PERTH & KINROSS INTEGRATION JOINT BOARD

15 February 2019

Strategic Programme of Care Boards – Progress Update

Report by Chief Officer (Report No. G/19/13)

PURPOSE OF REPORT

The purpose of this report is to update the IJB on progress from the four Strategic Programme of Care Boards which have been recently established by the P&K Health and Social Care Partnership.

1. RECOMMENDATION(S)

It is recommended that the IJB:

- notes the progress on establishment of the four Strategic Programme of Care Boards
- notes that the four Strategic Programme of Care Boards intend to provide an update on progress for all IJB meetings
- notes that the four Strategic Programme of Care Boards intend to provide quarterly updates on progress and performance for scrutiny to the P&K Audit & Performance Committee by means of agreed performance frameworks
- notes the proposed and planned strategic delivery actions for each Board (section 3 below)

2. SITUATION/BACKGROUND / MAIN ISSUES

2.1
As part of its refresh of the Strategic Commissioning Plan, the P&K Health and Social Care Partnership reorganised its Strategic Planning Framework into four Programmes of Care:

1. Older People and Unscheduled Care
2. Mental Health and Wellbeing
3. Primary Care
4. Carers

These Boards have been established to provide a coordinated approach to achieving the objectives of the Health and Social Care Partnership's Strategic Commissioning Plan. The Boards will enable a more effective and focused approach for the planning of service delivery and will be an essential enabler in determining the key priorities of the refreshed IJB Strategic Commissioning Plan. The Boards will report to the Strategic Planning and Commissioning Board.

2.2
The roles and remits of all four Boards are captured within each Strategic Board's Terms of Reference. These Terms of Reference are also being presented to the IJB today for endorsement.

3. PROPOSALS & PROGRESS

3.1 Older People & Unscheduled Care (OPUSC) Board

3.1.1
The vision for OPUSC Board is to develop a Perth and Kinross model of care for older people "To support people to remain in a homely environment for as long as possible, providing access to personalised and sustainable integrated rehabilitation and reablement models of care and in partnership with communities promote healthy active ageing." This will be achieved by:

- Promoting thriving, resilient communities through additional support to access sports, leisure and encourage volunteering and neighbourhood initiatives
- Investing in a rehabilitative model of care, based in communities to significantly improve people's ability to remain at home for as long as possible
- Reviewing the use of our inpatient hospital bed base and care home placements, exploring where possible, new models to support people in their own homes for as long as possible and to ensure equity of access
- Radically enhancement of technology enabled care and home health monitoring to help people remain living in their own homes
- Continuing to improve the Admission and Discharge Pathways for people between hospital and the community

3.1.2
In order to achieve the vision and aims, and continue to build upon the momentum already established over recent years but also accelerating progress still further, the Board are proposing to:

- ***Develop and promote thriving, resilient communities through volunteering, social prescribing and neighbourhood initiatives:***
  By developing and promoting thriving, resilient community's older people will be supported to be safe and healthy, independent and maximise their potential to make a positive contribution within their community which will reciprocally support them. The Partnership will continue to collaborate with voluntary and community sectors as key partners to develop, for

example, dementia friendly neighbourhoods, additional care about physical activity opportunities and promotion of a Thriving Third Age. The Partnership's Locality Management Groups will continue to work with Local Action Planning Groups and communities to increase community empowerment, wellbeing and equality.

- ***Build on the enhanced community support approach:***
  The Enhanced Community Model (ECS) is where multi-disciplinary teams, including the voluntary sectors and others, work around GP Cluster to ensure coordinated support for people living in the community. This model is key to the delivery of our aim of supporting older people longer in their own homes as they age and grow frailer. Perth & Kinross was an early adoptor of the ECS model with pilots undertaken in several GP Practices and the benefits of this model has been clearly evidenced across Tayside. We will therefore invest in this model, enhancing on a recurring basis, our rehabilitation and social work services to provide a more comprehensive proactive approach to care co-ordination, planning and reviewing for early intervention and prevention by utilising the eFrailty Index Tool to identify people with mild to moderate frailty. The aim will be to target potentially preventable admissions by GP practice. It will also target early supported discharge linking with the front door Frailty Team and Discharge Hub. It supports the transformation of Care at Home and more recent development of the Home Assessment Recovery Team offering a rehabilitative reviewing support at a locality level.

- ***Develop an enhanced respiratory community support approach*:**
  As part of Enhanced Community support approach and linked to the Primary Care Improvement Plan, the Partnership would further complement our integrated teams by provision of specialist community respiratory services. A Community Respiratory service will provide specialist support to patients with Chronic Obstructive Pulmonary Disorder (COPD) and asthma within their own home setting during exacerbations of their condition, to support early discharge from hospital and help improve self management to reduce avoidable A&E attendances and future hospital admissions. COPD is related to high healthcare costs largely from hospital admissions. Supporting people in the home environment has been evidenced as being safe and effective and should be used as an alternative way of caring for patients who would otherwise be admitted to hospital.

- ***Review bed based resources and medical model for rehabilitation:***
  In July 2018, Perth and Kinross Health & Social Care Partnership commenced a scoping exercise to develop an option appraisal to review rehabilitation inpatient beds with support from external consultants Deloitte. This review is being taken forward to explore and develop a future model of care which will enable the Partnership to provide equity of access to inpatient rehabilitation beds across each locality and identify opportunities to shift the balance of care to enhanced community models. The above review will align with the future model for service delivery on the PRI site as part of an integrated multi-site co-ordinated and complementary approach to service delivery. The Partnership will also review use of care home

placements, as our strategic aim is to support as many people as possible in their own homes, rather than needing to move to a care home. In collaboration with NHS Tayside a review the Psychiatry of Old Age bed model across Tayside will be taken forward, to shift the balance of care into the most appropriate setting eg commissioning beds within the independent sector to provide support for more complex patients.

- ***Significant enhancement of technology enabled care and home health monitoring to help sustain community living:***
  The use of technology is playing an increasing role in our everyday lives and has the potential to increase people's choice and control over the support they require. With the shift in the balance of care from hospital to community settings we are working with people with much more complex needs who would previously have been admitted into hospital or moved to care homes. Working towards a focused early intervention and prevention service to mitigate such admissions and to support early discharge, our aim is to help these individuals remain safely at home by providing more specialised equipment and adapting their environments in order to maximise their independence.

- ***Clinical Pathways/Large Hospital Set Aside:***
  The Partnership will work in collaboration with NHS Tayside to support the redesign of patient's pathways for scheduled and unscheduled care across Tayside. Over the next two years and with the investment proposed above, the Partnership will continue to work in collaboration with Acute and Partnership Clinicians to move support for patients from acute hospital wards to support in the community. (Large Hospital Set Aside). The large hospital set aside is the amount of budget set aside by the Health Board for delegated services (including unscheduled Medical, Respiratory and Emergency Department services) provided in large hospitals for the population of the Integration Joint Board. The Partnership will develop an integrated Discharge Service to provide timely discharges home for people in hospitals. The service will deliver a full discharge to assess service, assessing people in their own homes, rather than in hospital, when they are medically fit to go home. The strategy will be to work with partners across Tayside to develop a single approach to discharging, to support Perth and Kinross patients who are in hospitals outside of Perth and Kinross.

- ***Interdependencies with Primary Care Improvement Plan:***
  The Primary Care Improvement Strategy and Improvement Plan will have critical dependencies with the future models of care for Older People & Unscheduled Care in relation to the development of the Advanced Nurse Practitioner role, Community Care and Treatment Services, Community and Urgent Care Services.

3.2 Mental Health & Wellbeing (MHWB) Board

3.2.1
The MHWB slightly differs from the other Programme Boards in that four existing strategy groups, listed below, report to it:

1. Mental Health and Wellbeing Strategy
2. Learning Disability Strategy
3. Substance Use Strategy (ADP)
4. Autism Strategy

3.2.2
The vision for the Mental Health and Wellbeing Programme is to

- Support individuals to maximise their independence and health with the right support at the right time
- Embed multi-disciplinary team working at the heart of 'seamless' care pathways and support for people
- Implement a high quality model of care that is financially sustainable.

3.2.3
The Strategy Groups are critical to achieving the vision and aims of the Mental Health and Wellbeing Programme. They meet regularly and contain representatives from Health, Social Care, Third Sector and client and carer representatives.

3.2.4
The key priorities and proposals for the Mental Health and Wellbeing Board are:

- ***Complex Care:***
  Complex Care packages (ie packages costing over £35,000pa) account for over 70% of spend and the vast majority of these clients are people with a Learning Disability and/or Autism. Substantial funding is being spent on a relatively small number of individuals with complex care requirements supporting them in their own tenancies with bespoke packages of care. Whilst this provides highly personalised support there are significant concerns this model is not financially sustainable. A transformation project for Complex Care is being initiated and will report to the Mental Health and Wellbeing Board. The aim of this project is to develop a financially sustainable model that provides high quality care. The project will focus on assessment and review processes, accommodation, carer support, behavioural support and intervention, transitions, promoting independence and improving predictions of future demand.

- ***Refreshing the Strategy Groups:***
  A workshop has been arranged with representatives from each of the strategies to clarify their role and membership to ensure they are able to fulfil their responsibilities. Any outstanding issues will be escalated to the Mental Health and Wellbeing Board for resolution.

- ***Action 15 Monies:***
  Recurring funding was allocated to Perth and Kinross HSCP by Scottish Government to improve support for people with mental health issues by

increasing the number of dedicated mental health professionals (Action 15 of the Mental Health Strategy). All the necessary governance arrangements are in place and we received our full allocation of £300,357 for 2018/19. As can be seen in table 1 below, the monies are being invested to improve the pathway of statutory and non-statutory supports for people presenting at GP surgeries and the Social Work intake team who have mental health issues. Supports for people with mental health issues in Perth Prison are also being increased.

Table 1 **2018/19**	**Planned allocation of funding per project £000's**	**Forecast Expenditure £000's**
Mental Health Nurses aligned to GP clusters	79	79
Trainer / support for "Do you need to talk" chaplaincy service	8	5
Mental Health Support Worker	29	15
Funding to 'Mindspace'	106	106
Computer Based Training	13	0
Brian in hand application licences	13	12
Social Care intake team	15	8
Prison on site team	35	0
Sub-totals	**298**	**225**
Annual allocation	**300**	**300**
Balance	**2**	**75***

*Projected underspend in this financial year caused by reconsideration of the benefits of computer based training and longer than expected lead times to recruit into new roles.

- ***Alcohol and Drug Partnership Monies:***
  New recurring funding of £464,000 p.a. was allocated by Scottish Government to reduce problem drug and alcohol use. As can be seen in table 2, this is being used to fill gaps in service provision identified during the development of a 'Recovery Oriented System of Care' across Perth and Kinross. Examples include implementation of multi-disciplinary assessment clinics, a Recovery Community and increased support for harm reduction.

Table 2 2018/19	Planned allocation of funding per project £000's	Forecast Expenditure £000's
Training for band 5 to band 6 nurses	5	5
Social Work Assistants	34	16
Band 4 nurses	30	15
Community response to overdose prevention	9	9
Whole family approach	11	5
Counselling sessions	13	13
Drug death information analyst	5	3
Non-fatal overdose pathway co-ordinator	6	3
Prison non-medical prescriber	20	10
Recovery community	20	10
Safezone – CATH /TCA	90	0
Independent advocacy service	100	100
PKAVS participatory budget	100	100
Toolbox talks training materials	5	5
Sub-totals	**448**	**295**
Annual allocation	**464**	**464**
Balance	**16**	**169***

*Projected underspend in this financial year caused by reconsideration of the Safezone investment and longer than expected lead times to recruit into new roles.

3.3 Primary Care (PCB) Board

3.3.1
The PCB is collaborating with colleagues across HSCP to produce a robust Strategic Plan. It is however recognised that notwithstanding the need and desire for such an overarching plan, there are large pieces of work which are already being undertaken as follows.

3.3.2
Primary Care Improvement Plan (PCIP) – Progress:
The pan-Tayside PCIP seeks to develop primary care services in direct support of general practice under the terms of the 2018 General Medical Services contract (the GMS contract) so that GPs can be more focussed on their role as expert medical generalist. The IJB approved the plan in June 2018 and it was subsequently approved by the other Tayside IJBs and the Local Medical Committee before being submitted to the Scottish Government.

3.3.3
Following approval of this overarching plan, a more detailed plan was produced which set out the initial allocation of funding per project and an outline of proposed models for delivery. These proposals were drafted in the early stages of engagement with stakeholders and were provided to the Scottish Government in September 2018 to set out the aspirations of the programme.

3.3.4
It can be seen in table 1 that there is considerable slippage against the in year budget. This is largely due to the whole year effect of the budget combined with projects taking longer to progress through planning and stakeholder engagement phases. It is anticipated that expenditure against each of the projects (new services) will increase substantially in 2019/20.

Table 1 **2018/19**	**Planned allocation of funding per project £000's**	**Forecast Expenditure £000's**
Vaccinations Transformation Programme	88	80
Pharmacy	294	212
Community Care and Treatment	180	29
Urgent Care	24	0
MSK	49	29
Mental Health	67	8
Sub-total(s)	**703**	**358**
Budget	**1249**	**1249**
BALANCE	**547***	**891***

*The Primary Care Improvement Fund is a ring fenced budget which can only be used to deliver the Primary Care Improvement Plan which encompasses the implementation of the 2018 GMS Contract. Expenditure against this resource is jointly agreed between Integration Authorities and the Local Medical Committee.

3.3.5
It can now be reported that relative to the expenditure outlined above the following projects are starting to move into the implementation phase. This phase will see projects start to deliver services to a small number of practices and then increase throughout 2019/20 and beyond.

3.3.6
The Primary Care Improvement Programme:

- ***Vaccinations Transformation -*** This project seeks to shift responsibility for the delivery of routine vaccinations away from general practice. This is being taken forward in a staged process across NHS Tayside over a three year period.

- ***Pharmacotherapy -*** This project seeks to create and provide a uniformity of pharmacy services to all General Practices. This will address considerable variance in the services delivered to different practices and

by increasing the staffing cohort to deliver these services burdens on GPs will be reduced. Slippage against the allocated budget for this project relates to difficulties in recruiting the requisite staff. Additional recruitment exercises are being undertaken to try to address this however it is acknowledged that there is a national shortage of qualified pharmacists. Other more innovative solutions in respect to the skill mix within teams are also being explored as a mitigatory measure.

- ***Community Care and Treatment -*** The new GMS contract places responsibility on Integration Authorities for the delivery of a wide range of services which have routinely been provided in General Practice ie phlebotomy, wound care, blood pressure monitoring, suture removal, electrocardiograms (this is not an exhaustive list). This project remodels the delivery of these services so that they remain close to patients but are delivered by the Health and Social Care Partnership. The aspirations of the contract are that this is done in a holistic manner so that services are designed, set-up and delivered sustainably. This is a complex undertaking and has required a significant level of engagement with GP practices and clusters. This is particularly the case when considering the favoured model for delivery across Perth and Kinross. It can be reported that the favoured model is now at an advanced stage of development and new services are planned for start-up in early 2019.

- ***Urgent Care*** - In order to allow GPs to focus on more complex patient needs a range of other roles will be necessary to support the patient population. Advanced Nurse Practitioners (ANPs) will in future form a core element of wider multi-disciplinary teams aligned to practices. Plans are at an advanced stage in the recruitment process to appoint 3 roles initially with the potential for this to increase in the later years of the programme. Slippage against the allocated budget for this project is due to the ongoing engagement with GPs on the roles and responsibilities of ANPs as well as the model for integration with general practice. It is also acknowledged that there is a limited pool of eligible candidates for these valuable roles and so recruitment to all posts may not be possible initially. To mitigate this issue, plans are being developed in collaboration with the Scottish Ambulance Service in respect to the potential for Specialist Paramedics to undertake a similar role.

- ***Musculoskeletal (MSK) first contact service -*** This project alters the patient pathway for MSK presentations so that patients initially see an MSK physiotherapist rather than a GP in appropriate circumstances. This new service started in early January 2018 with 1.5 WTE staff delivering 13 clinical sessions across Perth City and the South Perthshire cluster. Additional clinical sessions across Perth and Kinross are planned to commence from April 2019. Slippage against the allocated budget for the project is due to delays in project start-up and the phased approached to roll out. This has required less resource initially but will benefit from the lessons learned in the early stages.

- ***Mental Health -*** Funding from the Primary Care Improvement Fund (PCIF) has been combined with "Action 15" funding in order to create a range of new positions to support patients with low level anxiety and depression. Action 15 funding is received by Integration Authorities under the Scottish Government's Mental Health Strategy. With particular reference to PCIF funded positions, 6 WTE Mental Health Nurses are currently being recruited (4 funded from PCIF). These posts will be closely aligned to general practices to support/treat patients and to streamline the signposting and referral to other wider services. Many of these other services are being developed in tandem with these roles and are being funded via "Action 15" monies.

3.3.7

GP Prescribing:

The annual expenditure against the prescribing budget represents an ongoing challenge for the Health and Social Care Partnership with the latest financial data (Sept 2018) indicating a funding gap of £1.2m.

3.3.8

To understand the drivers for the gap between the budget and the forecast expenditure, it is necessary to analyse the variances in prescribing behaviour across GP practices. For several months, work has been undertaken to create and produce reliable variance reports which provide sufficiently detailed data at practice level. This work is nearing completion and early analysis is providing opportunities to engage practices which are most a variance

3.3.9

When considering engagement at GP practice level, it can be seen that practices which have been supported to focus on quality prescribing have been able to show notable reductions in overall expenditure.

3.3.10

Despite this overspend position the latest data available in respect to overall prescribing trends (November 2018) highlight that all of the major indicators demonstrate improvements. It can be seen that overall expenditure, the number of items prescribed and the average cost of each item are all in decline when compared to the same period in the previous year.

Table 2 - % Growth in prescribing indicators for the 12 months to November 2018 when compared to the previous 12 month.

Performance Indicator	Angus	Dundee	Perth & Kinross	Unallocated	Tayside	Scotland
% Growth – No of Items	-1.50%	-0.74%	-0.48%	-0.23%	-0.86%	0.11%
% Growth – Average Cost Per Item	-3.85%	-3.62%	-2.98%	5.62%	-3.36%	-1.79%
% Growth – Expenditure	-5.03%	-4.33%	-3.46%	-5.63%	-4.19%	-1.69%

3.3.11
The Board has approved plans for the Quality Safety and Efficiency in Prescribing (QSEP) Programme Management Team to expand the use of GP engagement funding to maximise the potential of the current pan-Tayside programme of interventions.

3.3.12
The approved plan seeks to identify areas of individual variances in GP prescribing which cannot easily be explained or justified. This approach will again assist in focussing attention on the areas most in need to maximise the potential of savings plans for 2018/19. It will also assist in the development of future plans for the 2019/20 QSEP programme.

3.4 Carers Board

3.4.1
Since the last update to the IJB, the Carers Programme Board approved the Perth & Kinross Health and Social Care Partnership Short Break Services Statement on 6 December 2018. It was a requirement of the Carers (Scotland) Act 2016, (Carers Act) that each Health and Social Care Partnership publishes their Short Break Services Statement by 31 December 2018 and our Short Break Services Statement was made available on the PKC website on 24 December 2018. A summary version of the Statement and a supplementary information leaflet regarding the Statement is to be produced to raise awareness of the short breaks that are available to carers in the area, to minimise carer breakdown and support carers in their role.

3.4.2
A draft Carer Strategic Plan identifying the aims and priorities of the programme has been developed. This plan will underpin the Carers Strategy, which will ensure that carers in the area have access to good information in relation to the resources and support that is available to them. It will enable carers to inform developments in the services which are commissioned and the work we do, to improve the support that is available to them. This will enable carers to continue caring and to have a life alongside caring which has been developed and informed by their own interests and outcomes.

3.4.3
The Carer Strategy (2019-2022), is currently in development following the Carers' Conference in November 2018 and a workshop which was held in December 2018. Both events involved carers, officers and key stakeholders from the voluntary and third sectors. They identified the key commitments for the strategy and the activities which will support them. The Carer Strategy (2019-2022) will apply jointly to both Young and Adult Carers and the Partnership is working with colleagues in Education and Children's Services to ensure that the document reflects this. The Strategy is consistent with the Health and Social Care Standards which are based on five outcomes relating to the experience of people involved with Health and Social Care and the five principles which reflect the way that everyone should expect to be treated. Consultation with carers for the development of arrangements to support them

is critical to this work and is also required under the Carers Act. The strategy is to be available for approval by IJB before 1 April 2019.

3.4.4
Data validation has taken place for the first six months' submission of the Carers Census 2018/19 to the Scottish Government, to ensure the quality of information presented.

4. CONCLUSION

All four Boards are now functioning as Strategic Boards however further progress is necessary to fully establish their longer term strategic delivery plans. The Boards will raise or escalate matters of relevance to the Strategic Planning and Commissioning Board as required. Further progress reports will be provided at each Integration Joint Board. The Strategic Programme of Care Boards intend to provide quarterly updates on progress and performance for the purposes of scrutiny to the P&K Audit & Performance Committee via performance frameworks.

5. DIRECTIONS

There are no Directions from the IJB to NHS Tayside or Perth & Kinross Council identified or required at this stage.

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NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report.