Suffolk County Council

Agenda Item 6a

Health Scrutiny Committee, 14 March 2017

Supplementary Information Bulletin

The Information Bulletin is a document that is made available to the public with the published agenda papers. It can include update information requested by the Committee as well as information that a service considers should be made known to the Committee.

The information below is supplementary to Item 6, and covers the following items:

1. **Winter planning task force update**
2. **Connect Suffolk Integrated Neighbourhood Teams (INTs) - Update Summary (December 2016)**
3. **Quality Accounts**

1. Winter planning task force update

Background

At the Health Scrutiny Committee on 21 January 2017, members received a report from Councillor Sarah Adams, who chaired a Task and Finish Group on 12 December 2016 to look into how health and social care would be managing during the winter months.

Areas highlighted in the Task and Finish Group report included: a need to improve mechanisms and processes for community care, multi-disciplinary team (MDT) working, keeping hospitalised patients as mobile as possible and improving criteria for discharge.

At the last meeting, the West Suffolk Accident and Emergency (A&E) Board, which is a multi-agency group, was represented by Stephen Dunn, who sits on that board and is also Chief Executive of West Suffolk NHS Foundation Trust. As the east was not represented at the meeting, members asked for a written update specifically on how the east system coped over the busiest months.

Overall the system has performed well in very difficult times. True system working, in the light of the work done to develop proposals for how the system will be sustainable in the future, has lead to much improved relationships and some significant successes and interventions over this winter, which has seen benefits for patients and means the system has managed well when compared to the rest of the country.

Accident and Emergency (A&E) front door

Councillors asked about the changes to the A&E front door. The table below sets out the most recent record of the urgent care indicators covering the bank holiday period 2016/17. Members should note the total numbers of attendances to A&E varied from its highest (1809 people) to its lowest (1528 people). Most of those who attended were because of major incidences, and between 25-32% were then admitted. This means around one in four attenders required a hospital stay, likely because of the complexity of their condition or seriousness of their injuries.

Urgent Care Indicators

Data up to: 02-Jan-17		Weekly Performance vs Approved Trajectory						Weekly	Month	Year	Plan /
		28-Nov-16	05-Dec-16	12-Dec-16	19-Dec-16	26-Dec-16	02-Jan-17	Trend	to Date	to Date	Target
Accident & Emergency	A&E 4 hour emergency department standard	80.3%	93.9%	90.5%	89.3%	88.2%	78.2%		52.9%	91.1%	95%
	A&E Trajectory as agreed with NHS-I	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*		*95.0%*	*92.7%*	
	Number A&E breaching 4 hour standard	356	98	160	177	180	371		247	6,056	
	No. breaching 4 hour std - subsequently admitted	210	54	99	74	115	155		78	2,922	
	Admissions waiting in A&E for 8 to 12 hours	209	54	99	74	115	155		78	2,914	
	Admissions waiting in A&E for over 12 hours	1	0	0	0	0	0		0	7	
	Number A&E attendances Total	1,809	1,610	1,687	1,658	1,528	1,701		524	67,762	
	Number A&E attendances Majors	1,314	1,132	1,191	1,128	1,116	1,117		290	43,546	
	Number A&E attendances Minors	442	438	376	406	327	366		67	20,125	
	Number of emergency admissions	482	421	448	429	492	475		129	17,920	
	Percentage of emergency admissions	26.6%	26.1%	26.6%	25.9%	32.2%	27.9%		24.6%	26.4%	25.75%
	Number of GP Referrals to A&E	57	51	46	54	32	44		5	1,409	
	A&E Median waiting time in minutes	171	169	172	176	179	183		211	173	
	A&E 95 percentile waiting time in minutes	342	328	335	341	349	373		450	300	240
	A&E Time to initial assessment (median time)	14	14	15	14	14	15		25	13	
	A&E Time to treatment (median time)	88	86	88	90	90	95		127	97	
	% A&E left without being seen	4.9%	2.4%	3.4%	4.6%	4.5%	5.1%		6.1%	4.6%	5%
	Number Medical emergency admissions	377	322	358	338	402	368		99	13,620	
	Number Surgical emergency admissions	99	95	84	68	80	98		26	3,781	

Members should also note the number of people who attended with minor injuries, which can be anything from cuts and sports injuries to colds and fever. Although it is difficult to measure, the system's communications teams, Healthwatch Suffolk and Community Action Suffolk (CAS) worked closely to amplify messages during December and January.

A brief example on 6 January, the system shared specific keep well messages, promoting use of the pharmacy, use of 111 and OOH urgent GP appointments. CAS alone reached the following audience:

- Email to 274 CAS members who work with Older People
- Email to 575 CAS members in our Health and Wellbeing network (may be some duplicated contacts with the above list)
- News story on CAS website
- Post on Facebook
- Post on Twitter
- Internal email to all CAS staff

In addition, Ipswich Hospital Trust (IHT) decided to commission an external expert Dr Kevin Reynard to review how their Emergency Department worked and he suggested a number of recommendations to which IHT has been taking forward since February 2017. These include:

- Earlier senior clinical decision making;
- Improved internal streaming;
- Improvements to discharge summary compliance;
- GPs working alongside ED staff;
- Geriatrician and senior integration matron working in the department;
- Revised staff training and education programme;
- Improvements to ambulance handover performances;
- Staff listening events.

Delayed Transfers of Care (DToC)

On 7 November 2016 there were over 80 people who were medically-fit to leave Ipswich Hospital but were not able to be discharged into their home. On 28 February 2017, there were 21 people who fitted this category.

A small DToC taskforce was formed with representatives from Ipswich and East Suffolk Clinical Commissioning Group, Ipswich Hospital, Adult Community Services and Norfolk Community Health Care being released for their day job to address the problem.

This change has been achieved through a series of actions led by the DToC Taskforce and embedding processes, including system-wide weekly multi-disciplinary team (MDT) DToC meetings, focused on individual patients, which are carried out in hospital and now also in the community hospitals. It also benefited from a review of processes from Dr Ian Sturgess, from NHS Improvement, who shared national evidence with the system on 20 December 2016. This national evidence set out findings which included that 48% of people over 85 die within one year of hospital admission and 10 days in hospital bed (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80.

The following actions have taken place recently:

- A multi-disciplinary checklist is now being used at Ipswich Hospital on discharge. This is placed in the front of the patients notes so that all staff see the importance of discharge planning and to ensure the information is all in one place.
- A Patient Access Policy for Unplanned/Non-elective Care has been developed and now needs to be ratified by IHT and implemented. Along with robust process to produce Patient Target List to support MDT DToC.
- Development of a system (Ticket Home) to empower the patient/ their family to challenge staff constructively with the knowledge that they need to ask the right people the right questions.
- Adult Community Services (ACS) continue to experience their own challenges in domiciliary care market (around Support to Live at Home);
    - Specifically on the 'hot spot' areas and addressing these gaps in domiciliary care provision both with Home First and longer term domiciliary care needs and;
    - On the 'hot spot' areas for residential and nursing care needs:-
        - Home first has been providing in reach into the Community Hospitals and working with Crisis Action Team Plus (CAT+) who are testing an early supported discharge model of care;
        - ACS has started to work on a domiciliary care arm to Home First and are expecting this to be up and running in June 2017 to tie in with CAT+ proposals/findings from the evaluation which were shared with the Integrated Care Network on 14 February 2017.
- East Suffolk Care Home Forum is being utilised to address operational findings from DToC Taskforce and specifically those which relate to training and education, and alternatives to managing individuals' care needs, particularly patients in nursing homes.
- Two Care Homes have taken ownership to train their staff to address the more complex/specialist care for their residents.
- IHT and CCG have developed a proposal to support patients with delirium in specific care home/s and in the longer term earlier on in the delirium pathway through prevention and self-care with Public Health. This proposal will be incorporated into a wider business case need to support Discharge to Assess (D2A) in general and will be discussed at the Integrated Care Network in April 2017.

- IHT and community services are working up a proposal to upskill community hospitals to provide level 2-3 rehabilitation and what this service would look like along with needs.

For further information, please contact Clare Banyard, Associate Director (Redesign), Ipswich and East Suffolk Clinical Commissioning Group; Email: clare.banyard@ipswichandeastsuffolkccg.nhs.uk Tel: 01473 770011

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2. Connect Suffolk Integrated Neighbourhood Teams (INTs) - Update Summary (December 2016)

Good progress has been made in nine Connect Suffolk sites as detailed below and early 2017 (first quarter) launch dates are planned for the other four sites (Woodbridge & Wickham Market, and South Rural in the east and Bury Town and Haverhill in the west). The benefits and positive impact of co-location and co-working are beginning to be evident. Work is in progress in many of the locations to improve IT and WiFi facilities to support hot-desking opportunities and co-location where possible.

West Suffolk

Sudbury *(INT start date February 2015)*

Adult Community Services (ACS) & Suffolk Community Healthcare (SCH) are now co-located at Sudbury Community Health Centre and communication between teams has improved. The Integrated Neighbourhood Team (INT) Directory, Workplace Shadowing and "Lunch 'n' Learn" sessions are now established. A Home First Occupational Therapist (OT) attends SCH allocations, which is reducing duplication of visits, and in addition the ACS OT is sharing information. ACS's closer working relationship with the police, including joint visits, has resulted in a better understanding of roles. Planning is now in place to widen this to the ambulance service. A 'Connect in the Community' event is being planned in the spring of 2017 for all local organisations to promote their services to the public/local community.

Forest Heath (Mildenhall, Newmarket and Brandon) *(INT start date April 2016)*

The Community Health team moved into the Forest Heath Building, Mildenhall in September where ACS Social Work Services and Home First colleagues are already based. Co-location has had a positive response. Since October, the ACS and SCH teams hold 'Connect Wednesdays' as a meet and greet session between community health and social care staff on the second Wednesday each month. Shadowing for new starters is in place in Newmarket & Brandon as part of induction. Hot-desking is being explored at Newmarket Hospital and Brandon Health Centre. The INT Directory is in process.

Bury Rural *(INT start date April 2016)*

The INT Directory is complete. Meet & Greet sessions have taken place between ACS and SCH. General Practitioner (GP) instigated Multidisciplinary Team (MDT) professionals' meetings were well attended and supported full engagement, sharing of information and knowledge of other teams. The SCH Co-operation and Competition Panel (CCP) attend the fortnightly Bury Rural allocation meeting with a printed list to identify shared people. OT joint visits are in place.

East Suffolk

East Ipswich *(INT start date June 2015)*

The INT Directory, workplace shadowing and "Lunch 'n' Learn" sessions are now established. Shared training and joint management meetings take place bi-weekly. Triage review is taking place to include West Ipswich staff. ACS workers hot-desking

at Bluebird Lodge (BBL) are getting to know each other and working jointly across ACS and Health. Regular South liaison meetings continue and ACS now has a simple equipment clinic every week at BBL. Occupational Therapy Assistant (OTA) joint working with a band 4 has proven a positive outcome for the public as they only tell their story once and all the issues are covered when needed, so it serves as a preventative action. The Community Matron is based with ACS at Landmark House once a week.

Eye and North West *(INT start date March 2016)*

The project group is established and meeting monthly. A "Lunch 'n' Learn" session on mental capacity was planned for January with additional sessions planned to take place every three months. The INT Directory is in progress and work shadowing is being discussed. Effective case management with OTs is avoiding duplication on a weekly basis. Work is taking place to enable joint working between Social Workers and District Nurses. The Integrated Delivery Team (IDT) and OneLife Suffolk have been invited to be part of the INT. The Town Council is linked with Kate Turner, Suffolk Information Partnership Co-ordinator (ACS) to help widen the community's involvement. There are hot-desking opportunities at Hartismere. MDTs attended in Eye and are seen as effective.

West Ipswich (*INT start date April/May 2016)*

The INT Directory is in progress. Workforce shadowing and combined "Lunch 'n' Learn" sessions with East Ipswich are being discussed. Continuing MDTs are under review. Band 4 staff members from ACS and health are to review patients together. The Community Matron is hot-desking at Landmark House. An ACS worker is based weekly at BBL. Combined project management arrangements with East Ipswich are being considered.

Felixstowe (*INT start date May 2016)*

The INT Directory is complete. "Lunch 'n' Learn" sessions are well established with over 30 staff attending one on mental health and a joint Making Every Contact Count (MECC) training session has been arranged. Standard practice includes very good working relations on the ground and joint visits between SCH and ACS. OTs are linked up and visit Bluebird Lodge to discuss local cases. Social workers are based once a week at The Grove Surgery. A drop-in at Felixstowe Community Hospital to discuss cases has been established one day a week which has been well received by SCH staff and further hot-desking is being discussed. The IDT and OneLife Suffolk have been invited to be core members of the INT and additional links with relevant organisations are being established. Two pilot projects are in process: Discharge to Assess including Shared Plan, and a social worker at Grove Medical Practice one day a week to take referrals. MDTs attended in Felixstowe.

Stowmarket *(INT start date May 2016)*

Some joint work is already in progress. Two "Lunch 'n' Learn" sessions are planned for early 2017 including a team introduction session along with a MECC training session. Team integration is underway with a plan for managers to attend each other's team meetings to explain how teams are working together and the advantages of integration, and the Community Care Practitioner is to attend SCH caseload reviews monthly to discuss joint cases. There is potential for co-location at Stow Lodge or Kingsfield Centre.

Saxmundham, Aldeburgh and Leiston *(INT start date June 2016)*

The INT Directory is complete. Some staff members have been put forward for work shadowing opportunities with a further roll out being explored. The first successful "Lunch 'n' Learn" took place in October and as from December, a one hour session is booked every two months. The February session was planned to include voluntary organisations. Joint training on MECC was planned for January. Members of the

Integrated Delivery Team (IDT) have been invited to be core members of the group along with OneLife Suffolk. Kate Turner, Suffolk Information Partnership Co-ordinator (ACS) is now involved in the INT as Trusted Adviser. Home First OTs and SCH OTs are having weekly conversations. Hot-desking is currently being scoped and may include Aldeburgh Hospital and the Saxmundham ACS building. GPs are being encouraged to continue MDTs.

For further information contact: Isabel Cockayne, Head of Communications, West Suffolk Clinical Commissioning Group, Ipswich and East Suffolk Clinical Commissioning Group; Email: isabel.cockayne@suffolk.nhs.uk; Tel: 01473 770012

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3. Quality Accounts

A Quality Account is a report about the quality of services by an NHS healthcare provider. Providers, including those from the independent sector have, since 2009, been required to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50 and a turnover greater than £130k per annum. Quality Accounts are required to be published annually and are available to the public.

Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive, and patient feedback about the care provided. Local Healthwatch use Quality Accounts to support discussions about NHS healthcare matters in the area. Quality Accounts also give healthcare providers the opportunity to engage with stakeholders representing their patients and service users.

Prior to publishing their Quality Account, providers are required to consult the local Healthwatch and Health Overview and Scrutiny Committee, who may provide a statement. Healthwatch and Health Overview and Scrutiny Committees are not required to respond and may decide to prioritise and comment on those providers where members and the service users they represent have a particular interest.

The Department of Health requires providers to submit their final Quality Account to the Secretary of State by uploading it to the NHS Choices website by June 30 each year. This requirement is set out in the Health Act 2009.

For further information please contact Theresa Harden, Business Manager (Democratic Services), Tel 01473260855, email Theresa.harden@suffolk.gov.uk

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