Thanet Plan – Delivery Update

Thanet Health and Wellbeing Board Meeting 13 November 2014

1. Introduction

We are planning and delivering the two-year Thanet Operational Plan through six clinically led workstreams:

- Patients receive high quality equitable and accessible GP services
- Patients receive high quality, integrated out of hospital care covering physical and mental health
- Patients receive timely, clinically appropriate and high quality care in hospital
- Patients receive high quality mental health and wellbeing care in the most appropriate setting
- To ensure high quality children's services
- To contribute with partners to reduce health inequalities in Thanet

Workstream membership comprises colleagues from across the Health System, Thanet District Council and the Voluntary Sector.

Since the last report to Thanet Health and Wellbeing Board all workstreams have met and this report highlights progress to deliver the plan.

2. Workstream One - Practice Development

2.1 Delivery

1. Over 80% of Thanet patients are represented through GP Practices that have agreed to take part in 'MIG', a system designed to provide system wide health professionals with timely and appropriate access to patient data. Final testing of the system is being carried out by East Kent Hospitals University NHS Foundation Trust (EKHUFT), the first provider to go live with MIG. Testing is to ensure the integrity of the Queen Elizabeth Queen Mother Hospital (QEQM) based system prior to 'go live' which is slightly delayed due to this testing.

2. The Dementia trajectory is agreed with NHS England in line with national targets. This means a very ambitious target for Thanet, which has a poor record in dementia diagnosis, and the CCG has a clear operational plan to encourage and support Practices to improve their diagnosis rates. We have recently secured additional GP support to provide clinical leadership for this programme; Dr Reddy is to provide direct support to practices and nursing homes through visits and clinical support by telephone.

3. A programme of practice visits is continuing; practices are being made aware of performance against peer groups and are being provided with links to performance tools such as the Practice Profiles.

4. We have received and are reviewing interim progress reports from all practices that had successfully bid for additional funds to plan and deliver improvements in care for over-75s.

5. A small group from the wider GP workstream met in October and has incorporated into the work programme two additional themes of work to support the goal of Improved Access to GPs:

- public education to guide and inform the most appropriate access to/use of health and social care services
- guidance and support for GPs that will back-up decisions to limit the number and type of patient contacts and interventions - the authority to say "no".

6. Our newly appointed workforce facilitator is reviewing requirements on practices for the impending 'compulsory' national Workforce Audit. The Membership Development team are to be trained regarding this work, to enable support to be given to Practices. We are also coordinating a register of Thanet practice staff who are trained/being trained to support implementation of the 'new' diabetes pathway.

7. We are working with KKC to stop inappropriate attendance at GP surgeries by children and their parents who are asking for evidence of 'authorised' absence from school. The influx of consultations was caused by unilateral rule changes introduced by KCC.

8. We have augmented Clinical leadership for this workstream through securing additional GP involvement.

2.2 Challenges

9. Recruitment issues at Dashwood Medical Practice are still to be resolved.

10. Garlinge Practice remains in dialogue with NHS England Area Team regarding a review of their contract funding.

11. A final decision is awaited regarding the contract arrangements for the Broadway practice, post March 2015.

3. Workstream Two - In Hospital Care

3.1 Delivery

1. As part of a wider package of initiatives to improve patient flow through the hospital to ensure length of stay is appropriate/is not extended due to operational failures or lack of capacity, we have commissioned a GP in A&E scheme. This went live on 1st October and is staffed by a GP and Advanced Nurse Practitioner between the hours of 11.00 and 23.00. The intention is that patients are assessed upon arrival in A&E and those not requiring acute services are streamed to see the GP. In October the number of patients seen by the GP averaged only 1.7 per hour against a target of 4. We are reviewing the data to identify where improvements are needed to ensure achievement of the target.

2. The Integrated Discharge Team is a multi-agency, multi-provider team based within the QEQM. It consists of EKHUFT Discharge Co-ordinators, Social Care Managers, Community based Integrated Care Team, including dedicated Occupational and Physio Therapists under a single manager. The team went fully live at the start of November and will focus on preventing admissions and reducing delays in discharge.

3. We have set up monthly Operational meetings for our Clinical Leads with EKHUFT colleagues to address areas of pressure within the hospital and to work together on solutions.

3.2 Challenges

4. There is considerable pressure on the acute trust which is failing to achieve the 4 hour target. We have brought in Emergency Care Intensive Support Team (ECIST) and are planning a clinically led 'perfect fortnight' to re-boot A&E. The aim will be to ensure operational changes made and lessons learned are sustainable to achieve long term improvements both within and beyond the hospital.

5. EKHUFT is also failing to deliver the 18 week RTT target. T/O referrals are exceeding capacity and the backlog is not reducing. The Orthopaedic Recovery Plan is insufficient to resolve the situation and each East Kent CCGs through the Contract Delivery Group are considering additional local actions to ensure delivery.

6. Delivery of Cancer targets and care is also an area of serious concern.

4. Workstream Three - Out of Hospital Care

4.1 Delivery

1. Work to deliver support for diabetes patients closer to their homes is progressing well and we are on track to go live with a strengthened community service from April 2015.

2. A new to Thanet Age UK Support at Home Service commenced on 1 November 2014. This non statutory service for people who require support but are not eligible for Social or Intermediate Care will:

- Offer timely response, low level practical and emotional support from 9am to 4pm, 5 days per week (Monday to Friday) initially. If there is an evidenced need that extended hours are required this will be considered following evaluation of the pilot.
- Provide access to locality based community support to avoid unscheduled attendances and admissions as a result of social crisis.

- Have strong links with the local health and social care networks, with the ability to be directly access appropriate services as required.
- Have in reach to the local acute trust via the planned Integrated Discharge Team to facilitate safe and timely discharge, and support an overall drive by the health and social care system to reduce current length of stay.
- Support early identification of patients that require further discussion by GP practice Multi-Disciplinary Teams to develop appropriate, patient centred care plans, to avoid unnecessary A&E attendances and potential social crisis.
- Underpin the healthcare system approach to risk stratification care planning for vulnerable individuals through providing early intervention.

3. We have commissioned three additional GP step up beds bringing the total to 13. This scheme provides high quality and appropriate short-term (1-14 days, longer by exception) care for patients without admitting them to hospital. The aim is 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.

Admissions can be requested by GPs, or other 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 is agreed within 24 hours of admission, which includes a plan for discharge.

Discharge destination	No.	%
Own home	70	50%
Care home	31	22%
Hospital	16	12%
Died	6	4%
Westbrook House	7	5%
Unknown	9	6%

4. We are collaborating with KCC to implement a number of changes at Westbrook House, Victoria Unit, to ensure the CCG can optimise the functions of Westbrook House more flexibly.
These are:

- CQC registration
- Review of current medical cover (linked to wider Care Homes project)
- A review of medicine management is under way
- Planned re- launch of Victoria Unit in April 15.
- We have re-established a care homes working group including members from KCC, KCHT, KMPT, Pilgrims Hospice and Secamb. This will be a task and finish group to look at:

- GP managed beds usage and improved links with KCC to support patients in their own homes
- Reviewing current criteria for GP managed beds
- Review process for care planning in care homes
- An options paper will be submitted for CLT consideration in December 2014 including a review of the current Care homes LES.

5. Following decision by the CCG's Clinical Leadership Team we are increasing carers support payments to £800. We are also exploring options for rapid response for carers through Crossroads.

6. In conjunction with Macmillan we have appointed Thanet's Macmillan funded GP facilitator. The GP role will:

- Promote cancer service improvement and share good practice across practices
- Support development of local cancer awareness and early diagnosis
- Provide clinical leadership to influence local cancer services commissioning Enhance communication between primary care and other sectors to facilitate effective continuity of care for patients

There is also funding available from Macmillan for practice nurse training to enhance the knowledge, skills, attitudes and confidence of Practice Nurses to take a more active role in managing cancer as a long term condition.

7. A joint Health Education Kent Surrey Sussex (HEKSS) bid has been submitted in collaboration with Pilgrims Hospice and EKHUFT for 'one chance to get it right 5 priorities of care'.

8. A joint HEKSS bid has been submitted in collaboration with South Kent Coast CCG for 'Keep older adults well and safe in their own homes' through applying best practice models to design, test and evaluate digital technology and MDT education.

5. Workstream Four - Mental Health

5.1 Delivery

1. IAPT contracts expire in August 2015. There has been a full review of the current specification and future financial modelling. Thanet CCG has met local providers to build relationships and to gain better understanding of service user demographics.

Thanet CCG is currently meeting all the national targets in relation to access for service users and recovery rates within Thanet.

2. A summit was held in October to consider the Neurodevelopmental Pathway (all ages). The summit involved providers, Commissioners and voluntary sector organisations and there is commitment to create a clearer pathway for patients

throughout Kent and Medway. A Steering Group to take this work forward has been set up and is due to meet on 12th November 2014.

3. The CCG has been running a Primary Care Mental Health Specialists Pilot since 2012. Preliminary evaluation of the project by the University of Kent has shown the introduction of experienced Mental Health Professionals into Primary Care has been well received by service users and an extension to this pilot is being negotiated with KMPT. Full evaluation of the pilot is due in December after which consideration will be given to wider implementation.

4. We have augmented Clinical leadership for this workstream through securing additional GP involvement.

5.2 Challenges

5. Thanet currently has 50 patients on the Autism waiting list, with 43 of those patients waiting over 16 weeks for assessment by KMPT. The Consultant currently carrying out the assessments is leaving KMPT and although additional funding has been provided for locum support, KMPT has not yet made this appointment. South East CSU has provided a paper detailing options for procuring other providers in order to reduce the waiting list.

6. ADHD prescribing - we are in discussion with a Thanet GP regarding her ability to support Dr Chopra (Canterbury) in working with South London and Maudseley NHS Trust in providing a further GP led prescribing clinic. This is currently a gap for Thanet patients.

6. Workstream Five - Children

6.1 Delivery

1. CAMHS waiting times are down to an average of 10 weeks from referral to routine assessment. This is a significant improvement when set against the very long waiting lists the provider (Sussex Partnership Foundation Trust) inherited when they took over the contract 2 years ago. This has been achieved though robust performance management of the provider and by establishing strong relationships with the local service manager in Thanet where regular monthly meetings take place to discuss operational issues affecting Thanet children.

Additionally we have facilitated the inclusion of CAMHS staff into meetings with Pastoral Officers at Thanet schools where specific cases can be reviewed and have also ensured that the local service manager attends the Thanet Head Teachers' Forum regularly.

2. We have secured new Clinical leadership for this workstream through appointment of two GPs.

7. Workstream Six – Inequalities

7.1 Delivery

1. This workstream is responsible for inequality proofing the Thanet Plan to ensure there is sufficient focus, targeting and prioritisation of areas where there is greatest inequality for Thanet's population. This work is ongoing and on December 9th when all Clinical Leads are meeting to review and re-fresh plans for the year ahead, this workstream will play an important role in identifying areas where greater emphasis may be needed to address health inequalities.