Thanet Clinical Commissioning Group

| | |
|---|---|
| **Report to:** | Thanet Health and Wellbeing Board |
| **Title of Report:** | Update on Thanet Better Care Fund Programme Delivery |
| **Author:** | Fay Gooderson – Commissioning Manager, Thanet CCG |

## 1. Purpose of Paper

To update the board on the programmes in place to support the delivery of the Better Care Fund.

## 2. Introduction/Background

The aim of the Fund is to deliver the health and social care services within this Section 75 agreement to the people of the area maximising quality and value for money. A key element of the agreement is a commitment to drive continuous improvement of services within resources available. To this end, the services each party have included in the agreement are those which must work most closely together to benefit the provision of out of hospital health and social care services to local people.

## 3. Thanet's Vision for Health and Social Care Services by 2020

Thanet's vision for integrated health and social care service includes:

- GPs taking a lead for coordination
- Multi-Agency Integrated teams
- Delivering wraparound care to patients
- Delivering community care through a single point of access
- Delivering shared access to patient information
- Delivering enhanced support to carers
- Supporting independence & self-management
- Providing seamless end of life care

We recognise the need for transformational change and that no single agency can deliver the improvement working in isolation

Under the Better Care Fund, we aim to provide care that crosses organisational boundaries that best services the population needs

## 4. Better Care Fund Schemes

The Better Care Fund for Thanet is composed of the following schemes:

- Enhanced Primary Care
- Integrated Health and Social Care teams including enhancing community teams and care co-ordination
- Flexible use of Care Homes and Westbrook House
- Falls Prevention
- Improving End of Life Care

| 5. | Enhanced Primary Care |
|---|---|

**Objectives:**

- GP practices working together to enable different access opportunities for patients
- GP in Accident and Emergency at the acute hospital in Margate to build links between the acute hospital staff and Primary care colleagues.
- Patients 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;

**Update:**

- Developments of Thanet based Integrated Care Organisations, which equates to 4 locality clusters (Quex, Margate, Ramsgate and Broadstairs)
- Developments in 8-8, 7 day working programme to support patient access to core primary care services
- Developments of integrated primary care hub, underway with QEQM to support reduction in attendances and patient education
- Improved coordination for Enhanced services for Long term conditions
- Development of core pathways starting with prevention and self-care with management to end of life care
- Established Integrated Discharge Teams working within acute sites to support multi-disciplinary and early discharge from hospital
- Developments of a shared care plan for patients under the umbrella of the Multi Interoperability Gateway (MIG)

| 6. | Integrated Health and Social Care Teams |
|---|---|

**Objectives:**

- Deliver access to services seven days a week
- Share clinical information to assist with decision making out of hospital
- Access to a rapid response service for patients at high risk of acute admission
- Coordinated community intermediate care providing patient centered wraparound support
- Robust integrated discharge process with post-discharge community support

**Update:**

- Developments of Thanet based Integrated Care Organisations, which equates to 4 locality clusters (Quex, Margate, Ramsgate and Broadstairs)
- Development of wraparound patient services under targeted and holistic model of care within community and social provision 7 days per week
- New discharge to assess work programmes to support prevention of admission and reduction in length of stay
- End of life strategy to support high quality end of life care
- Development of whole system pathways for better care co-ordination across the health economy

| 7. | Flexible Use of Care Homes |
|---|---|

**Objectives:**

- Delivery of improved community solution offering flexible service
- Reduction in need for acute admission
- Support for early discharge of patients from hospital

**Update:**

- Development and implementation of a revised model of care
- Links to frailty work programme as part of whole pathway including education and better patient outcomes
- Model of 'step up' and 'step down' beds for health and social care support

| 8. | Scheme 04 – Falls Prevention |
|---|---|

**Objective:**

- To reduce the number of unplanned admissions due to falls
- To improve quality of life for Thanet residents
- To lessen the effects of ill health relating to falls

**Update:**

- Development of a multi-agency frailty programme which is clinically led
- Development of frailty pathways which start and end in the community to support self-care/prevention to end of life care.
- Development of a protected frailty unit based at QEQM to prevent admission and support early discharge
- Increase support of care homes through over 75s schemes including wider use of care plans

| 9. | Improving End of Life Care |
|---|---|

**Objectives:**

- To improve overall coordination of end of life care
- To ensure patient wishes are recorded
- To ensure patients are given their choice of place of death wherever possible

**Update:**

- Development of a layered end of life care strategy
- Development of a shared care plan between organisations
- Development of education for workforce to support advanced communication skills for end of life care.