TOTAL HEALTH & CARE SERVICE

PROGRESS AND IMPACT REPORT 2024

"An Integrated Health and Social Care Team providing collaborative care for local people of all ages, in their own homes, ensuring the right help at the right time without patients having to go into hospital, enabling holistic diagnosis and long term health management with the most appropriate support"

2024

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WHAT IS THE TOTAL HEALTH & CARE SERVICE

Total Health Excellence East and West Primary Care Networks (PCNs) started a journey in July 2024. Six months of discussions and planning to deliver an ambitious vision for integrated working in East Kent is now realised.

This vision is aimed at providing the very best care in the community for local people. This builds on a proactive care model, previously tested in a pilot led by the PCNs in our areas, which proved to have positive outcomes for the local population.

The Total Health and Care Service has been developed based on an Integrated Neighbourhood Team (INT) model. The development plans included input from patient participants, members of the NHS, social care, voluntary organisations, care sector and public health. The journey towards development has been led by Dr Tuan Nguyen, the PCNs' clinical lead who is fully committed to this exciting opportunity to work differently and improve services for the 80,000 patients that the PCNs serve. He has enlisted the support of Dr Farida Hadi, who has already established a very successful Children and Young peoples (CYP) multi disciplinary team across Kent.

Their enthusiasm extends to all members of both teams, who to jointly support a wide range of local people from young infants to the elderly.

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The success of the PCNs Integrated Neighbourhood Team (INT) is its multi-disciplinary team (MDT) who are working hard and with a shared approach to support, education and learning; especially for unpaid carers who care for the patients every day.

These unpaid carers benefit from this system as much as the patients themselves – being able to access support which in turn prevents many health issues from arising because of their own stress and a lack of understanding their own arising conditions.

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THE TEAM

Our team consists of Care Co-ordinators, who identify patients in need of additional support and make the first visit to assess the patients' needs. They then refer them to the most appropriate professional to provide the support and treatment that the patient (or other members of the family) might need from any of the following members of staff from a variety of partner health and social care organisations:

- A General Practitioner
- A Mental Health Nurse
- A Frailty Nurse
- Pharmacists
- Community Nurses
- Social Workers
- Social Prescribers
- Carers support team
- Medicines management team
- Community Rehab Team

Members of this team meet regularly to understand the patients' specific needs and work together to ensure they and their families get the treatment and support they need, when they need it either out in the community or in their own homes.

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CHILDREN & YOUNG PEOPLES MULTI-DISCIPLINARY TEAM

The already established and very successful Children and Young People Multi-disciplinary Team works closely and in co-operation with the Health and Social Care Team. A representative attends regular meetings and connects with the care-coordinators to support any issues with children and young people identified within families. This ensures we have a “total age” service available to support local people.

CARE HOMES TEAM

This team works very closely with staff on the INT, and will support anyone who is taken into one of the local Care Homes and works with other health and social care service colleagues to achieve a multidisciplinary care approach. Without this support some patients may need to be transferred to an acute hospital for the specialist care they might need. The service was established by Total Health Excellence Primary Care Networks in Folkestone and Dover, following NHS England’s Primary Care Network contract to enhance care in Care Homes.

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SUCCESSFULLY ADDRESSING THE HEALTH CHALLENGES IN EAST KENT

This way of working is proving to be a clear answer towards preventing previously identified strains on health and social services brought about by:

- rapidly increasing numbers of elderly patients in our area.
- decreasing numbers of GPs
- Increasing populations
- an urgent need to increase capacity in primary care in “innovative ways”.
- providing care at home wherever possible.
- decreasing the burden on our acute services, by preventing people from going into hospital.
- enabling people to get the help and support they need when they need it

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SUCCESSFULLY ADDRESSING THE HEALTH CHALLENGES IN EAST KENT

It has long been identified that these issues can be reduced by

- focusing attention on better ill health prevention.
- for care to be provided as close as possible to home by well-trained and highly motivated people, including proactive primary and local care staff who could ably provide high-quality services.
- for care and treatment to be given at the right time, in the right place, which is often in a person's own home

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The Total Health and Care Teams' plans are built around these well-known health challenges in our area. Our teams work plans are aimed at helping to protect the population from re-occurring visits to hospitals and developing multiple increased conditions which remain undetected until it may be too late.

THE PCNs passionately support all these aspirations, and we have already come a long way towards achieving them within our capabilities as they currently stand with the establishment of this excellent multidisciplinary team, which is operating within the existing budgets and working collaboratively.

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ENSURING OUR ASPIRATIONS ARE PUT INTO ACTION

By providing these services we strive to ensure that the elderly population in our areas are living a healthier, happier, more independent life, and not using acute services anywhere near as often as they used to because of our services. We additionally ensure that any issues with younger members of the family identified during care coordinator visits are addressed, whilst always working with the families to ensure they fully support any interventions.

Everyone working on the Total Health and Social Care Team have a common goal: to ensure the care provided is as good as it can be; where patients have access to high quality care when they need it. Our staff are encouraged to speak up and challenge, and when negative comments are received, we act on them swiftly.

Through Involvement in individual care and treatment plans our Patients feel supported by the services we provide. Our patients, their families and carers are consulted in decisions made about their care at all stages of the patient journey. The organisation and staff individually and diligently encourage feedback from our patients regarding their treatment.

OUR HEALTH & SOCIAL CARE TEAM IS PROVIDING

Care *- Helping people when they need us; treating people with compassion, dignity, and respect; having pride in our work and our organisation.*

Clinical Excellence *- Giving our patients the best possible care; leading and sharing the best clinical practice; learning from staff and patient feedback and experiences to improve our care.*

Commitment *- Setting high standards and delivering against them; supporting our staff to grow, develop and thrive; learning and growing to deliver continual improvement.*

We believe that providing good, quality and safe services which are tailored to the holistic needs of individual patients is the paramount goal. Our Care coordinators encourage families and carers to be as involved in their own care and become as fully informed as possible.

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OUR PATIENTS AND THE COMMUNITIES WE SERVE ARE

- at the heart of everything we do.
- fully supported to engage and contribute to decisions that impact on their care.
- engaged in a way which reflects the diverse needs of individuals in our communities.
- enjoying care at home or as close to home as possible outside of a hospital setting.
- Benefitting from professional care and support from qualified staff from a range of organisations all working together

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HOW MANY PATIENTS HAS THE TEAM SUPPORTED SINCE JULY

As of November 2024, the care coordinators have physically identified and seen 74 patients, who have been referred to the most appropriate members of the multi-disciplinary team in order to support appropriately. When these visits have been made, other needs have often been identified and satisfied.

The number of referrals is increasing quite quickly, as information about the team and how to refer to them is being understood across the health and social care system. The impact their work is having on patients is being recognised across our health and social care organisations.

From January 2025, the MDT will be holding two meetings a month to ensure they can support the number of patients being referred and react to their requirements as quickly as possible.

OBTAINING FEEDBACK FROM OUR PATIENTS AND THEIR FAMILIES

There have been many expressions of satisfaction and gratitude from our patients, which clearly demonstrate that our patients are benefiting from these services. We are currently planning a “friends and family” style feedback system, but it is too early to be able to publish a true feedback picture.

The “Fit together” service run by Folkestone Sports Centre reported that a member of the group praised the support she had received from the team. She was very keen to record her gratitude for all the support she had received - to getting the treatment she needed and encouragement to support herself to meet her health needs.

She was referred to the group by her care coordinator, who also encouraged her to join Age Concern group meetings, all this has changed her life for the better. Friends and family feedback needs to be actively pursued in 2025, and that system is currently being put in place.

POSITIVE RESULTS

The data we have been able to gather to prove the success of our Children and Young Peoples service is very encouraging for our expectations of the Total Health and Care Team.

In the first 12 months since being established the CYP MDT has:

- Reduced Young Peoples attendances in our hospitals A&E from 44 in the previous 12 months to 9 in the teams' first 12 months – a reduction of 80%
- The team reduced hospital admissions from the community to the acute services by 67% in its first 12 months
- The team reduced unplanned GP appointments by 47% from 104 unplanned appointments in the previous 12 month to 55 in the first 12 months of being established

This saved the system £4,795 in A&E attendances and £2,744 in GP appointments.

(based on the assumption that a GP appointment costs £56 and A&E Attendance £137)

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WORKING TOWARDS AN EVEN HEALTHIER COMMUNITY FOR 2025

The Total Health and Care Team have clear plans to increase the number of people they support in the next six months by: -

- Doubling the number of multi-disciplinary team meetings to cope with increasing numbers of referrals
- Increasing awareness of the service within the local health and social care system and how to refer patients
- Establishing an expert patient programme in June 2025 enabling people to support each other to live more independently and manage their health conditions with support from the Total Health and Care team
- Create a reliable feedback system to monitor and record patient satisfaction
- Continue to work closely with the Children and young people team to ensure service right across the population regardless of age

REPORT COMPILED BY
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DECEMBER 2024