Updated November 2014

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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	**Thanet CCG**
Boundary Differences	**No Boundary Differences**
Date agreed at Health and Well-Being Board:	**17th September 2014**
Date submitted:	**13th September 2014**
Minimum required value of BCF pooled budget: 2014/15	
2015/16	**£9,698,000**
Total agreed value of pooled budget: 2014/15	
2015/16	**£9,698,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**Thanet CCG**
By	**Hazel Carpenter**
Position	**Accountable Officer**
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) 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**
Joint Strategic Needs Assessment	**http://www.kmpho.nhs.uk/commissioning/needs-assessments/**
Kent Health and Wellbeing Strategy	**http://www.kmpho.nhs.uk/commissioning/needs-assessments/**
Kent Integrated Care and Support Programme Plan	**Pioneer Delivery Plan**
HWB Assurance Framework	**https://democracy.kent.gov.uk/documents/s45113/Item%206%20Assurance%20Framework%20mv%202.pdf**
Kent HWB BCF Mapping Exercise	**Summary included**  HWB analysis template.xlsx
Kent Summit Schedule	
Kent HWB Paper 26 March 2014	 140326 BCF HWB report v2.docx
Thanet CCG 5 year Strategy	**www.thanetccg.nhs.uk/EasysiteWeb/getresource.axd?AssetID=371546**

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

At the start of 2013 we set out our vision for healthcare in Thanet for the next five years:

'To transform 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 our local communities to be ambitious about their own health and to challenge us to commission the best possible care in the best possible environments within our resources.'

We have made good progress towards delivering this vision in the first year of operation but in developing as a commissioning organisation it has become clear that the challenges we face cannot be met by simple step changes and that to achieve the high ambitions we have there needs to be significant transformational change if we are going to deliver the improvements we are committed to making.

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.

There are serious challenges for our local population. Of the twelve local authorities in Kent Thanet is the most disadvantaged. Nationally it is the 49th most disadvantaged locality. Within Thanet deprivation is more acute in some areas, 25 of the 84 Lower Super Output Areas (LSOAs) are amongst the top 20% most deprived areas in England.

The impact of this deprivation is seen in the health outcomes for the people of Thanet. The difference in the number of years between highest and lowest life expectancy at birth by electoral ward is 12.1 years.

The population of Thanet also differs in composition compared to the rest of England. Thanet has the highest levels of births compared to the rest of Kent and Medway and the over 65 population is higher than the rest of England the impact of this is discussed later within this document. In contrast Thanet's population exhibits a considerably smaller proportion of under 50s compared to the England profile.

Our 5 year Strategy underpins our commitment to the Kent Joint Health and Wellbeing Strategy we want to ensure:

- **Every child has the best start in life**
- **There is effective prevention of ill health by people taking greater responsibility for their health and wellbeing**
- **The quality of life for people with long term conditions is enhanced and they have access to good quality care and support**
- **People with mental health issues are supported to 'live well'**
- **People with dementia are assessed and treated earlier, and are supported to live well**

Our local service users have given us a very clear mandate. They want to receive seamless care delivered by the right professional at the right time in the right setting. They want to be empowered to take control of their own healthcare and they take great pride and show a strong allegiance to local health and social care services.

What is clear is that no single agency working in isolation can deliver the improvement required for our population and through our combined efforts we are determined to deliver the improvements the Thanet population expect. The Better Care Fund offers the opportunity to do that.

Too often care is fragmented with patients confused by the 'system' and subject to contact from multiple professionals. Care across providers is fragmented with information not shared across services. The challenges of an aging population and providing care to a population with significant inequalities means we have to work smarter.

Over the next five years our vision is to empower the individual to take more control of their own health. To allow an aging population enjoy independence for as long as possible. When they need to access services care will be joined up ensuring the right care is delivered by the right professional.

Through an integrated risk stratification process we will target the groups at higher risk of unplanned admission as described in section 3 of this document.

We will see GPs taking the lead for care co-ordination. Practices will come together in local alliances to share resources allowing integrated teams to work together to wrap care around patients. Community care will be delivered through a single point of access by professionals who have access to relevant patient information to allow them to deliver the right care. Support to carers will be an integral part of our planning acknowledging the key part they play in supporting patients to be as independent as possible.

When patients require inpatient care it will be seamless and co-ordinated from admission to discharge and providers will work together to ensure the main goal is to ensure patients are supported to regain their health and independence as quickly as possible. Where equipment is required to support re-ablement this will be delivered through a more integrated approach.

As people come to the end of their lives we will aim to deliver end of life care through seamless support in the place of their choice.

b) What difference will this make to patient and service user outcomes?

There is no simple solution to the challenges we face. It will take commitment and co-ordination. During the next five years we have set ourselves some realistic and measurable goals that will demonstrate we are making progress. Over the next five years we expect to see:

- Patients will be empowered to take control of their own health and supported to live independently

- A reduction in treatment of patients in hospital where it is appropriate to provide care within the community, particularly for the frail elderly. By 2016 we aim to reduce unplanned hospital admissions by 3.5%.

- Ensuring 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 supported by a multi-disciplinary team of professionals as required.

- A 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

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Within our overall 5 year strategic plan we have set out a clear vision of how services will look in 2019/20 informed by discussions with our local population and other stakeholders.

- A smaller 'hotter' Acute Hospital
- High quality Integrated Urgent Care provision
- Integrated community, primary and social care teams with a single point of access and rapid response capability 7 days a week
- GPs will be the care navigators
- Organisational boundaries will be invisible with care moving around the individual not the other way round
- Access to mental health services will have parity with main stream NHS provision to provide locally appropriate services based on the needs of our population funded at an appropriate level
- Children's services will be integrated across health, social care and education. The commissioning of these services will be achieved through pooled budget arrangements and joint management

We are clear that the Better Care Fund is a key enabler to help us deliver this change. Through the Better Care Fund we will:

- Develop services collaboratively across all service partners
- Ensure services are clinically 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

We are clear that the proposals set out in this plan are just the beginning of the journey. Initially we will focus our efforts on enhancing GP services. By wrapping services around distinct geographical units of primary care. We will work to remove the barriers that prevent professionals working together and ensure that relevant information is shared between professionals.

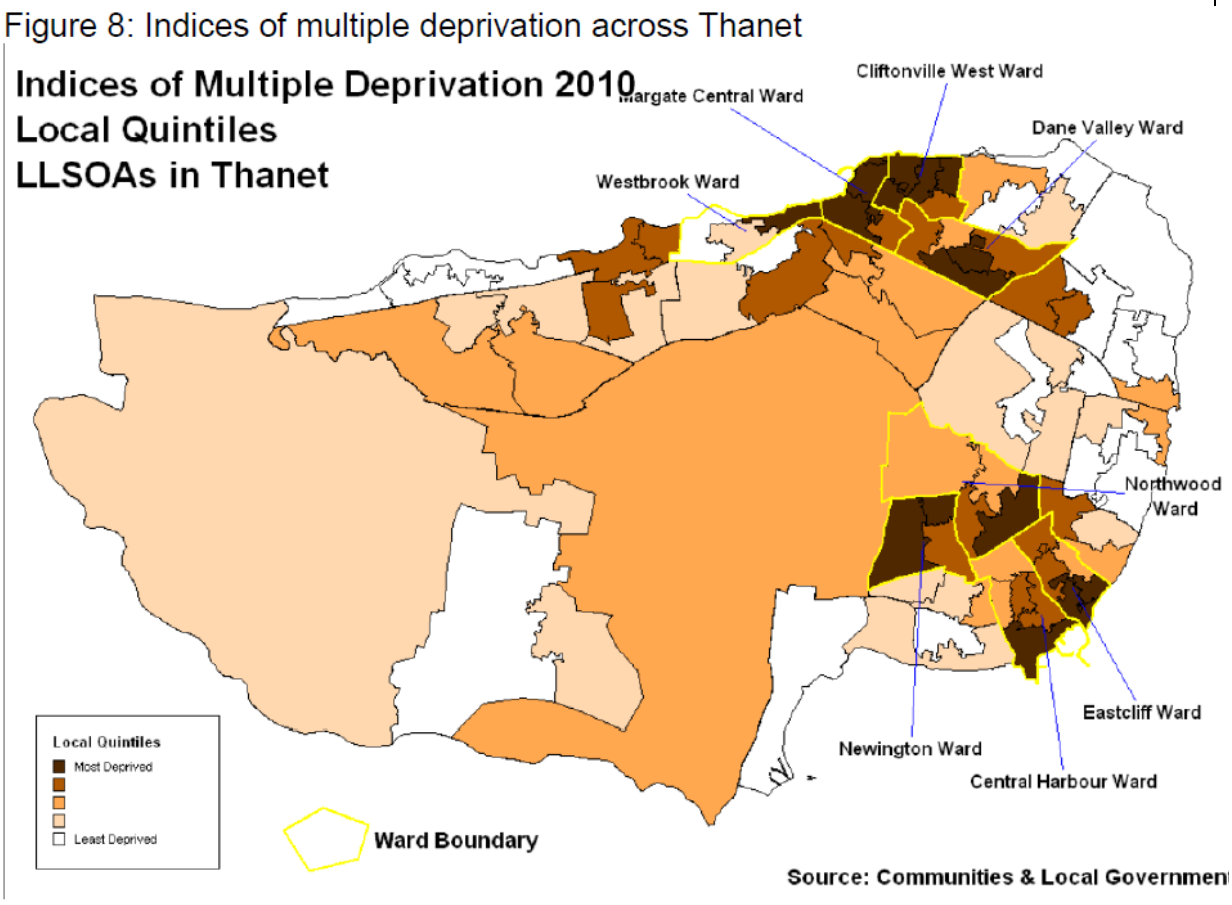
3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

In July 2013 in conjunction with Public Health and Social Care Colleagues we undertook a risk stratification process to understand better the needs of our local population and to inform our 5 year Strategic Plans. The key findings are included in Annex 3 of this plan.

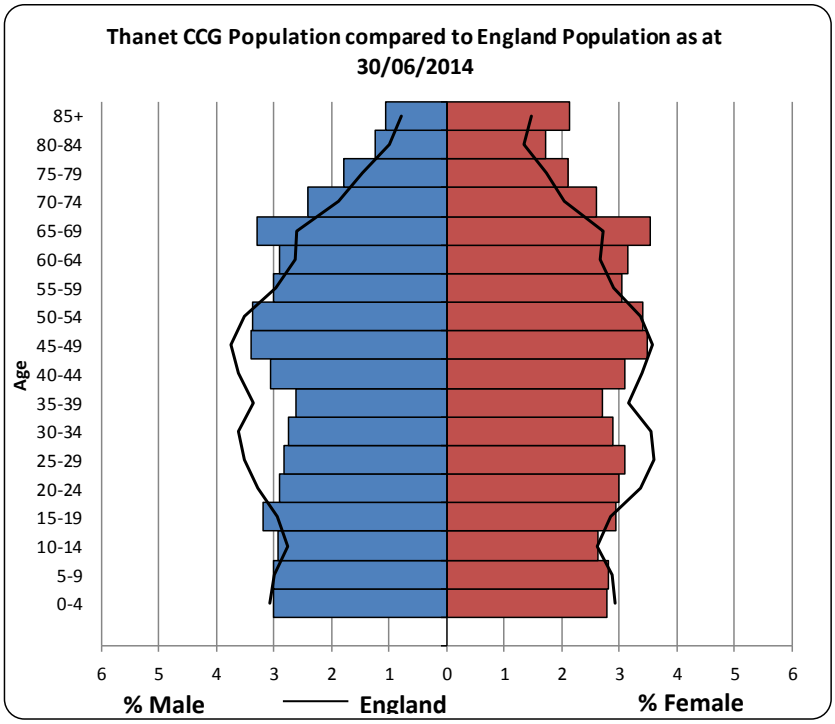
Of the twelve local authorities in Kent Thanet is the most disadvantaged. Nationally it is the 49th most disadvantaged locality. Within Thanet deprivation is more acute in some areas, 25 of the 84 Lower Super Output Areas (LSOAs) are amongst the top 20% most deprived areas in England.

Figure 8: Indices of multiple deprivation across Thanet



The population demographic of Thanet is also significantly different compared to the rest of England. The over 60 population is significantly higher than the England average. Whilst conversley the population between 20 and 50 is below the English average.

Population pyramid



10% of Thanet's population are over the age of 75 years. For the whole of England this age group represents 7.8% of the population.

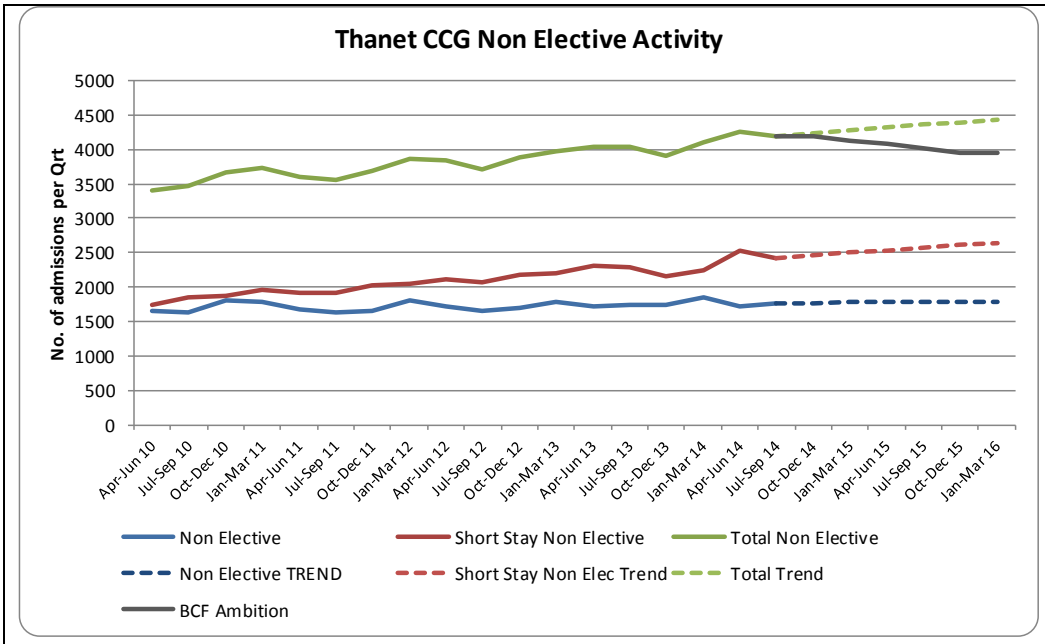
There is an additional challenge to the CCG as it faces a relatively high aging population when compared to England averages (22% of the population in Thanet are over 65 years old whereas the England average is 17%)

In measuring the impact of the Better Care Fund Thanet has set itself a target to reduce unplanned admissions by 3.5%.

By convention some unplanned admissions in those with ambulatory care conditions are those thought to be avoidable.

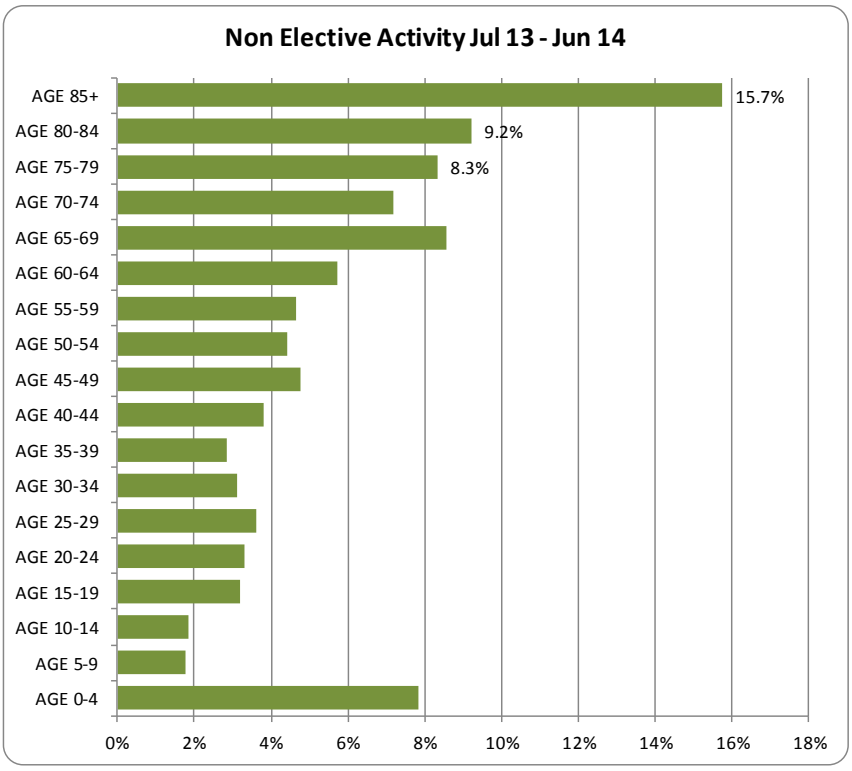
In the UK, 40% of hospital admissions were unplanned. Over the last decade emergency admissions have risen by more than 30%. The majority of such bed days were utilised by those aged 75 or over. The frail and elderly with co morbidities accounted for a disproportionate majority of those attending hospital. Although labelled emergency admissions and frequently the result of a crisis, the root causes of such admissions may not have been always unavoidable crises.

The risk factors for admission appear to be socio economic with deprivation and lower educational attainment being major contributory factors. Proximity to an Emergency Department also influences admission rates with asthma admissions being higher by 12% for each kilometre less from the Emergency Department.



Short stay non-elective admissions are in growth and represented around 57% of non-elective admissions in the last year.

Age

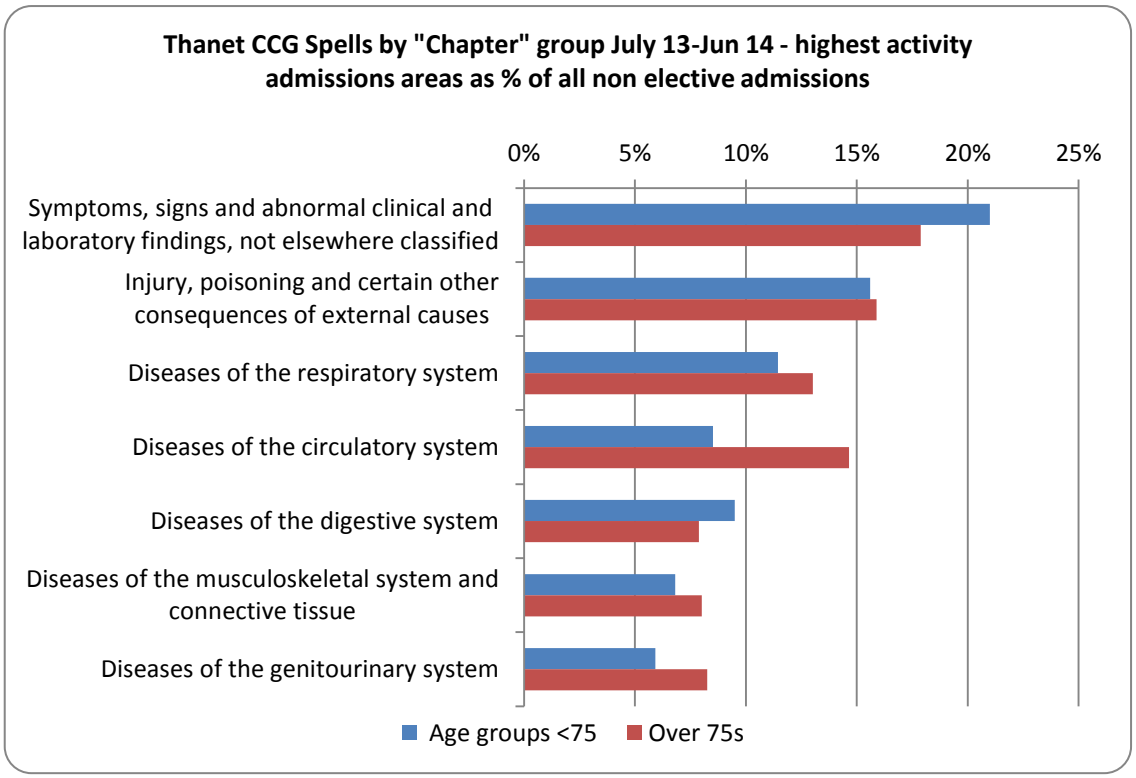


It can be seen from the chart above that a third of all non-elective admissions are with patients over the age of 75. (with a cost of over £11.5m)

In the last year a quarter of Thanet's over 75s population have had an emergency admission to hospital.

Of the 5428 admissions in the over 75s the actual number of patients were 3382 (an average of 1.6 admissions per patient).

Highest causes:



Note: 66% of highest category results in “no procedure”.

Of “injury, poisoning and certain other consequences of external cause” there does appear to be a large proportion of treatments in this area that may be attributable to falls. Table shows:

	No. of admissions in over 75s		
Injury, poisoning and certain other consequences of external causes	863		
diagnostic description	**No. of admissions**		**Cost**
Fracture at wrist and hand level	6		£5,890
Fracture of femur	212		£1,095,666
Fracture of foot, except ankle	4		£8,271
Fracture of forearm	42		£78,776
Fracture of lower leg, including ankle	30		£74,141
Fracture of lumbar spine and pelvis	35		£66,179
Fracture of neck	4		£12,856
Fracture of rib(s), sternum and thoracic spine	10		£16,489
Fracture of shoulder and upper arm	29		£56,025
Fracture of skull and facial bones	7		£18,089
	379	43.9%	**£1,432,382**
Intracranial injury	38		£69,599
Superficial injury of head	74		£39,463
Open wound of head	89		£89,086
	201	23.3%	**£198,148**

Falls Prevention

Nationally the NHS Confederation suggests that a Falls prevention strategy could reduce the number of falls by up to 30% and that effective falls prevention schemes can be implemented at little cost with the involvement of professionals working in health, social care and the community.

Education for COPD Patients

A review of evidence suggests that education (patient and health care staff) through encouraging and supporting self-management in reduce hospital admissions in COPD.

Specialist clinics

Heart failure patients benefit from specialist clinics, which reduce admissions after 12 months.

End of Life

Of the over 75s with an unscheduled admission to hospital 400 died at hospital of which 235 died within 1 week. The cost of treatment in hospital for these patients was £585,000. It has been demonstrated that early palliative care and implementation of care plans with support to patients and family reduces unplanned emergency admissions for terminal care and deaths in hospital.

Factors associated with General Practice

There is very strong evidence that the nature of general practice services in an area have an effect on admissions.

These include the range of services a practice offers (usually associated with size) and the ratio of patients to practitioners. The presence of GP trainers were also associated with lower admission rates.

Out of hours care

Changes in provision of out of hours care has been implicated in the rise in emergency admissions. Clinician factors have also accounted for a much as five-fold variation in admission rates. Clinician and patient factors implicated include the admitting (locum) clinicians lack of knowledge of the patient and/or the condition, communication difficulties between GP and hospital and patient preference based on the perceived benefits of admission to hospital. Others include lack of social care resources and distribution of beds between community, sub-acute and acute care.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The CCG has identified eight broad schemes under the BCF details of milestones in relation to these are as follows.

Enhanced Primary Care including (self care)

To deliver a set of Primary Care services to the patients of Thanet CCG to an agreed high level of quality
To improve patient access to a set of services which are thought to be of high importance and impact to the care of the patients in Thanet CCG
To improve the health of patients, reduce inequalities and ensure the most cost effective use of resources

Evaluate how the risk stratification tool has supported the management of high risk patients. Practices are working with multi discipline teams reviewing identified high risk patients. The impact of this intervention needs to be reviewed and assessed. *Ongoing*
Review current schemes in primary care and effectiveness Q3 14/15

Integrated Health and Social Care teams including enhancing community teams and care co-ordination

Thanet community services will ensure that each patient is at the centre of care and involved fully in his or her own care, supported by their own family and community networks. The Practice Team retain control of the overall patient care whilst the Universal Nursing Team work with the practice team, as part of the overall provision of care. The combination forms the Universal Care Team. The Universal Care Team ask for more specialist advice where needed. That advice will then in reach to the patient and support the team to continue to manage care. The only time that a patients care is fully (but temporarily) transferred to another service is when the patient is admitted to hospital or another comprehensive service e.g. virtual ward. Even then, the practice/nursing team work alongside the hospital to bring back the patient to their own community as quickly and safely as possible

Established Interim teams Q3 14/15
Reporting and reviews on agreed relevant contract KPIs via regular monthly performance meetings - in place.
Each practice knows their universal nurse Q2 14/15
Practices and teams to agree /develop mechanism for MDT teams linking to the Enhanced primary care schemes as above Q3 14/15 - ongoing
Review existing universal nursing teams following recommendations from Community Services Review(2013) Q1 15/16

Flexible use of Care Homes and Westbrook House

The health and social integrated care beds provided by Westbrook house (Victoria unit) are for patients who require limited nursing and a period of recovery supported by social care enablement and the intermediate care team. During their stay patients are encouraged to become less bed bound and more active so that they can return to

their previous level of independent living. These beds can be used for step-up or step down patients.

Following a recent review of Westbrook house Integrated Health and Social Care Centre (Victoria Unit), staffing, section 75 contract, CQC registration, model of care, GP contract, criteria for admission and discharge, pharmacy input, ICT and equipment there will be a requirement for the following ;

To continue with Model of care meetings on a regular monthly basis
Review of contract for medical provision to the unit during Q2 14/15
Review of CQC registration to unit Q2 14/15
Paper to be taken to December 14 Clinical Leadership meeting.
To evaluate service provision along with data reporting on a quarterly basis.

Care Homes

The aim of the local enhanced service is to:
•ensure there is a framework in place to provide enhanced care for nursing care home residents in Thanet.
•provide enhanced local medical services to nursing care home residents by always visiting the resident within their care home and by the provision of planned and agreed visits for routine care.
•improve patient access to medical services within the nursing care home environment.
•recognise the extra workload and complexity involved in providing this local enhanced service.

Residents of nursing care homes will receive the most appropriate nursing, medical and social care to meet their needs. All residents are entitled to both health and social care through NHS services and care management.

To undertake a review of the care homes enhanced service to include residential care too. Q3-4 14/15 Paper to Clinical Leadership Team December 14.
Agree revised enhanced service provision Q1 15/16
Implement new enhanced service provision Q2 15/16

GP managed beds

The service aims to reduce hospital admissions for patients who need a period of care support during short episodes of acute illness. These patients have temporary dependency but do not need hospital treatment. Any elderly person living in their own home or with relatives can be offered short term residential care in a practice managed care home bed as an alternative to hospital admission. The intention of the placement in a residential home is to provide the support that could reasonably be expected to be provided by a caring relative

Examples of when this might be used are
• For periods when the normal carer is not able to manage
• Periods of infection e.g. respiratory infections or urinary tract infections.
• To recover from chemotherapy or radiotherapy
• For bowel preparation prior to investigations
• For support with a new catheter
The admission to the practice managed bed will be for 1 - 14 days (longer by exception). Admissions can be requested by GPs or health professionals (currently this can only be done with the knowledge of the practice, i.e. not the out of hours

service.) A care plan will be agreed within 24 hours of admission which will include a plan for discharge.

To evaluate current GP managed beds within care homes and effectiveness Q2 14/15
To provide further GP managed beds within care homes across TCCG. Q3 14/15 – 3 additional beds have come on line November 2014.

Falls Prevention

The overall aim is to improve the quality of life for Thanet residents (particularly over the age of 65yrs) and to lessen the burden of ill health related to falls.
The aim would be to
Improve patient outcomes and improve efficiency of care after hip fractures through compliance with core standards.
Respond to a first fracture and prevent the second – through fracture liaison services in acute and primary care settings.
Early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries.
Prevent frailty, promote bone health and reduce accidents – through encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards.

This will be achieved through collaborative working across a range of stakeholders including acute trust, community health trust, CCGs, adult social services, local authorities and voluntary organisations

Review current falls pathway Q4 14/15
Set up task and finish group Q1 15/16
Agree changes to local falls pathway and develop action plan Q1 15/16
Develop details of local integrated ambulance falls response service.Q2 15/16
Implement integrated falls pathway across the care homes and the Integrated health and social care centre Westbrook house Q215/16
Implement local integrated ambulance falls response service Q2 15/16
Communicate revised pathway with stakeholders Q3 15/16
Following evaluation of new pathway implement local specialised falls and fracture prevention service.Q4 15/16

Support for carers

The way that carers are supported is crucially important and will be increasingly so in the future as the number of older people increases in Thanet.

There is substantial evidence supporting investment in carers' services to achieve better outcomes, prevent admission to care homes/hospitals and long term savings
Thanet Clinical Commissioning Group is working closely with Kent County Council.
The aim will be
To provide improved Advice Information and Guidance to carers.
To increase access to carers assessments and a range of support, including health checks
Health prescribed support for carers
Carers have access to timely short breaks
To provide access to a range of flexible Carers Day Care Support
Ensure carers have access to support in a crisis

Increase access to Shared Lives to provide alternative options for Carers Support
Ensure carers are well supported through end of life
Ensure the carer's perspective is integral to all training delivered to health and social care staff
To provide better Support for Carers in Acute hospital settings
Increase range of volunteer support available to carers

To understand current carers support Q4 14/15
Implement new Age UK befriending scheme to support discharge October 2014.
To assess gaps within service provision Q1 15/16
To develop working group to address needs Q2 15/16
To implement recommendations of identified gaps Q3 15/16
To evaluate support for carers following implementation of schemes which will include data analysis Q4 15/16
Ensure high quality support for family and carers (this will be ongoing) and develop links with voluntary sector.

Improving End of Life Care

Despite preferences that suggest otherwise, the acute hospital remains the most frequent place of death (46%) for the 7,400 people that die every year in East Kent. This proportion has been steadily reducing but the disparity between preferences of place of death and the reality remains stark.

There is an expected increase in the number of cancer and non-cancer deaths due to demographic changes in the population. This will have implications for the EOLC service and adequate planning needs to be undertaken to deal with:

- The overall increase in capacity due to increasing cancer deaths
- Developing services to meet the needs of non-cancer patients
- Ensuring adequate support is available to meet the EOLC needs of an emerging cohort with dementia and other long-term conditions.

The difficulty in ensuring everyone achieves a good death is linked to the differing needs of the population, the unpredictability of the terminal course and the co-ordination required between the myriad of health and social care services involved.

Early identification of EOLC need is the most important factor in maximising the chance for patients and health professionals to plan adequately and ensure needs and preferences of individuals are met.

To achieve this, the various health and social care services need to share data and share and analyse this data more smartly. The implementation of EPaCCS will help inform health and social care professionals who are adequately trained, to identify and meet the needs of those nearing the end of their life, so that they can help patients achieve their preferred place of death.

A major opportunity to address some of the key issues outlined above 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 co-ordinated and integrated with each other.

To implement EOL strategy 2014 key recommendations via local EOL working group which include the following;

To support delivery of EK Strategy and safe, effective care for Thanet EOLC patients Q3 14/15
Review and implement EOLC community contract (service specification) for Thanet practices Q4 14/15
Development of Electronic Palliative Care Co-ordination System (EPaCCS) to meet national standard Q4 14/15
To Ensure Out of Hours care is aligned to EK EOLC Strategy Q1 15/16
Ensure effective patient, public and carer engagement and mutual attendance at partner events where they are held.Q1 15/16
Identifying the 1% of patients at risk of dying in the next twelve months. This will link to the Risk stratification in Primary care on a regular monthly basis
Ensure Advance Care Plans are in place for all EOLC patients across providers Q1 15/16
Implementation of advanced communications skills for workforce involved in EOLC Q1 15/16.
Education programme for health care professionals which will include DNACPR Q1 15/16.

b) Please articulate the overarching governance arrangements for integrated care locally

Thanet CCGs Better Care Fund Plan is an integral part of the overarching Kent Better Care Fund Plan. The responsibility and management of the Better Care Fund sits within this by using existing governance structures with the Kent Health and Wellbeing Board as systems leaders, informed by local governance arrangements.

Thanet Health and Wellbeing Board, the Whole System Board, Thanet CCG Board, Integrated Commissioning Groups incorporated within Thanet's Out of Hospital Group will ensure delivery and the Integration Pioneer Steering Group providing advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within Whole System Boards, the HWB and on the Integration Pioneer Steering Group.

At CCG level and at care economy and system wide level there will be monitoring of the financial flows associated with implementation of the Better Care Fund. It will be possible to identify what is working well and where schemes should be driven forward at greater pace, or where schemes are not achieving desired outcomes and need to be amended or stopped.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

At CCG level the Better Care Fund will be monitored through the Out of Hospital Group and will report delivery progress through the Operational Leadership Team to the Governing Board.

The Kent HWB will retain a county wide oversight of delivery of the BCF in line with

CCG plans attached and local governance structures.

A county wide performance and finance group supported by the Area Team and involving all CCGs and KCC will be established in Sept 2014 to support development of the pooled fund and area section 75 agreements. It is recommended that this group retain responsibility for regularly reviewing progress on the BCF and making recommendations to the Kent HWB as appropriate.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Enhanced Primary Care including (self care)
2	Integrated Health and Social Care teams including enhancing community teams and care co-ordination
3	Flexible use of Care Homes and Westbrook House
4	Falls Prevention
5	Support for carers
6	Improving End of Life Care

5) RISKS AND CONTINGENCY

a) Risk log

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 and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
The extensive workforce reconfiguration in the community and across secondary care is required to deliver all	5	5	25	Each responsible organisation to develop a detailed workforce plan to support delivery of each scheme. Cross organisational

elements of the scheme and 24/7 availability. There is a risk that within the next 10 -15 years there will be a shortage of healthcare professions due to an aging workforce..				working Review of Terms and Conditions of employment Increasing skills of workforce
Different skills and training required across multiple professionals and organisations.	5	5	25	Training and skills requirements for each scheme to be linked to workforce plan to support the delivery.
Governance of the fund should be clearly defined				Section 75 formal arrangements
The delivery of a fully integrated health and social care system that is clinically led	5	5	25	Through incentivisation and performance management
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	5	5	25	Robust communication plan to be developed to support delivery of each scheme.
IT systems	4	5	20	Integrated system

across services not integrated and therefore do not enable shared care plans between organisations and support integrated outcome measurement and monitoring.				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.	5	5	25	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.	5	4	20	To be discussed with NHS England.
Cultural change – significant shift in how systems need to work in the future requirement large culture change	4	5	20	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	5	5	25	Provide feedback to NHS England

environment – current arrangements not always looking at how the overall system works				on this issue via the Kent Pioneer Programme.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

To ensure delivery of the 2015/16 schemes a programme plan setting out details of the key milestones is in development and will be refined in the last half of 2014/15 This will ensure clarity when the changes come into effect and the implications of these changes as the expected outcomes.

All partners across health and social care within Kent are committed to delivering the outcomes required of the Better Care Fund plan and the wider deliverables as part of Kent's Integrated Care and Support Pioneer programme. The Health and Wellbeing Board at a Kent and local level will be responsible for monitoring outcomes being achieved and identifying further system changes that will be require to achieve success.

This will include reviewing areas that are working well and increasing the pace of delivery or collectively deciding what should be stopped or amended.

Regular review through identified governance structures will be required to ensure whole system buy-in and there will be additional overview through contract monitoring and balance.

Contract negotiations for 2015/16 will address risks to acute service in the case of targets for reduction in admissions not being met. The 2015/16 contract will need to reflect a reduction in activity, with agreed compensation should reduction targets not be met.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

We already have a number of areas of integrated work which the Better Care Fund will allow us to build on. 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.

Delayed Transfers of Care

- Integrated Discharge Team
- Purchase of step up step down beds (GP step up bed project)
- Westbrook House
- 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
- Support to Care Homes from Paramedic Practitioners

Admission Avoidance

- Frail Elderly (over 75s schemes)
- Practice Level Risk Stratification
- Falls service Intermediate care
- Care navigators
- Social enterprise scheme to support dementia
- Personal health budgets
- 7 day working in locality teams
- Social transport

Work has commenced through a number of key integrated work streams on delivering Thanet CCGs 5 year Strategy.

- Improving Primary Care
- Out of Hospital Care
- In Hospital Care

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Thanet's Better Care Fund Plan has been developed as an integral part to delivering the vision for improving services in the next five years.

The schemes outlined in this plan have been developed in partnership with social care commissioners and our public health colleagues. The schemes, along with the overarching 5 year commissioning strategy will support addressing the needs identified in the local JSNA particularly around care of older people. These health priorities are:

- The challenges of an aging population
- Tackling inequalities
- Improving access to primary care
- Managing mental health including dementia
- Delivering care closer to home
- Managing Long term conditions
- Addressing variations in care
- Improving the management of diabetes
- Prevention in Primary Care (addressing lifestyle choices)
- Working closer with partners to support carers

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Thanet CCG has submitted an Expression of interest to undertake commissioning of primary care services for our local area.

We believe this opportunity will allow us to:

- Meet the needs of our local population better by enhancing our ability to deliver our 5 year strategy
- Allow us to develop a new approach to commissioning that is collaborative and developmental.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Thanet CCG wants people to be ambitious about improving their own health and we are committed to empowering people to take that control.

In support of that vision protecting social care services in Kent means ensuring that people are supported to maintain their independence through effective re-ablement (including the appropriate use of assistive technology), preventative support such as self-management, community resilience and support for carers, mental health and disabilities needs in times of increase in demand and financial pressures and the effective implementation of the Care Act.

Significant numbers of people with complex needs, who live in their own homes, want to stay and be supported in their own homes. They do not require daily support from health but have needs that would change and deteriorate without social care contribution to their support. This includes support for loss of confidence and conditions that have changed but do not require acute intervention from hospital or GP but do require enablement services from social care to regain their previous levels of independence. By providing effective enablement where a person has either been discharged from an acute setting or is under the care of their GP, admission or readmission can be prevented.

Social care is also responsible for commissioning of carer support services which enables carers within Thanet to continue in their caring role, often it is the carer who may have health needs that deteriorate. Through pooling funds the CCG and KCC will be able to deliver better value for money.

KCC will maintain its eligibility criteria at the 'moderate' until such time that the national minimum threshold come into effect. In keeping with its corporate priorities such as prevention and partnership working, it will continue to invest in voluntary and community sector organisations that have a role to play with demand management.

Our current and future usage of the £2.631m of Section 256 funding includes plans for:

Improving Hospital Discharges

- Residential Placements from Hospital
- Domicilliary Placements from Hospital
- Short term Bed Placements Outside Block Purchased Beds
- Staffing
- Direct Payments
- Equipment

7 Day working

- Enablement Capacity

- Case Management & Senior Cover

Self Care and Prevention

- Carers
- Befriending
- Autistic Spectrum Team
- Postural Stability

Joint Commissioning

- Health and Social Care Co-ordinators

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

To deliver whole system transformation social care services need to be maintained as evidenced through Year of Care. Current funding under the Social Care Benefit to Health grant has been used to enable successful delivery of a number of schemes that enable people to live independently as set out above.

For 14/15 and 15/16 these schemes will need to continue and be increased in order to deliver 7 days services, increased reablement services, supported by integrated rapid response and neighbourhood care teams. Further emphasis on delivering effective self-care and dementia pathways are essential to working to reduce hospital readmissions and admissions to residential and nursing home care.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

In 2015/16 Thanet CCG has identified £331,000 which is our local proportion of the £135m for the implementation of the new Care Act duties.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The new legal framework introduced by the Care Act 2014 will be implemented for the most part from April 2015 but some of the key changes (care costs cap and raising of the capital threshold) do not start until April 2016. In many cases existing duties are simply consolidated into the new legislation. However the Act does introduce a number of new duties and powers and makes some changes to existing duties and processes. On 6 June the Government released for consultation the draft regulations and guidance for the 2015 changes and KCC has submitted a formal response to these. The final versions will be issued in October this year. The draft regulations and guidance for the 2016 changes are expected to be issued for consultation later this year. We therefore do not yet have the final details of how the reforms will work.

In order to prepare for the significant changes being introduced by the Care Act, KCC has a Care Act Programme which encompasses several workstreams/projects. From 2015 the most important changes concern eligibility, the new duties to provide support

to carers, duties towards self-funders, powers to delegate most adult social care functions, new duties towards prisoners and the enhanced duties to provide information, advice and advocacy. From 2016 the introduction of the lifetime cap on care costs and the extended means-test are the two most significant changes. We anticipate that these 2016 changes in particular will involve assessing significant numbers of people who in the current system are self-funders and unlikely to be known by the local authority. We are therefore examining various mechanisms for this including the role of self-assessment and partner organisations in the statutory and voluntary sector.

It is expected that decisions on several of the above issues will be taken by the Cabinet Member in December this year or early 2015, following discussion at the Adult Social Care and Public Health Cabinet Committee. Until certain decisions have been taken, it is difficult to be more specific about our plans.

v) Please specify the level of resource that will be dedicated to carer-specific support

Thanet CCG has identified £295K to deliver carer-specific support.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There has not been significant change to budget from the original BCF plan, however failure to deliver all or part of the required Better Care Funding mentioned above (£2.962m), would require Adult Social Care to begin to slow down other commitments to stay on course to meet its requirements for Transformation to 2016. Thanet CCG is committed to maintaining its share of this contribution.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

As part of our Kent Pioneer programme we are committed to not only providing seven-day health and social care services but also furthering this to a proactive model of 24/7 community based care. Adult Social Care has recently shifted working hours to be 8-8, 7 days per week as standard. Further work is taking place within the Adult Social Care Transformation Programme to identify the steps required to achieve extended working hours in all areas of delivery.

All schemes within Thanet CCGs 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..

We are also committed to effective reablement to ensure people remain at home or are facilitated to return home, supported across Thanet by enhanced rapid response and urgent care services to further support admission avoidance and timely discharge. This includes a commitment to community responses within 4 hours to mirror the targets and pressures in the acute trusts.

c) Data sharing

i) Please set out the plans you have in place for 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 the NHS number is used across all correspondence.

KCC achieved approximately 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).

ii) Please explain your approach for 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 explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice 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 for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

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.

The risk stratification process identifies those patients at highest risk of hospital admission and then through to the lower risk patients. This means that the amount of clinical time and intervention decreases with lower risk patients. There is an expectation that such intervention through multi-disciplinary teams will go some way to preventing these at risk patients from deteriorating as fast. This prolongs 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.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Risk Stratification is delivered by a multi-disciplinary team clinically lead by a GP. Jointly agreed anticipatory care plans are developed according to patient need.

The teams are locally agreed but typically include GP, Practice staff, Community Nurse and Social worker along with any relevant professional i.e. Hospice representative. The teams meet on a regular basis to review and update plans.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

GP Practices through the Risk Stratification tool are identifying around 2% of the population. Work is on-going to develop individual care plans.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

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 network that links the CCG with over 1,100 local residents.
- A number of engagement events with individual Practice Patient Groups
- Locality Meetings – GP planning events.

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

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

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 health 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.***

Part of the board's work involves developing a robust communications, information and engagement plan to provide stakeholder organisations, and their clinical staff and GP members with a coherent story that they have shaped together, and feel confident to share with the patients and public.

This shared approach includes forming the case for change: covering the scale of the challenge faced across the whole health and social care system, and the way that individually and collectively the commissioners and providers are working together to facilitate and agree a whole system solution(s). The prime aim is for the whole system to collaborate on an overarching strategy based on what is best for the patients, and what is best for the sustainability of the system.

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.

Having a co-ordinated approach and an overarching narrative and evidence base would give all these separate but linked activities a coherence, and would provide reassurance to both local staff stakeholders and patients as well as national policy leads.

This is intended to be a two-way process where staff, stakeholders and the public feel they have influence then there must be opportunities to share the problems and work together on agreeing the solutions. The fact that many of the problems are fundamentally complex means there may not be a single right answer. What is important is having the stakeholders take part in defining the solutions that emerge.

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.

ii) primary care providers

The Integrated Commissioning Group and Out of Hospital Group are led by GPs. Progress is regularly reported through engagement with Board Members through membership meetings as well as regular communication through local practice visits. Monthly meetings with member practices. Member Practices have agreed with the direction of travel and are keen to support the integration process further.

iii) social care and providers from the voluntary and community sector

The draft plans have been developed in collaboration with Social Service colleagues. Through our out of hospital work stream and care group forums we have worked with voluntary sector colleagues to further refine these proposals.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The plans align with the delivery of the CCGs 5 year strategy, as outlined above. The majority of savings will be realised by the reduction in non-elective short stay admissions this is targeted at 3.5% in the first year on a flat line basis. The local acute trust supports the direction of travel and are fully engaged.

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 should support the delivery 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.

Consideration will be required for future contracts to reflect revised activity levels,

with recognition that non-performance of targets would be compensated.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
THA01
Scheme name
Enhanced Primary Care
What is the strategic objective of this scheme?
The strategic objective of this scheme is 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 social care well-being focus. Integrated community models of care centred on GP practices requires significant change in primary care working patterns. New models need to be developed to ensure that the right levels of support and capacity are available within primary and community care settings. This will include alliances of GP practices working together in every community.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
• GP practices will work together in a way that enables different access opportunities for patients to include extended access via access to other practices in the town to improve responsiveness of service provision; • We will 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 robust links with and signposting to a range of services provided by the voluntary sector; • Integrated primary care provision to have greater support from specialist hospital teams and stronger links with rapid response services to enable patients to remain out of hospital. • GP in Accident and Emergency at the acute hospital in Margate will forge links between the acute hospital staff and Primary care colleagues, this will also provide challenges to colleagues where appropriate if the need for hospital admission is questionable. Equally this will also challenge why people may be admitted if primary and community care plan is sufficient to look after the patient in their own home. • The Integrated Discharge Team based on the acute site will also assist in managing attendances at A&E/ Clinical Decision Unit to liaise with primary and community care colleagues to avoid unnecessary admission and facilitate safe discharge at the most appropriate point in the care pathway. • 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 tele-health and tele-care, to assist patients to manage their long term conditions in the community;
- Patients will be given the opportunities to be educated about their long term condition as well as about preventative services such as weight management and alcohol services as part of the multidisciplinary assessment;
- Patients will be supported to inform and take ownership of their care plans which includes electronic sharing of care records with the patient and between health and social care professionals;
- Primary Care will work with the local community to ensure the correct information, advice and guidance is available to help manage long term conditions
- 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 .

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This will be delivered primarily by the 20 GP practices in Thanet.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Self-care interventions can reduce hospitalisations, improve outcomes and reduce costs for the system. For example, one study found that supported self-management had the strongest effect on clinical outcomes of all integrated care interventions, and reduced hospitalisations by 25-30%.

The evidence base highlights the following techniques:
- Involving patients in co-creating personalised self-care plans
- Telephone health coaching
- Tailoring interventions to the condition (e.g. structured education for
- diabetes self-care, behavioural interventions for depression)
- Programmes to encourage lifestyle and behavioural change

Further evidence on self-care:
- Naylor et al (2013) 'Long term conditions and mental health – the cost of comorbidities'
- Purdy S (2012) Avoiding hospital admissions: what does the research evidence say? London: the King's Fund
- De Silva D (2011) Helping people help themselves: a review of the evidence considering whether it is worthwhile to support self-management. London: The Health Foundation
- A NICE Local Practice example is available at: Self-care support for long term conditions
- For guidance on making a local business case for self-care, please see the work done by the NESTA people powered health programme: 'The business

case for people powered health'

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance Measurement of agreed KPIs. Regular meetings and reviews with providers

What are the key success factors for implementation of this scheme?

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

Scheme ref no.

THA02

Scheme name

Integrated Health and Social Care teams including enhancing community teams and care co-ordination

What is the strategic objective of this scheme?

- The strategic objective is to deliver access to services seven days a week, contactable through a single access point via a Local Referral Unit. Links between services will be facilitated by greater use of technology (BT Cloud, MIG, Share my care) to share clinical information to assist with clinical decision making out of hospital – using a care navigation approach to manage and signpost referrals appropriately.
- Access to a rapid response service will be available to patients at high risk of hospital admission and coordinate intermediate care and support in the community, including the use of community beds. 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.

- 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.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

- Aligned to every GP practice the Community Integrated Care Teams will be available 24 hours a day seven days a week and will coordinate the 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 is to provide continuity of care for patients who have been referred for short term or long term support in the community.
- They will provide post hospital discharge care and rehabilitation 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 community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, Social Case Managers and the voluntary sector 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
- Patients with complex needs will be supported 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.
- Integrated pathway to coordinate referral management, admissions avoidance and care coordination across health and social care and voluntary sector, supported by single access point(s) Links between services will be facilitated by greater use of technology (BT Cloud, MIG, Share my care)to share clinical

information to assist with clinical decision making out of hospital – using a care navigation approach to manage and signpost referrals appropriately. A single access point for Thanet would streamline access to alternative care pathways for a range of referring professionals ,including GPs, SECAMB, AHPs, IDT .providing a “one stop shop” approach for access and/or referral to a range of community based services including community, care management and voluntary services.

- Care coordination will be in place to co-ordinate appropriate support such as information, advice and guidance, befriending, medicines management, rehabilitative or enablement short term support as appropriate (care co-ordinators will be in place where appropriate to do this)
- Integrated assessments to ensure responsive onward referral to either rapid response services or intermediate care services in patients own home where possible and only if necessary ensuring transfer to most appropriate care setting Rehabilitative or Enablement 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 support the integrated discharge team in the hospital and ensure that they will be available to support people in their own home in response to patients in A&E within 2-4 hours of referral and initiate a co-ordinated admission avoidance intervention.
- The team will work closely with paramedic practitioners to support care homes to assess, diagnose and treat patients as an alternative to non-elective admission via A&E. Enhanced Rapid Response teams supporting admissions avoidance as part of intermediate care provision as well as respond directly to A&E referrals.
- Integrated discharge teams will be in place in the acute hospital that will link with the community services, this team will know what the patients care plan and wishes are, they will link with primary care to work with the primary care care plan.
- 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
- 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.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and

providers involved
The CCG will commission this through its contracts with EKHUFT, KCHT, and KMPT. KCC will deliver support through Social Care Teams
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Multidisciplinary teams (MDTs) bring together the relevant professionals needed to care for someone with complex needs. MDTs should include everyone required to look after the physical, mental and social health and care needs of the individuals they serve. The aim is to manage the complexity of individual cases and facilitate the delivery of the best possible care. The evidence base highlights the following techniques: Multi-disciplinary teams MDT meetings about every person admitted to hospital Hire specialists to work in community settings rather than hospitals Expanded hours for GPs and coordinators Dedicated housing workers for SEMI/vulnerable groups Allow nurses or nurse practitioners to prescribe certain drugs Mental health liaison teams Direct phone/email access from GPs to MH experts Further evidence on MDTs: Holland et al, Heart, 2005, 91, 899-906 Proactive care partnership http://www.sussexcommunity.nhs.uk/Downloads/services/proactive_care/proactivecare_coastal_leaflet.pdf Case study examples: NHS North West London, Torbay, Towers Hamlets
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Performance Measurement of agreed KPIs. Regular meetings and reviews with providers
What are the key success factors for implementation of this scheme?

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
- Pre and post evaluation of cardiac rehab programme
- Pre and post evaluation of pulmonary rehab programme

Scheme ref no.
THA03
Scheme name
Flexible use of Care Homes and Westbrook House
What is the strategic objective of this scheme?
To deliver an improved community solution which offers a flexible service that reduces the need for hospital admission and supports the early discharge of patients from hospital.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
• 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.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The CCG currently commissions GP step up beds from a number of private sector care homes through contracts with local GP Practices. Westbrook House is a jointly funded facility with KCC

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Health Act 1999 provided the "flexibilities" that allow qualified nursing staff to be seconded into local authority/County Council Registered Care Centres to deliver improved outcomes in nursing care and clinical input to meet the needs of those individuals identified to receive nursing care, in addition to their individual personal care and spiritual needs. The Department of Health (DH) has stated that effective and efficient joined up working between the NHS and Local Government is an essential part of how the care system works to meet patients' needs and public expectations at all times and particularly when increased demands are made of the services.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance Measurement of agreed KPIs. Regular meetings and reviews with providers

What are the key success factors for implementation of this scheme?

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

Scheme ref no.

THA04

Scheme name

Falls Prevention

What is the strategic objective of this scheme?

To reduce the number of unplanned admissions due to falls.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

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.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

CCG and KCC will jointly commission KCHT, EKHUFT, Primary Care and the Voluntary Sector to deliver the proposed Falls Framework.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Falls Prevention a Framework for Kent – Thanet CCG v2.1

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance Measurement of agreed KPIs. Regular meetings and reviews with providers

What are the key success factors for implementation of this scheme?

- Reduction in non-elective admissions due to falls.
- Improved patient outcomes and improved efficiency of care after hip fractures through compliance with core standards.
- Response to a first fracture and prevention of the second – through fracture liaison service in acute and primary care settings.
- Early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries.
- Prevent frailty, promote bone health and reduce accidents – through encouraging physical activity and healthy lifestyle and reducing unnecessary environmental hazards.

Scheme ref no.

THA05

Scheme name

Support for carers

What is the strategic objective of this scheme?

To improve the support to carers through a more integrated approach to commissioning.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

KCC and Thanet CCG currently fund a number of carers support schemes through two strands. Carers Support and Carers Short breaks. These include Planned Respite, Crisis Support and Respite for Carers. Through improved integration we intend to:

- Improve the Support to carers of those with dementia.
- Provide Support to carers who are elderly and/ or have their own health needs and for whom the caring role is particularly intensive, for example living with the person they care for, or spending over 100 hours a week caring.
- Support carers within new emerging BME communities.
- Ensuring easy access to information, advice and guidance for both known and unknown carers, particularly in deprived areas.
- Address the predicted decline of female 'mid life' carers when developing services for the future.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Combining resources from KCC and Thanet CCG to commission services from the Private and Voluntary Sector.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Kent Carers JSNA 2013/14

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance Measurement of agreed KPIs. Regular meetings and reviews with providers

What are the key success factors for implementation of this scheme?

- Increased number of carers supported through each of the three programmes.
- Access to crisis support
- Access to planned care respite
- Access to respite for carers

Scheme ref no.
THA06
Scheme name
Improving End of Life Care

What is the strategic objective of this scheme?
To improve the overall co-ordination of end of life care ensuring that patients wishes are recorded and patients are given their choice of place of death wherever possible.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
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.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
CCG commission services from Pilgrims Hospices, KCHT, EKHUFT and GP Practices.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
East Kent End of Life Strategy May 2014
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Performance Measurement of agreed KPIs. Regular meetings and reviews with providers

What are the key success factors for implementation of this scheme?

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
- % of patients dying in their place of choice

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Kent (relates to Thanet CCG)
Name of Provider organisation	Kent Community Health Trust
Name of Provider CEO	Marion Dinwoodie
Signature (electronic or typed)	 Karen Stone, Community Services Director Kent Community Health NHS Trust

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	16086
	2014/15 Plan	16552
	2015/16 Plan	15972
	14/15 Change compared to 13/14 outturn	+470
	15/16 Change compared to planned 14/15 outturn	-580
	How many non-elective admissions is the BCF planned to prevent in 14-15?	Growth over last 2 years is approx.. 4.5%. Although increase in activity this is at a lower rate (2.9%)
	How many non-elective admissions is the BCF planned to prevent in 15-16?	-580

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Based on the information provided at this stage, KCHT agree, in principle to the suggested schemes that will enable achievement of this challenging target. KCHT look forward to working with the CCG and other providers to understand the finer detail in the coming weeks and months.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	

3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Based on the information provided at this stage, KCHT can confirm that consideration has been made. However, KCHT would like to note that further work needs to be undertaken to ensure clarity is achieved on the detail of these implications and potential impact for KCHT specifically. Specific work needs to be undertaken to understand the continuation of surge and resilience funded schemes that may be a factor in achieving the results but are not within the current contractual baseline values.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Kent (relates to Thanet CCG)
Name of Provider organisation	East Kent Hospitals University Foundation Trust
Name of Provider CEO	Stuart Bain
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	16086
	2014/15 Plan	16552
	2015/16 Plan	15972
	14/15 Change compared to 13/14 outturn	+470
	15/16 Change compared to planned 14/15 outturn	-580
	How many non-elective admissions is the BCF planned to prevent in 14-15?	Growth over last 2 years is approx.. 4.5%. Although increase in activity this is at a lower rate (2.9%)
	How many non-elective admissions is the BCF planned to prevent in 15-16?	-580

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	EKHUFT are **not** able to agree with the data relating to the impact of the BCF, in terms of a reduction in non-elective admissions for 15/16. We fully recognise that the Plan is well thought out and detailed; high level Metrics have been identified by Thanet, based on % reduction, however we are unclear what the baseline information is within the Community. EKHUFT's non-elective activity has significantly increased over the past year therefore we are unclear as to the actual impact of any current schemes on our services.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	Whilst EKHUFT support some of the schemes identified, a number of these schemes are already in existence and, as previously stated, the Trust have seen limited impact on non-elective patient flow or indeed any substantial change in response as a result of extreme pressures within the system. Therefore, EKHUFT will be unable to agree the

		data without further clarification regarding the following points: • Current Capacity / Activity within the Community Teams / Primary Care (for existing schemes) • Expected Additional Capacity or Activity these schemes / investment will generate • Agreed improvement in response times / reduced waiting times associated with additional resources and investment • Additional capacity for supported discharge to enable a reduction in DTOC's • There are no agreed KPI's for any of the schemes or Timescales associated with 'expected date of impact' • Thanet's Plan states that a total reduction of 580 Admissions will be achieved, but there is no clear indication as to how this will be achieved or what this figure is based on.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Without specific details regarding: • baseline position, • expected impact, • timescales for achievement and impact • clear understanding as to how the performance of each scheme will be monitored • actions which will be taken in the event specific KPI's are not achieved, EKHUFT will continue to experience significant bed pressures and delays with patient flow. The proposed reduction in non-elective Admissions (580) equates to 1.58 admissions per day Trust-wide, however current non-elective activity is approximately **7%** above Plan, therefore it is unlikely to have any resultant implications on the acute services.

Annex 3

The use of risk stratification to understand population need and impact on health and social services

Thanet CCG

July 2013 Version 2.0

Dr Abraham P George Assistant Director/Consultant in Public Health

Natasha Roberts Head of Intelligence Kent & Medway Public Health Observatory

Public Health

Kent County Council

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Contents

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Foreword

This report describes the CCG level analyses of health and social care service utilization using the risk stratification approach. Every attempt has been made to illustrate and describe service utilization and cost for all year wherever data was available and consistent, but in many instances this was not possible. The graphs / charts / tables should be read and interpreted alongside the main report for proper context.

Baseline profile

Table 1

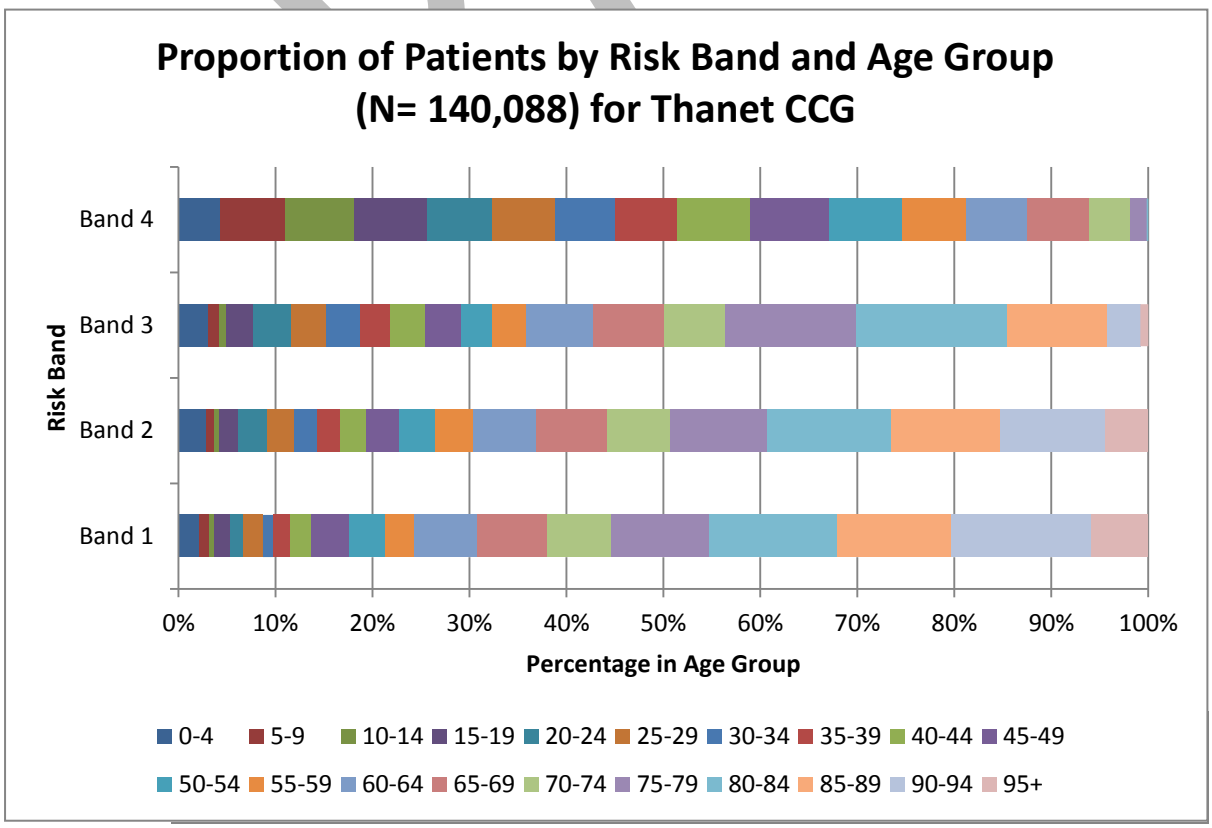
Risk Band	No. of patients as at 4.4.2011	% popn	Deaths during 2011/12	Proportion
1	974	0.7%	209	21.5%
2	8551	6.1%	573	6.7%
3	21319	15.2%	450	2.1%
4	109244	78.0%	433	0.4%
Totals	**140088**	**100%**	**1665**	**1.2%**

Population profile of each risk band

Age distribution

Figure 1 shows the age distribution in each risk band. (Please see corresponding section of the main report for further details).

Figure 1



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Prevalence of falls

Figure 2 and Table 2 show Hospital admission data was analysed for history of a fall for each risk band. (Please see corresponding section of the main report for further details).

Figure 2

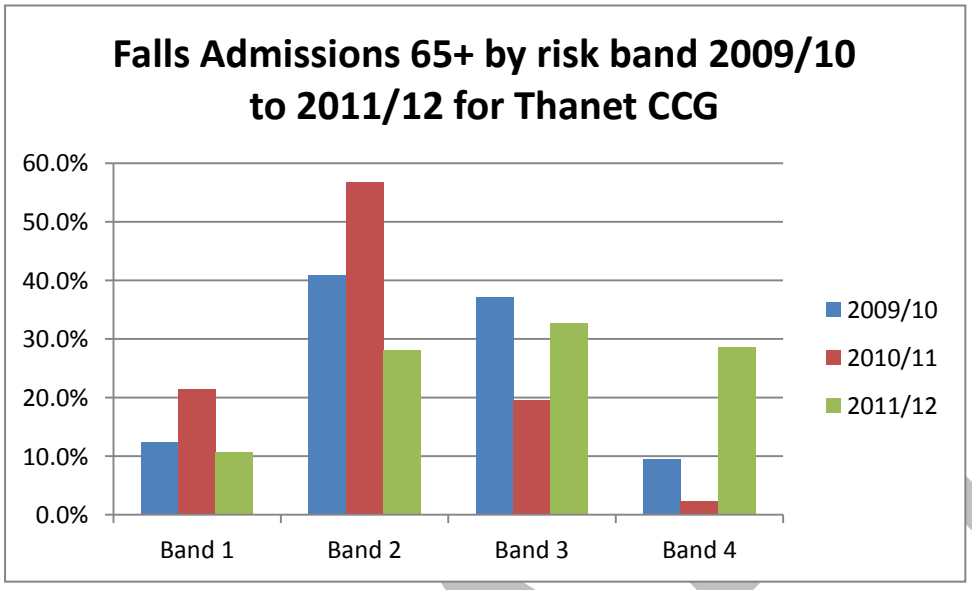

Table 2

Number of Falls admissions 65+ by risk band for Thanet CCG

	2009/10			2010/11			2011/12				
Risk Band	**Spells**	**%**	**Total Cost**	**Spells**	**%**	**Total Cost**	**Spells**	**%**	**Total Cost**	**Total Spells**	**Total Cost**
Band 1	73	12.4%	£214,264	167	21.4%	£565,289	126	10.7%	£318,149	366	£1,097,702
Band 2	240	40.9%	£712,636	443	56.8%	£1,311,311	331	28.0%	£856,165	1014	£2,880,112
Band 3	218	37.1%	£706,433	152	19.5%	£386,914	387	32.7%	£1,202,803	757	£2,296,150
Band 4	56	9.5%	£153,302	18	2.3%	£57,088	338	28.6%	£1,047,497	412	£1,257,887
Total	587	100.0%	£1,786,635	780	100.0%	£2,320,602	1182	100.0%	£3,424,614	2549	£7,531,851

Prevalence of dementia

Table 3

Thanet

Prevalence of Dementia		2009/10		2010/11		2011/12		Total	
Risk Band	Patients	Spells	Total Cost	Spells	Total Cost	Spells	Total Cost	Total Spells	Total Cost
1	149	79	£ 179,407	319	£ 949,589	244	£ 678,363	642	£ 1,807,359
2	469	272	£ 539,365	337	£ 862,271	587	£ 1,799,133	1196	£ 3,200,769
3	191	18	£ 35,648	7	£ 5,265	405	£ 1,245,736	430	£ 1,286,649
4	13					27	£ 73,081	27	£ 73,081
	822	369	£ 754,420	663	£ 1,817,125	1263	£ 3,796,313	2295	£ 6,367,858

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Analysis of Hospital data

Figures 3 to 6 and Tables 4 to 7 show the analysis for activity and spend for Emergency Admissions by risk band for years 2009/10 to 2011/12. (Please see corresponding section of the main report for further details).

Figure 3

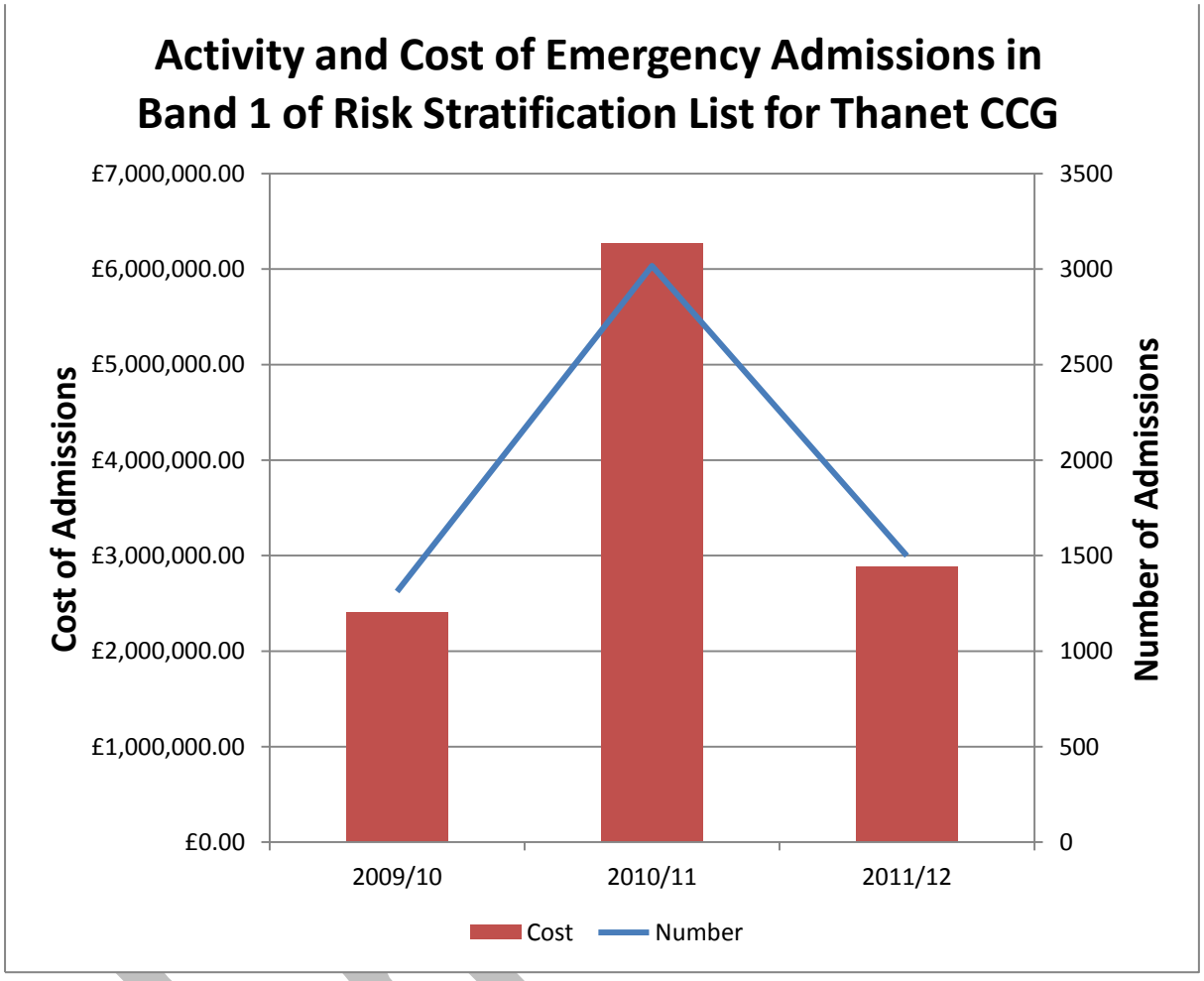

Table 4

Emergency Admissions Band 1				
Year	Number	Cost	Average Number of Spells	Average Spend
2009/10	1312	£2,401,619.00	1.3	£2,324.90
2010/11	3017	£6,264,192.00	2.9	£6,064.08
2011/12	1499	£2,877,174.00	1.5	£2,785.26

Figure 4

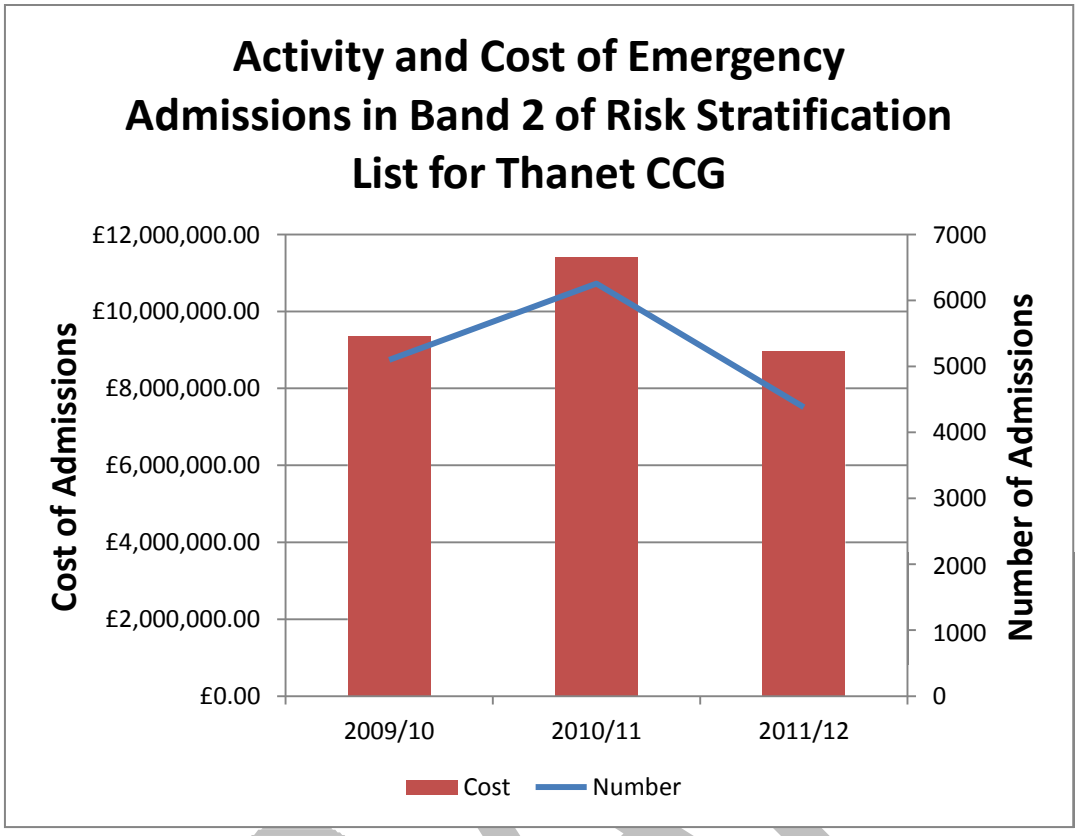

Table 5

Emergency Admissions Band 2				
Year	Number	Cost	Average Number of Spells	Average Spend
2009/10	5098	£9,349,564.00	0.520	£954.33
2010/11	6256	£11,412,743.00	0.639	£1,164.92
2011/12	4380	£8,954,599.00	0.447	£914.01

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Figure 5

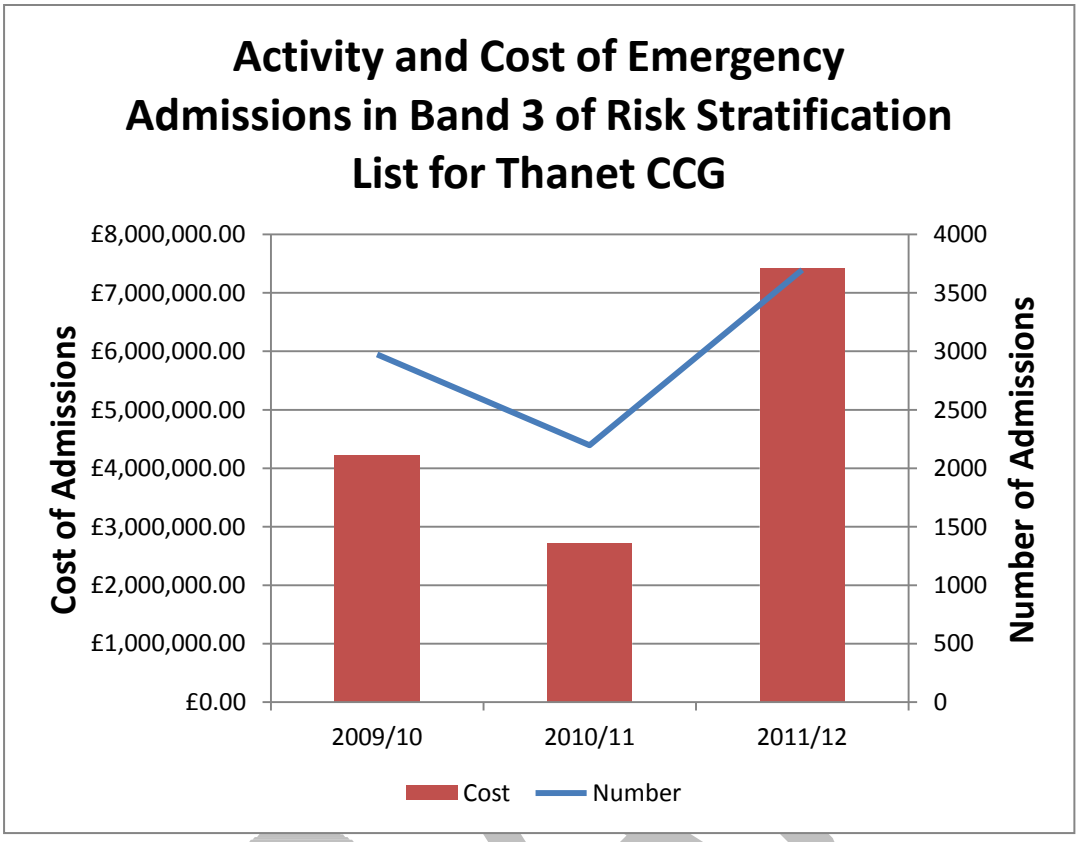

Table 6

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Figure 6

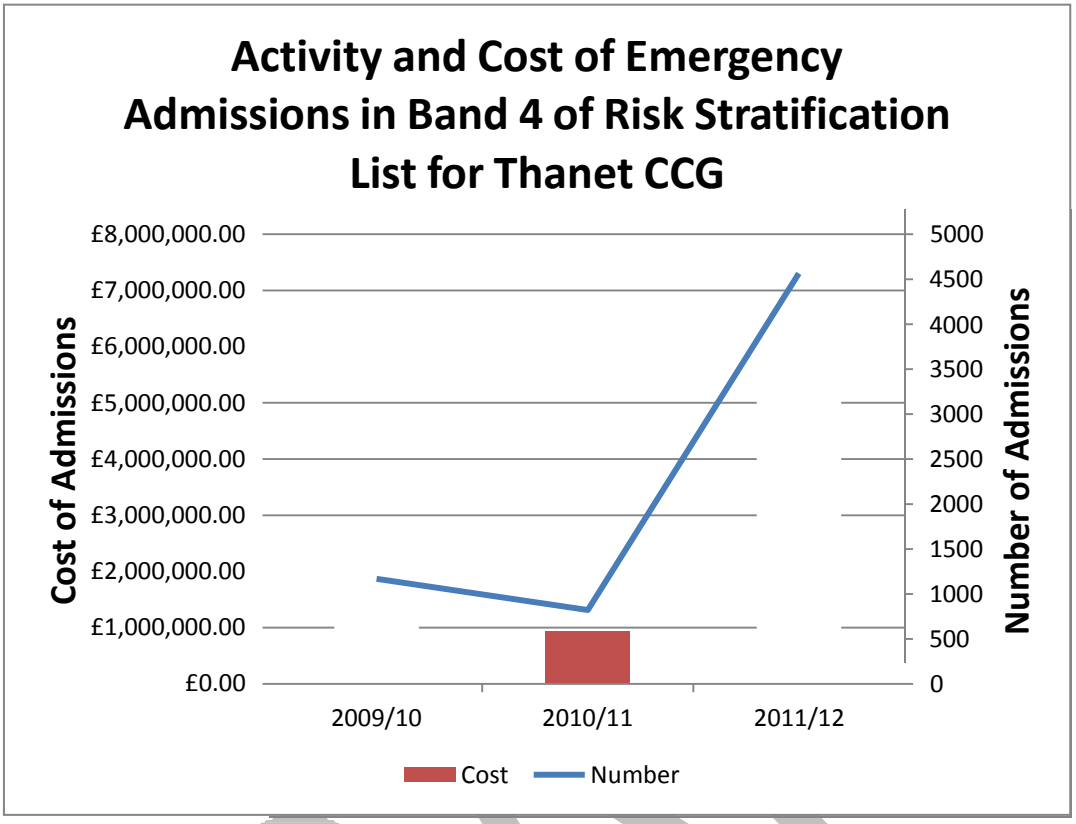

Table 7

Emergency Admissions Band 4				
Year	Number	Cost	Average Number of Spells	Average Spend
2009/10	1168	£1,207,448.00	0.011	£11.37
2010/11	820	£927,963.00	0.008	£8.74
2011/12	4565	£6,669,713.00	0.043	£62.79

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Analysis of Adult Social Care service utilization

(Please see corresponding section of the main report for further details).

Table 8 shows the breakdown of activity and spend of the matched clients by risk band and financial year.

Table 8

Financial Year	Risk Band	Contacts	Total Delivered Units	Total Delivered Costs
2009-2010	**1**	369	39092	£ 1,055,682.12
	2	1376	133024	£ 4,843,116.50
	3	1034	108275	£ 4,588,173.12
	4	675	109862	£ 5,148,516.89
Total 2009-2010		3454	390254	£ 15,635,488.63
2010-2011	**1**	434	50953	£ 1,881,448.23
	2	1333	167805	£ 7,210,932.89
	3	868	119576	£ 5,694,504.12
	4	717	154216	£ 7,307,750.03
Total 2010-2011		3352	492551	£ 22,094,635.27
2011-2012	**1**	370	41775	£ 1,821,914.18
	2	1378	175450	£ 7,977,298.34
	3	1209	136883	£ 6,608,464.09
	4	848	196812	£ 8,568,288.32
Total 2011-2012		3805	550920	£ 24,975,964.93
Grand Total		**10611**	**1433725**	**£ 62,706,088.83**

Figure 7 shows the distribution of matched social clients by risk band.

Figure 7

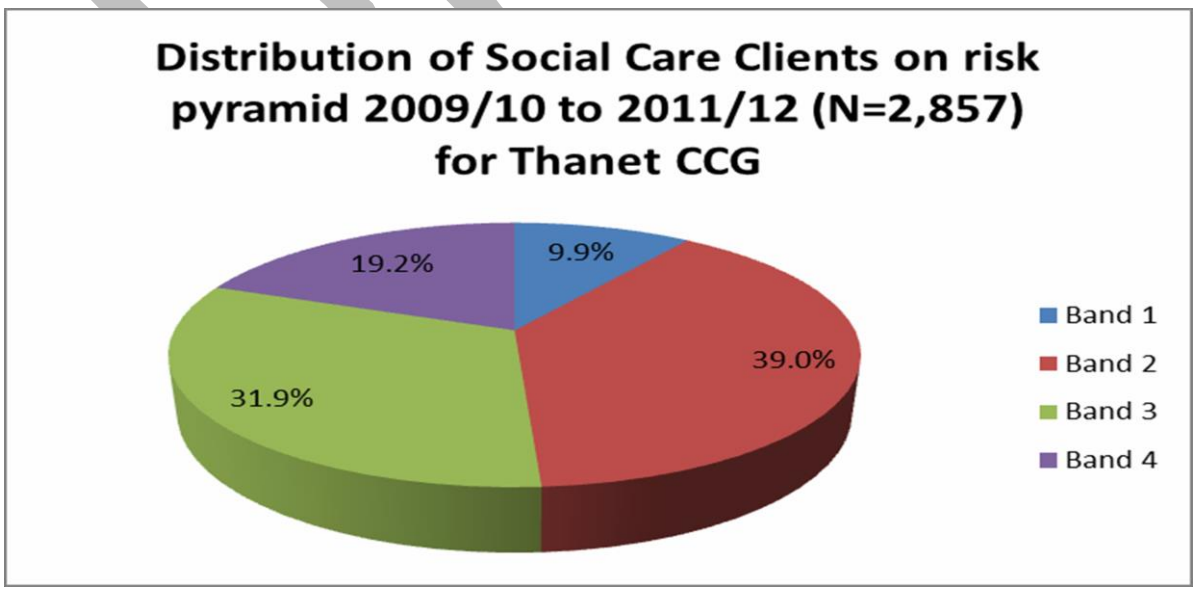

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Figure 8 shows the age distribution of clients across all 4 risk bands.

Figure 8

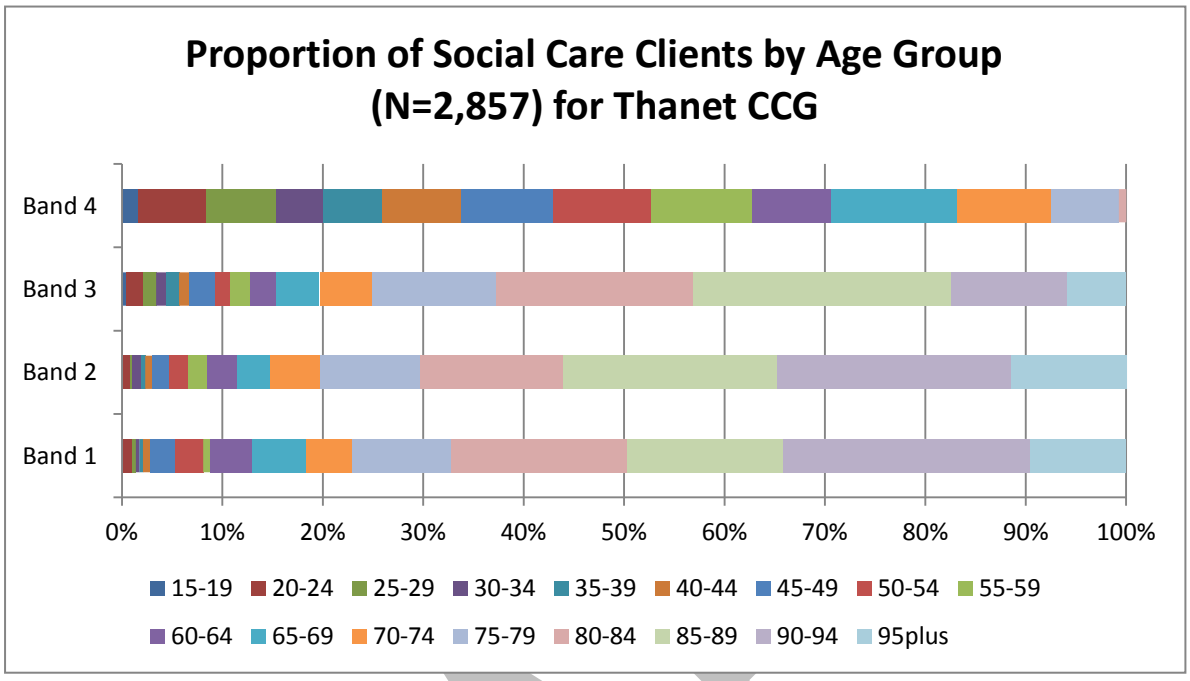
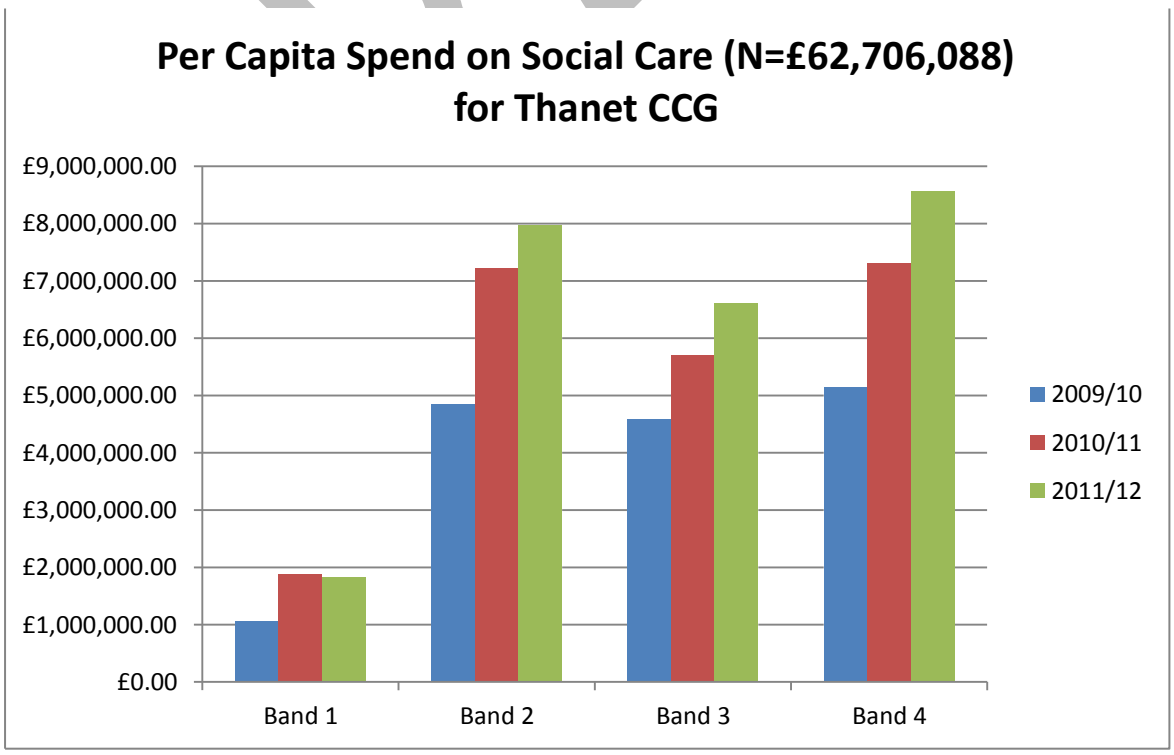


Figure 9 shows the per capita spend of social care across the 4 bands over the 3 year period.

Figure 9



Figures 10 to 13 shows the proportion of spend for the top 8 services which make approximately 95% of the total per capita spend, for each risk band.

Figure 10

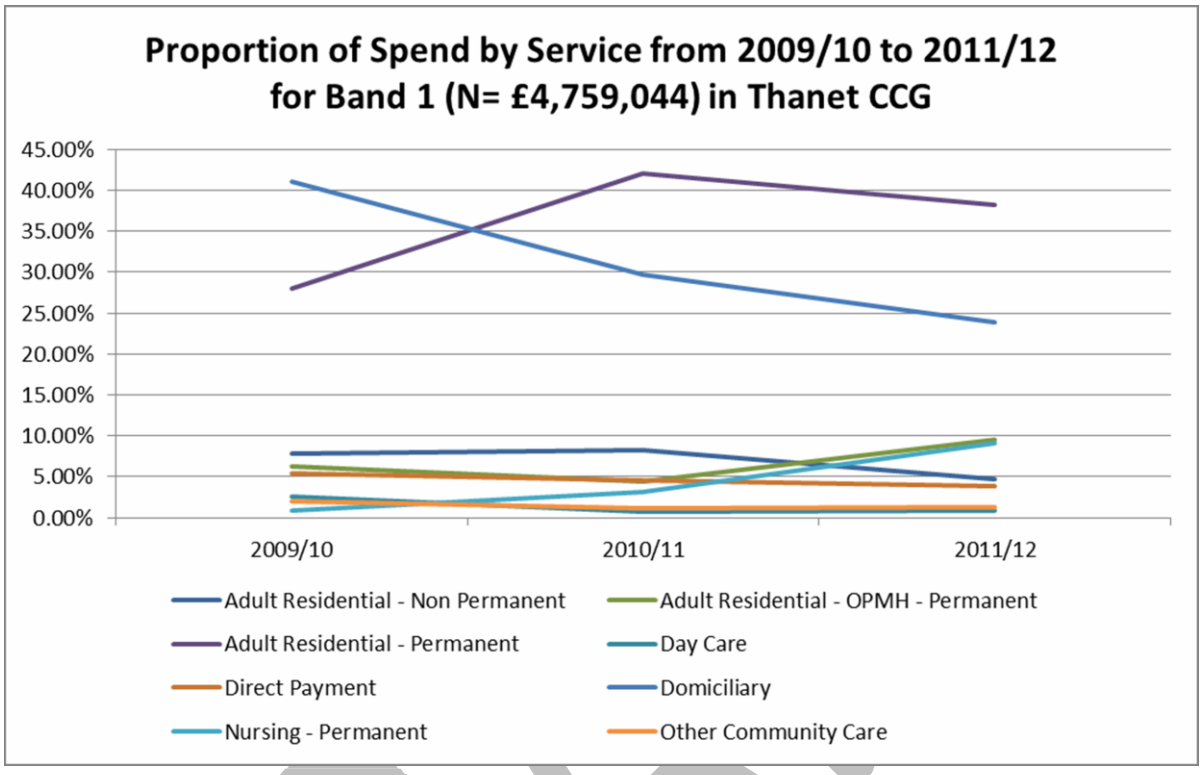


Figure 11

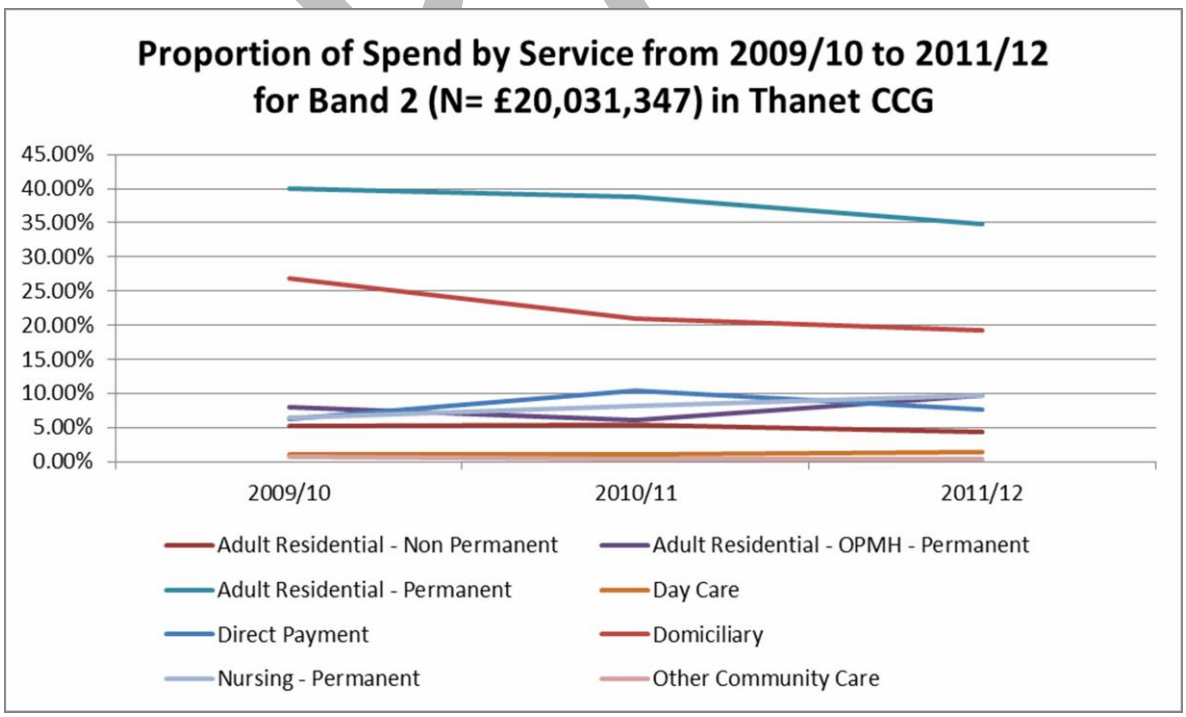


Figure 12

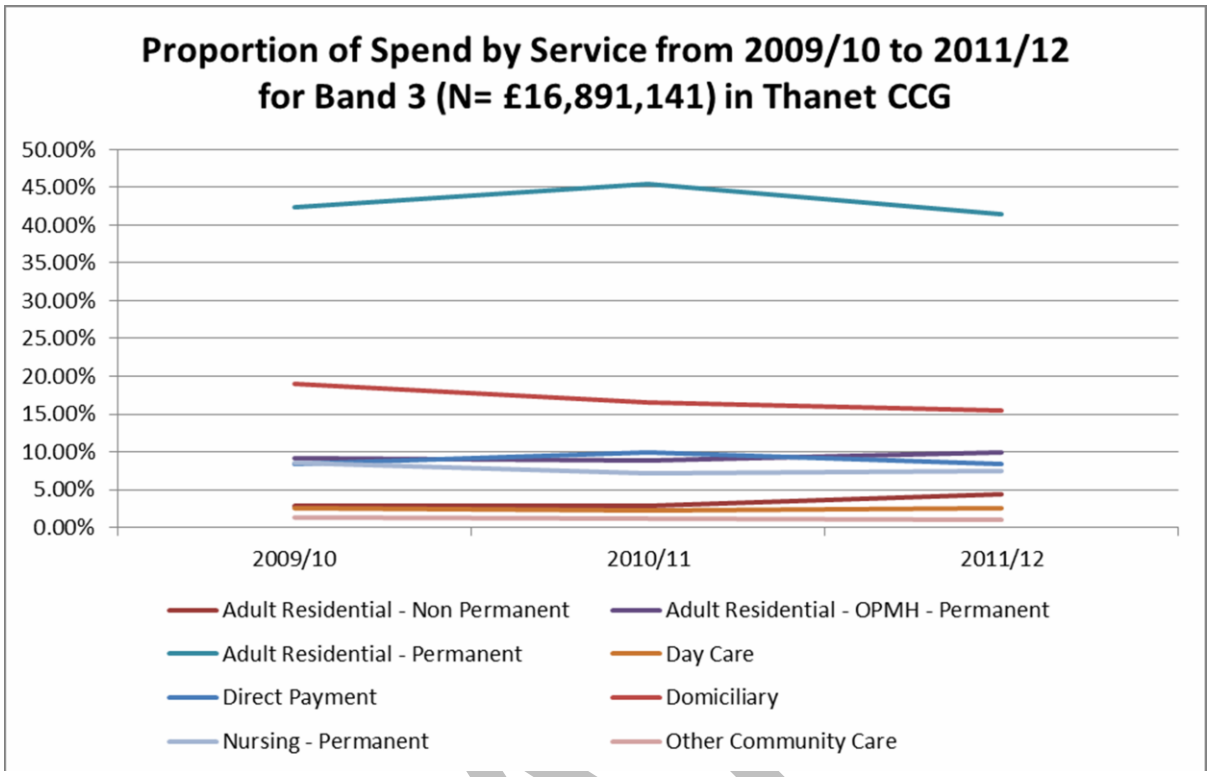


Figure 13

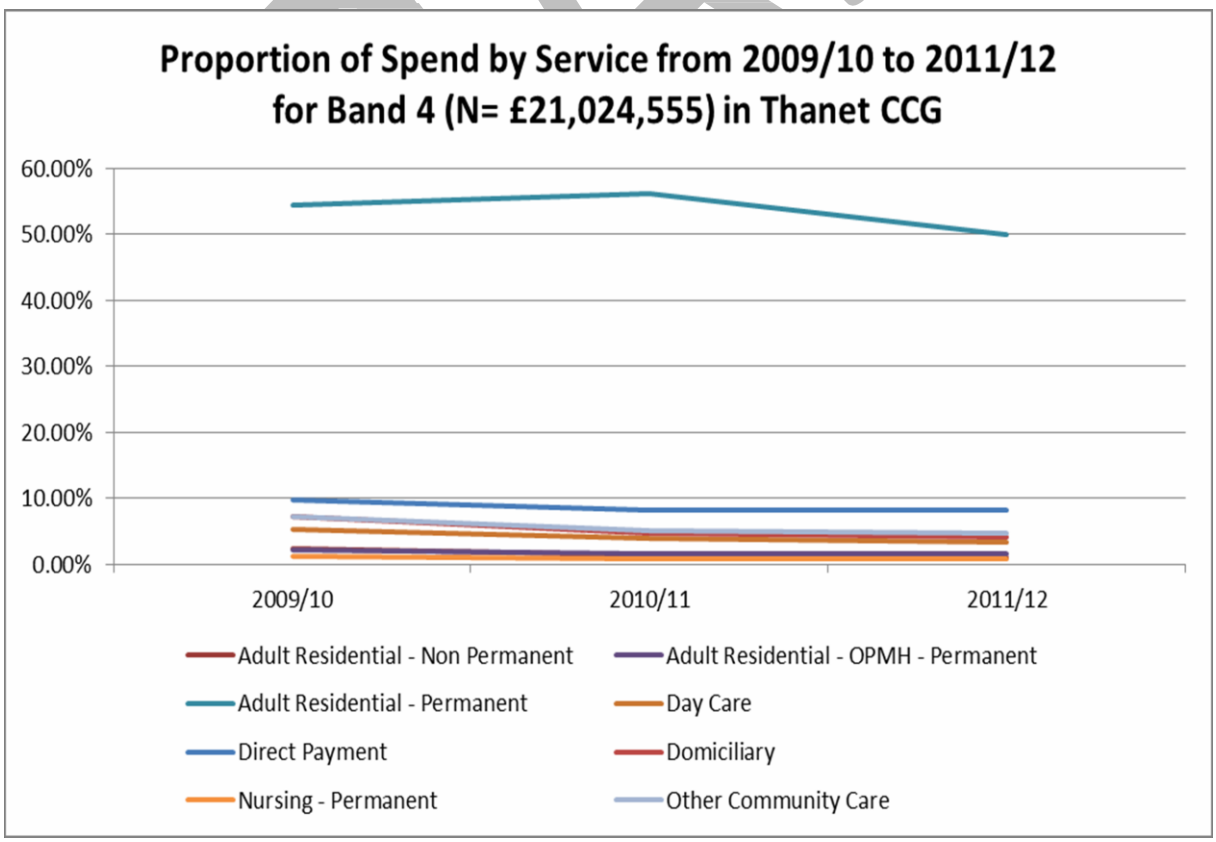
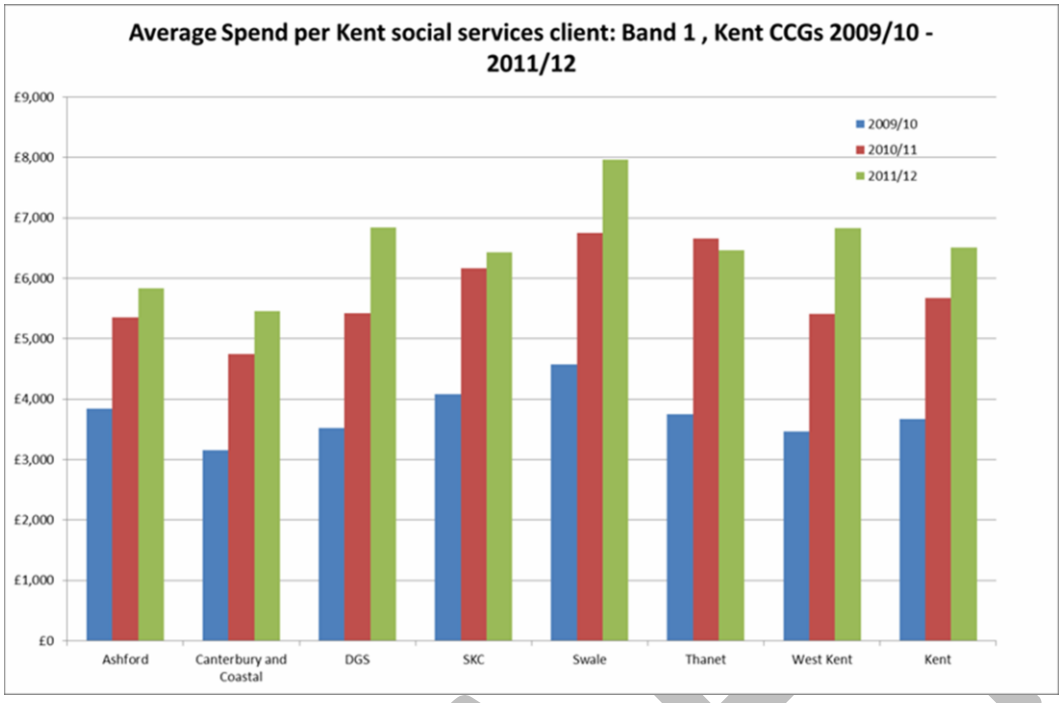
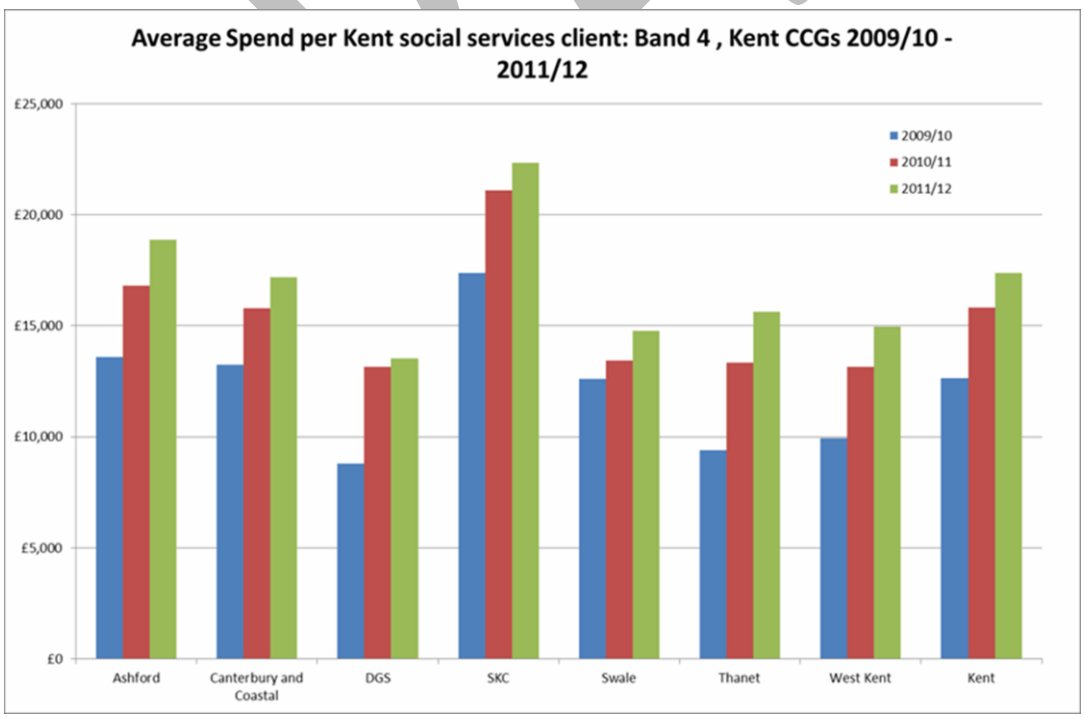


Figure 14



Figures 14 and 15 show the per capita spend in social care by CCG for Bands 1 and 4. Swale and SKC CCGs had the highest per capita spend in Band 1 and 4 respectively.

Figure 15



Analysis of Community Health service utilization

Figures 16 and 17 appear to show pareto distribution of service utilization which varied across the 4 bands. (Please see corresponding section of the main report for further details).

Figure 16

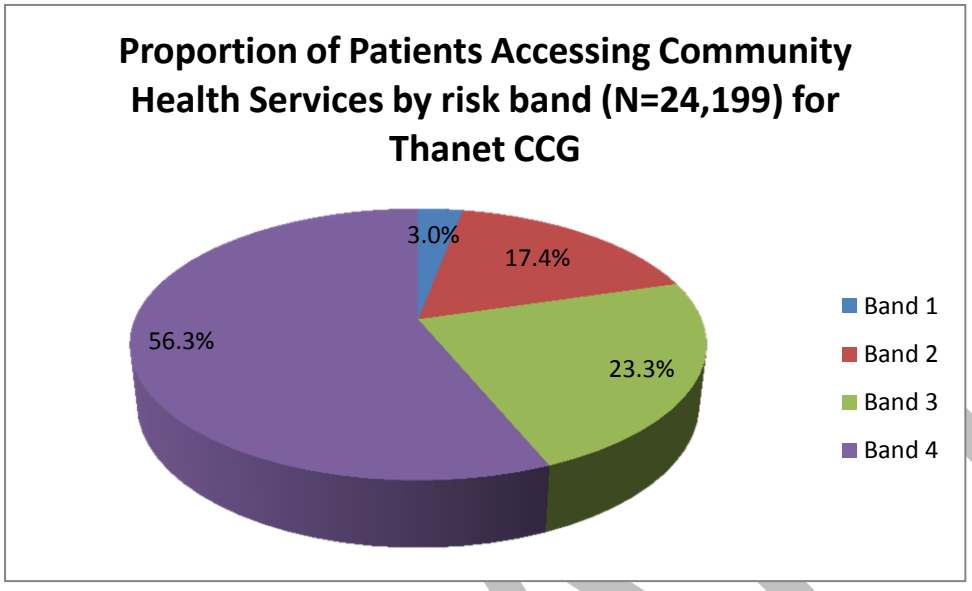


Figure 17

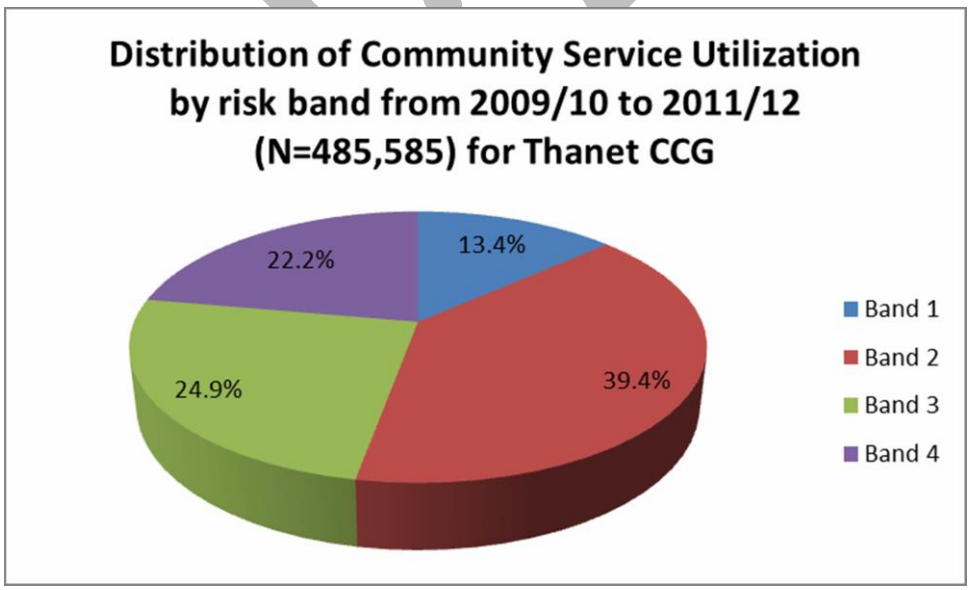
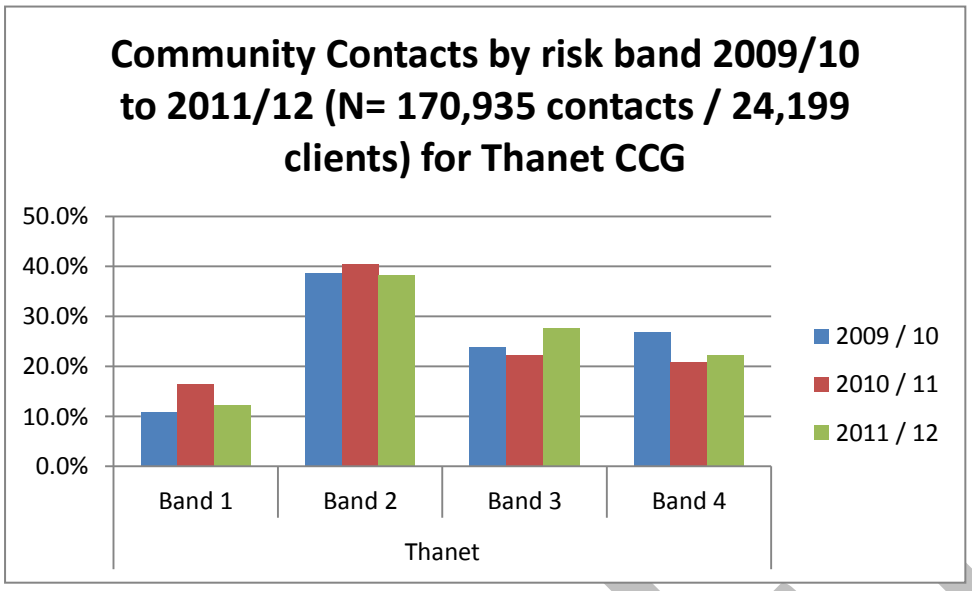


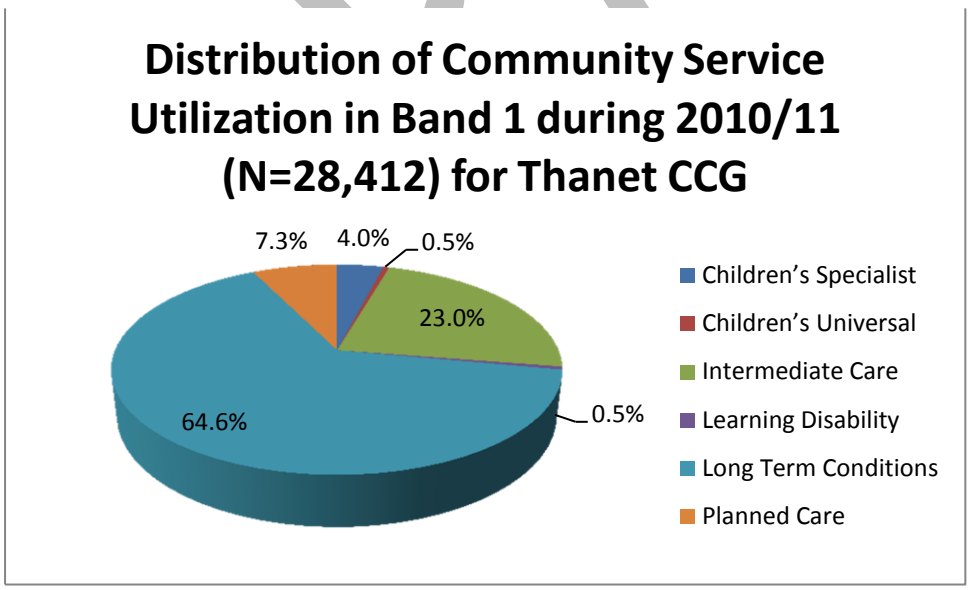
Figure 18 shows the variation in activity in the 4 risk bands over time.

Figure 18



Figures 19 to 22 show the breakdown of service utilization in each Band under 6 broad headings.

Figure 19



Figure

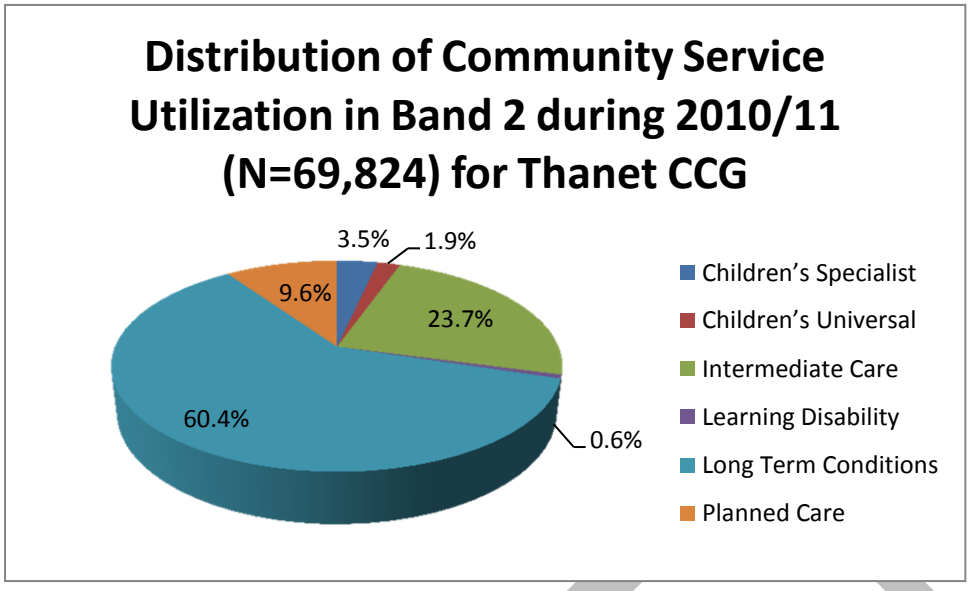
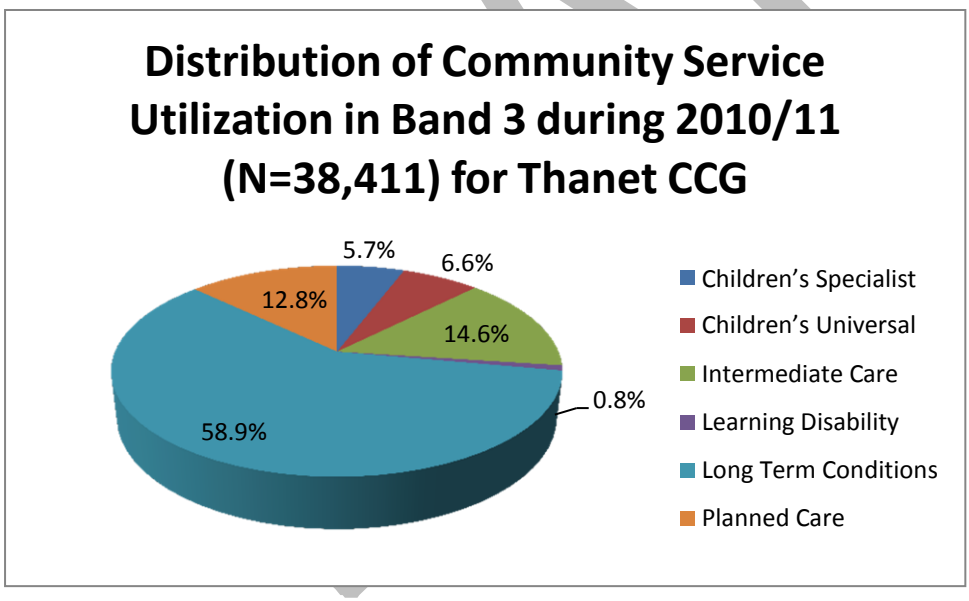


Figure 21



Figure

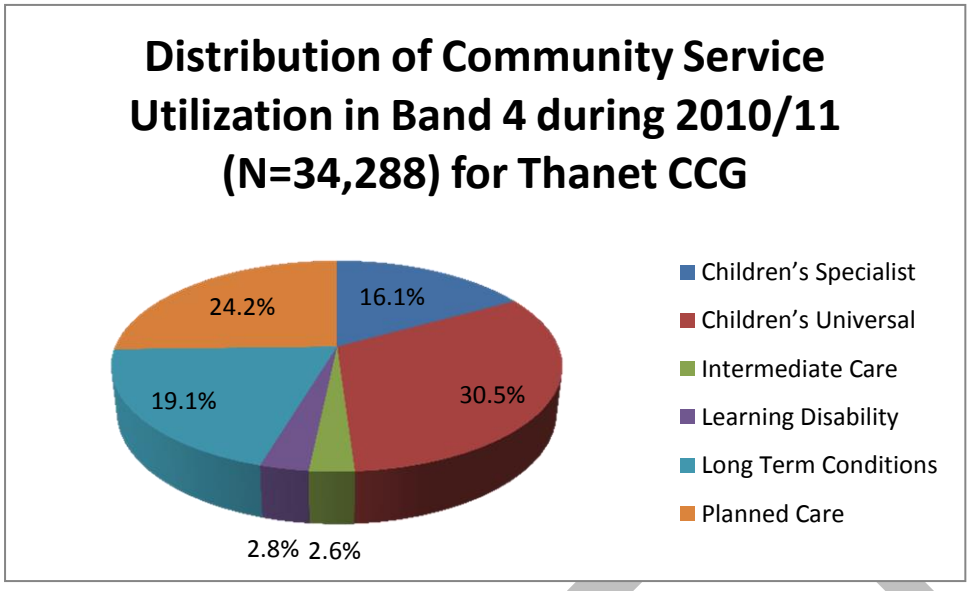
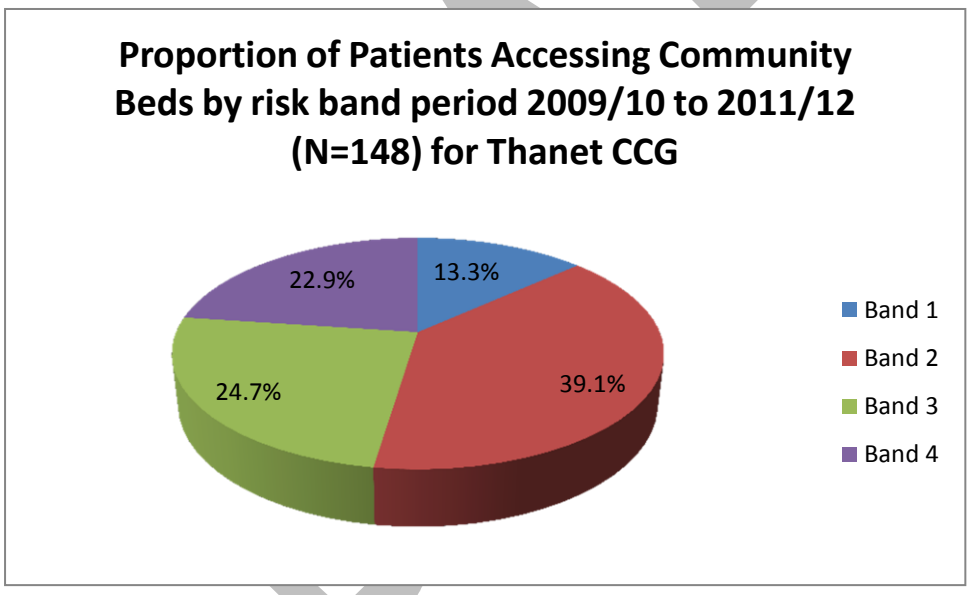


Figure 23



Figure

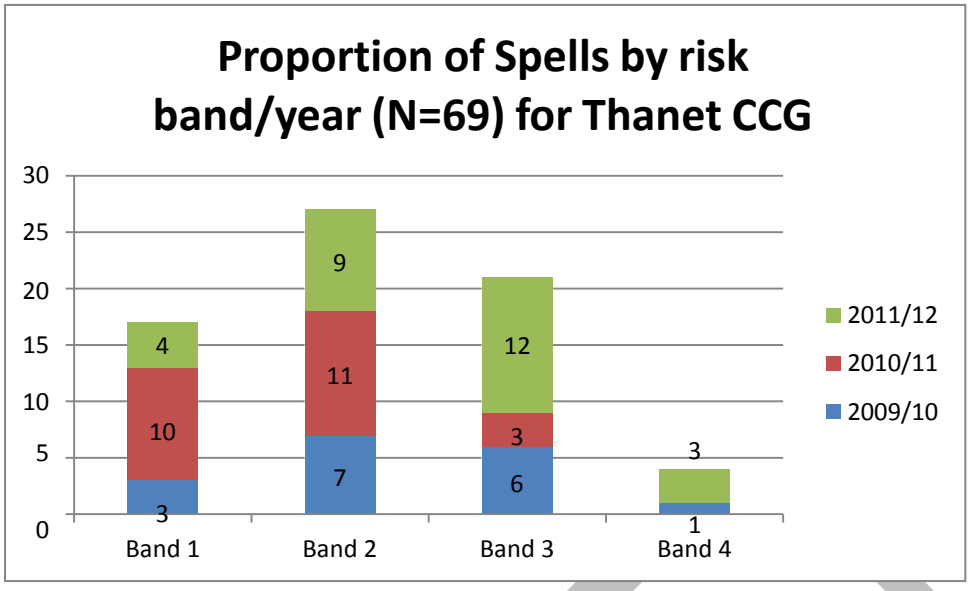
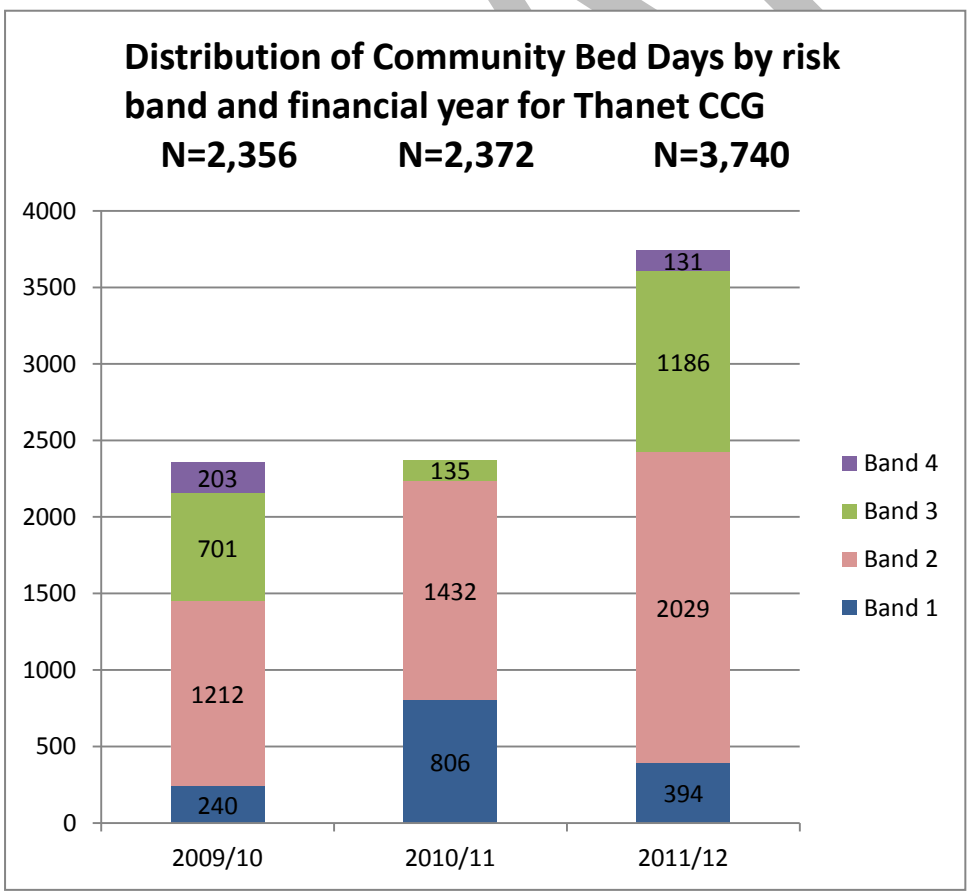


Figure 25



Analysis of Mental Health service utilization

Table 9 appears to show equivalent per capita usage of mental health services and beddays across all 4 risk bands, while figures 26 and 27 also show little variation in the use services over the 3 year period. (Please see corresponding section of the main report for further details).

Table 9

Contacts					Admissions				
Risk Band	**Clients**		**No. of Contacts**		**Risk Band**	**Clients**		**No. of Bed days**	
Band 1	343	5.3%	10584	7.7%	Band 1	56	9.4%	5680	9.8
Band 2	1586	24.4%	40427	29.5%	Band 2	236	39.7%	23866	41.2
Band 3	1856	28.5%	40305	29.4%	Band 3	191	32.2%	15612	26.9
Band 4	2721	41.8%	45762	33.4%	Band 4	111	18.7%	12799	22.1
	6506	**100.0%**	**137078**	**100.0%**		**594**	**100.0%**	**57957**	**100**

Figure 26

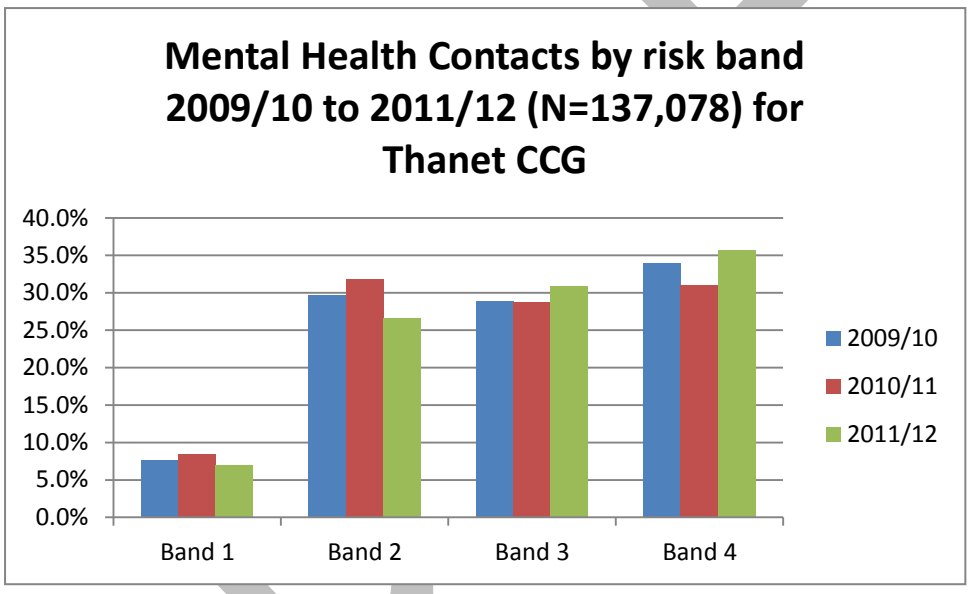
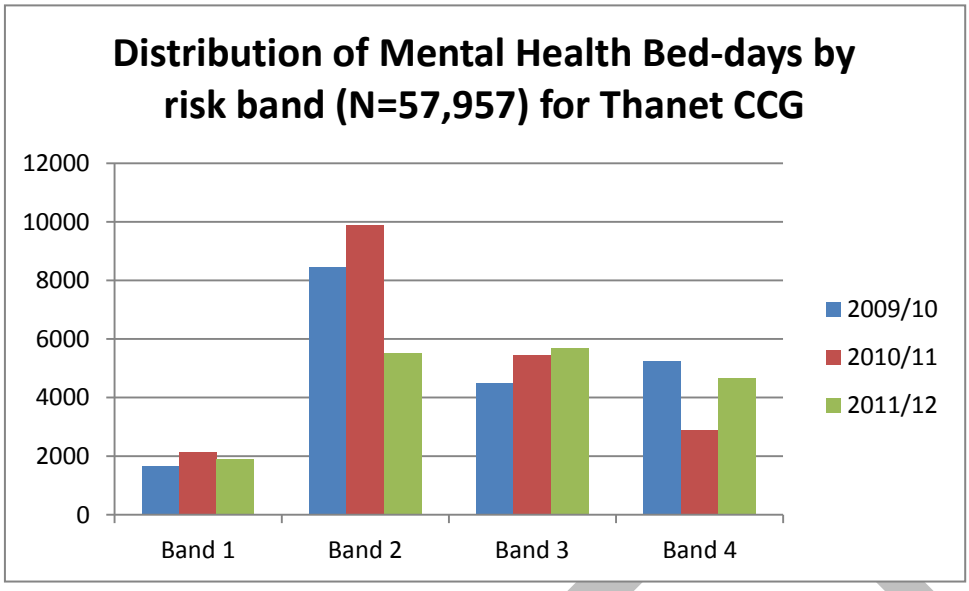


Figure 27



Distribution of patients in Pilgrim's Hospice (East Kent CCGs)

Summary data from **Pilgrim's Hospice** - of the 2066 records, 73 were not within the cohort 04/04/2011. The table below shows the breakdown by risk band.

Risk Band	Number of Records	Percentage
1	179	8.7%
2	767	37.1%
3	646	31.3%
4	401	19.4%
(blank)	73	3.5%
Grand Total	**2066**	**100.0%**

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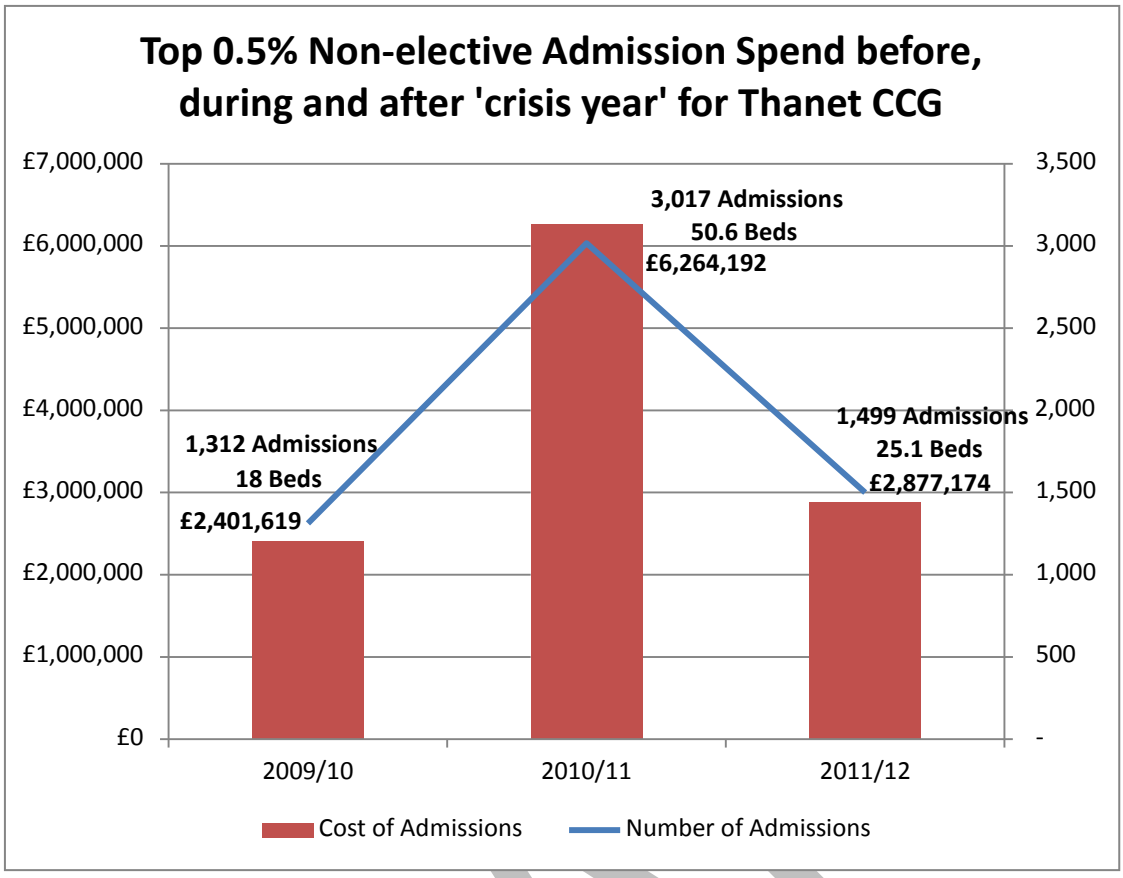
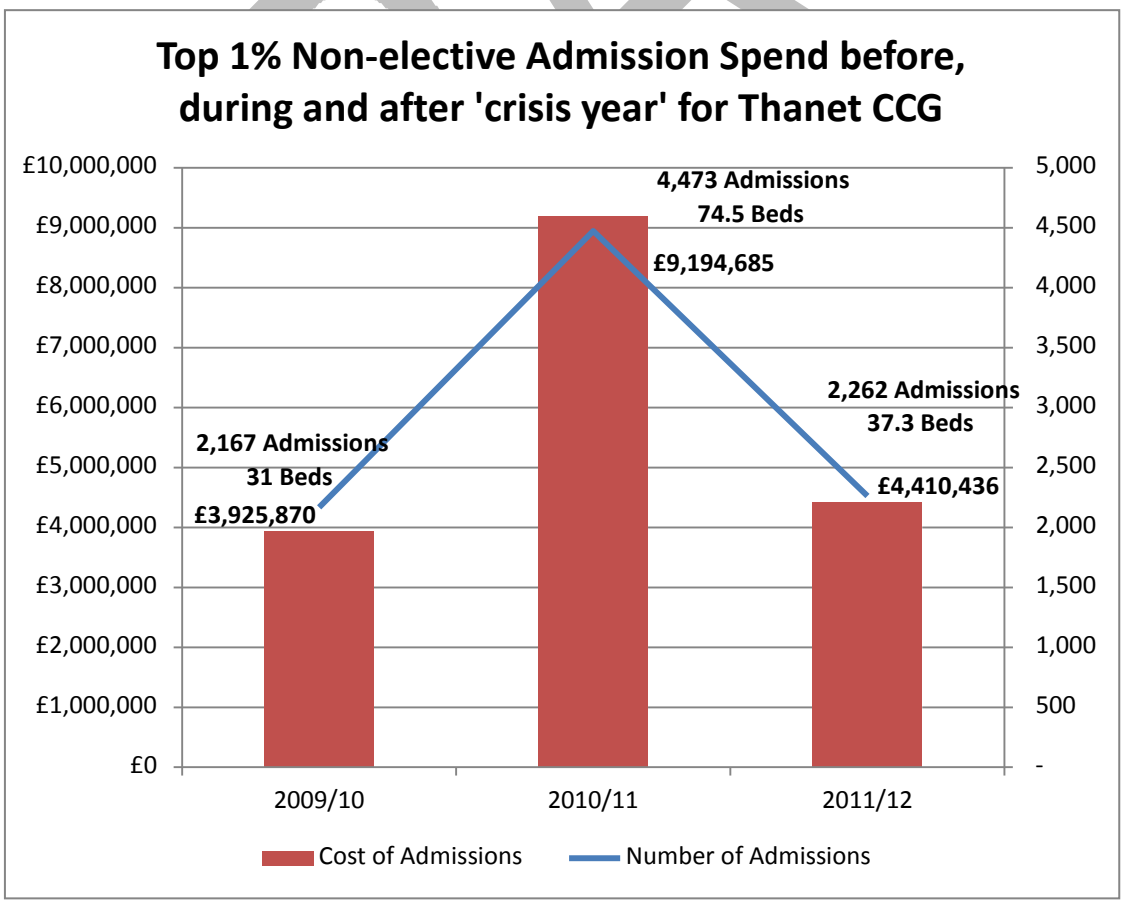

Top 0.5% Non-elective Admission Spend before, during and after 'crisis year' for Thanet CCG
£7,000,000
£6,000,000
£5,000,000
£4,000,000
£3,000,000
£2,000,000
£1,000,000
£0
3,500
3,000
2,500
2,000
1,500
1,000
500
-
3,017 Admissions
50.6 Beds
£6,264,192
1,312 Admissions
18 Beds
£2,401,619
1,499 Admissions
25.1 Beds
£2,877,174
2009/10
2010/11
2011/12
Cost of Admissions
Number of Admissions


Top 1% Non-elective Admission Spend before, during and after 'crisis year' for Thanet CCG
£10,000,000
£9,000,000
£8,000,000
£7,000,000
£6,000,000
£5,000,000
£4,000,000
£3,000,000
£2,000,000
£1,000,000
£0
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
-
4,473 Admissions
74.5 Beds
£9,194,685
2,167 Admissions
31 Beds
£3,925,870
2,262 Admissions
37.3 Beds
£4,410,436
2009/10
2010/11
2011/12
Cost of Admissions
Number of Admissions

Impact of preventing the 'crisis year' on acute provider activity, cost and capacity across Thanet CCG			
	Savings in non-elective admissions	Savings in cost	Savings in Bed days
Year 1 Top 0.5%	1,612	£3,624,796	10,618
Year 2 Top 1%	2,259	£5,026,532	14,796
Year 3 Top 2%	2,877	£5,982,624	18,140

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