams within the defined locality areas,** including acute physicians, community nursing and therapy, mental health and social care, resulting in the total achievement of non elective reductions, care home reductions, mental health placement reductions. We see this as the enabler to the achievement of the above metrics.

- **To achieve the financial efficiencies defined**, and operate within designated financial envelope for health and social care.

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 key implication for the Acute sector will be the reduction of non-elective admissions (NEL), based on audit work undertaken across North Kent by The Oak Group and The Kings Fund this ambition is set at 15% over two years:

- For DGS CCG this results in reduction in cost of NEL admissions of £8m (4.1m in 2014/15, and 3.9m in 2015/16).
- For Swale CCG this results in reduction in cost of NEL admissions of £2.9m (1.5m in 2014/15, and 1.4m in 2015/16).

e) Governance

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

How we will govern and manage these developments?

Across North Kent, we have invested significantly in building strong governance that

transcends traditional boundaries. The Health and Wellbeing Board and the local health and Wellbeing Board are maturing and our transformational plans and programmes are formally discussed and approved at local borough governance levels within each local authority and CCG. We have established regular meetings to discuss and agree strategic commissioning priorities.

9) NATIONAL CONDITIONS

a) Protecting social care services

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

Central to these plans is the need to build capacity and resilience into all health and social care teams, by making best use of sharing information and resource, and use of technology to streamline processes.

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

All proposed schemes include the need to ensure that integration between health and social care providers is central to delivering the overall aims.

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.

Multiagency Executive Programme Boards are in place within the DGS and Swale/ Medway care economies. These boards consist of Senior level representation from health and social care commissioners, and health providers. Within these Boards, key programmes have been agreed and are monitored. This includes the delivery of schemes to reduce emergency admissions and facilitate discharge of patients, as outlined within the Urgent Care plans for each area, and funded during 2013/14 by additional winter funds.

These schemes include the implementation of an Integrated (social care, acute and community, GP, mental health) Discharge Team who are based within the local acute Trusts 7 days per week to reduce emergency admissions and facilitate patients discharge. Monitoring is in progress, and the CCG has committed to continue commissioning this team while impact can continue to be demonstrated.
In addition, emergency care redesign projects are in progress within the local Acute Trusts to ensure consultant level leadership is available with Emergency Departments 7 days per week.

As part of the existing governance structure between CCGs, social care, local authorities and KCC (through a number of routes but predominantly through local and County level health and well being boards), a joint Executive Level Strategic Commissioning Group has been established across North Kent, including KCC, CCG, health provider and Health and Wellbeing Board representation has been established, to set the strategy for the BCF plans, and review development and implementation.

c) Data sharing

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

A proportion of NHS numbers are held within KCC's Adult Social Care System SWIFT.

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

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).

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))

Yes

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.

Yes

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.

We will be working towards single health and social care assessments that will require a much closer level of integration between primary health (GPs), community health (e.g. district nursing, physiotherapy), mental health (e.g. primary care mental health workers, dementia nurses), social care (support to live independently), and local authority (housing, benefit services) so that these services can identify, support and intervene much earlier to prevent a crisis occurring or someone feeling they are unable to access the support they need.

Joint plans will be implemented through the integrated neighbourhood teams and as part of implementation of the new GMS contract. This will include support for people with both physical and mental health, especially dementia, needs.

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
Workforce – issues with recruitment across all sectors due to proximity to London / aging workforce		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 processes releasing capacity.
Financial impact on NHS Providers		To be considered through contract negotiations.
Failure to deliver the reduction in acute emergency admissions		Detailed BCF plan and project management approach to implement n System changes and monitor impact