Health and Wellbeing Strategy Reporting Template
Goal 4: Quality care, centred around the person
Objective 4B: Care will be organised around the individual

Goal Sponsor: Acting Interim Accountable Officer Thurrock CCG (Mandy Ansell)
Objective Lead: Mark Tebbs

Action Plan 2016 / 2017

OBJECTIVE: **4B: When services are required, they are coordinated around the needs of the individual.**					**OBJECTIVE LEAD:** **Mark Tebbs**	
Action	**Outcome**	**Action lead**	**Delivery Date**	**Progress Report**	**Link to outcome framework**	**Reference to existing strategy or plan**
A. To roll out the electronic frailty index in Thurrock	To identify the severely and moderately frail people in Thurrock	Jeanette Hucey	End of December 2016	To date, the Electronic Frailty Index has been introduced to identify and assess need, and support care planning in one-third of the Thurrock practices.	Outcome Framework Indicator 1. The frailty index will enable us to identify the most vulnerable 2% of people in our community	For Thurrock in Thurrock/ Transformation CQUIN
B. To ensure that all patients identified have a comprehensive care plan, named care co-ordinator and escalation plan	To improve the proactive management of frailty and reduce A&E attendances/admissions	Jeanette Hucey	End of March 2017	Use in one practice highlighted that 25% of the people identified as living with frailty were not already known to the health and social care system and therefore had no care plan. These would be potential A&E attends/admits if left unidentified and unmanaged. Those who are not known to the system are being discussed with the respective GPs/at an MDT	Outcome Framework Indicator 1. Once identified we will ensure that they have an identified responsible person co-ordinating their care plan	For Thurrock in Thurrock/ Transformation CQUIN

				and a care plan (and escalation plan) will be put in place. This work progresses well and will roll into the NELFT 17/18 CQUIN.		
C. To develop a service specification for a system that is able to integrate data in Thurrock. The solution will incorporate data from different systems at patient level to give a holistic view of a patient's health and social care pathway	We expect the integrated data set to allow us to better identify people who are at risk of events such as falls, and hypertension to allow us to better target our early intervention and prevention Schemes.	Emma Sanford	End of October 2016	The specification was developed via the project steering group by the deadline.	Outcome Framework indicator No 2. The service specification will outline our key requirements for better data integration.	Better Care Fund
D. To procure the new system	To procure a new provider able to integrate health and social care data	Emma Sanford	End of March 2017	The procurement has successfully been completed. A provider has been appointed. There have been no challenges to the process. The team are working through the contract sign off process and mobilisation plan with the aim for the service to begin by the 1st April 2017	Outcome Framework indicator No 2. We will test the market to enable us to find the best provider.	Better Care Fund

Outcome Framework

Objective	4B: When services are required, they are coordinated around the needs of the individual.							
Indicators	**2016 Baseline**	**2017**	**2018**	**2019**	**2020**	**2021 Target**	**Data Source**	**Reporting Timescales**
Outcome Framework Indicator 1 **% of the 2% highest risk frail elderly in Thurrock with a care plan and named accountable professional.** This quantifies the proportion of people registered with identified GP practices, which have been classified as living with 'moderate' or 'severe' frailty, following screening using the Electronic Frailty Index (eFI), to have a Comprehensive Care Plan (CCP) and a Named Accountable Community Professional identified. We are aiming to identify the most vulnerable frail elderly in Thurrock through a standardised tool (currently the electronic frailty index). This will enable us to ensure that each patient has a CCP, a comprehensive escalation plan to manage worsening conditions and a named accountable community professional. Our aim is that we will be able to reduce non elective attendances by better managing people in the community. This is a new indicator.	**Baseline not available as yet**					**95%**		

Indicators	2016 Baseline	2017	2018	2019	2020	2021 Target	Data Source	Reporting Timescales
Outcome Framework Indicator 2 **Establish a data system linking records from primary, secondary, community, mental health and adult social care**								
Currently, there are a number of different information systems that hold patient-level health and social care data, but there is no easy way to link records, meaning it is difficult and often impossible to see who is accessing multiple services. This means it is difficult to identify residents who are at risk of becoming future users of expensive services, and therefore makes future service planning very complex. Approval has been given for the procurement of a solution that will enable Thurrock to maintain a Population Health solution, enabling population segmentation (i.e. being able to identify sub-populations who share similar characteristics to better target interventions), risk stratification across services, and predictive/scenario modelling to be carried out (enabling forecasting of future service use in line with population projection information to aid future planning).	**No system in place**	**System in place**	Future indicators/targets to be set using the outputs from this system					

Indicators	2016 Baseline	2017	2018	2019	2020	2021 Target	Data Source	Reporting Timescales
Outcome Framework indicator 3. **% of Early Offer of Help episodes completed within 6 months.**								
This indicator quantifies the proportion of all Early Offer of Help episodes that were completed within 180 days. Services provided under the Early Offer of Help aim to support families and children at the edge of statutory intervention or, where statutory intervention is already in place, to prevent this escalating to care proceedings. Reducing the risk of poorer outcomes by providing support at an earlier stage prevents more costly later intervention from both a health and social care perspective.	**76.5%** (2015/16)	**95%** (2016/17)	Note that indicator might change post 2016/17					