PERTH & KINROSS INTEGRATION JOINT BOARD

12 February 2020

LOCALITY INTEGRATED CARE SERVICE

Report by Evelyn Devine, Head of Health
(Report No. G/20/10)

PURPOSE OF REPORT

A key priority of the Strategic Commissioning Plan is to shift the balance of care to integrated community models in order to provide person-centred, preventative care and support, earlier.

This report outlines the progress achieved to date to deliver on this priority through the investment into enhancing community support by way of Locality Integrated Care Teams (LINCs).

This report also aligns to the progress report provided to the IJB on 17 December 2019 on the Review of Inpatient Rehabilitation Beds.

1. RECOMMENDATION(S)

The Integration Joint Board is asked to:

- Note the progress achieved in developing this model of enhanced community support.
- Support the further development and implementation of the Locality Integrated Care Service model.
- Note the proposed implementation date.
- Support the proposals to engage fully on the future model of care

2. SITUATION/BACKGROUND / MAIN ISSUES

The impact of demographic changes, combined with the financial constraints we are experiencing present serious challenges to and demands on health and social care systems. Unscheduled hospital admissions account for a high proportion of healthcare expenditure and therefore a reduction in these unscheduled admissions could allow a redirection of resources to enable a shift in the balance of care from in-patient to community services.

The Public Bodies (Joint Working) Act (2014) describes the Integration of Health and Social Care in Scotland and is based on three premises; shared responsibility, shared budgets and a focus on making services better for patients. This is especially related to those with long term conditions and disabilities, many of whom are older people, by providing joined-up, seamless health and care social provision closer to people's own home.

Perth and Kinross Health and Social Care Partnerships' refreshed Strategic Commissioning Plan for 2020-2025 has the ambition to develop enhanced community services, which intervene early to support people to remain healthy, active and connected in order to prevent later issues and problems arising.

Since the HSCP formed in 2016, we have been developing more integrated health and social care services across the three Perth and Kinross localities. There has been significant transformation to ensure that care and support is provided in the right place, at the right time by the right person. This evidences that many more people are cared for at home. However, despite this, hospitals and community services continue to experience increased numbers of people presenting for unscheduled care, a demand that outstrips our current resources.

This is partly evidenced through the indicators and measures set by the Ministerial Strategic Group (MSG) for Health & Community Care in 2018, which requires Integration Authorities to establish local performance improvement trajectories in respect of six indicators to enable more care to be shifted towards community. Since the baseline year of 2018, Perth & Kinross has seen an increase in Accident & Emergency attendances: emergency admissions and 7 day readmissions especially in the 65+ age group.

During 2015/16 the HSCP piloted an 'Enhanced Community Support' approach with several GP Practices in Perth City and Strathmore in order to respond urgently to people assessed as being at risk of crisis. Non recurring funding of £477k for health staff was approved to pilot this approach.

An evaluation of the pilot sites evidenced a measurable benefit of this way of working for patients and the multi-disciplinary team. From this, the Partnership approved recurring funding of £460k to continue the approach in Perth City and North Perthshire. There was no additional funding approved for South Locality. The South Locality tested ECS within existing resources from the Integrated Care Team but this was not sustainable due to the increasing demand.

A Project Team was re-established in April 2019 to review the learning from the pilot evaluation and to plan the introduction of a sustainable, comprehensive model of care which provides equitable access to early intervention and prevention approaches across Perth and Kinross. Since then, the Project Team has:

- Further developed the model and preparation of a service specification

- Identified the core staffing complement to ensure the correct skill mix and competency framework
- Agreed a single point of contact and triage process in each locality
- Developed the care pathways for:
    - Delirium
    - Falls / Frailty
    - Community Urinary
    - Complex Care and Rehabilitation
    - Urgent Care
    - Deteriorating Patient
    - Respiratory
- Reviewed the core documentation to reduce duplication and ensuring information sharing.

The proposed development and expansions to the Integrated Community Care Teams will provide a faster and co-ordinated approach to people with unstable, long-term conditions or exacerbated episodes of poor health, to prevent their admission to acute or long term care and to support self-management.

The proposed development will provide a rapid response to referrals in order to assess an individual's needs allowing the provision of appropriate high quality care which is time limited, through earlier intervention / prevention and supporting an individual's rehabilitation at home.

The proposed approach will involve referrals coming through a Single Point of Contact with triage and assessment in the localities. However, General Practitioners will still be able to refer directly to a professional within their local areas.

The service will target people who are;

- At risk of emergency/crisis admission to hospital or care home due to deteriorating health needs.
- Frail and vulnerable
- Presenting with complex health and care needs.
- Having difficulties with day to day living and who would benefit from a rehabilitation approach
- Early identification of delirium

3. PROPOSALS

From learning gained from the initial pilot and from similar developments elsewhere and recognising that our future workforce will involve new roles, expansion of current roles and a different approach to what we currently provide, the Partnership have identified the need to invest in the following staffing:

- Increase in health staffing in South Locality Integrated Care Team to ensure capacity to respond urgently to early intervention/prevention and provide equity of access across all localities in Perth & Kinross.
- Investment into specialist community based clinical practitioners (Advanced Nurse Practitioners) who have high level autonomous decision-making, including assessing, diagnosing and treating (including prescribing for) patients with complex, multi-dimensional problems.
- Increase in Rapid Response Social Care Officers to ensure urgent response for short-term, early intervention care and support at home.

This will ensure we achieve the commitment to develop early intervention/prevention community services in line with national and local strategic direction. In addition, this new model of care will ensure that there is the capacity, competencies, specialist knowledge, and skill mix to build a sustainable model to reduce unscheduled care demand in the medium to long term.

These posts are currently out to recruitment and once in place will be aligned to the Integrated Care Teams working in agreed partnership with local GPs, who will offer specialist primary care treatment planning and clinical case management input with advice and guidance, as required from a Consultant Geriatrician.

The Integrated Care Team will also align with the developing Specialist Community Respiratory Service that will provide earlier intervention/prevention assessment and self-management for people with COPD and asthma living in their own homes. In order to facilitate, support and sustain self-management approaches for people living with respiratory conditions, smart technology in the form of an APP is being explored. This APP will support patient-specific condition education and information links to community services.

An important factor will be to continue to build resilience in our communities to promote health and wellbeing to ensure long term sustainability. This is currently being delivered and developed in Partnership with Third and Independent Sectors, alongside communities. Current examples are:

- Care About Physical Activity in Care Homes and Care at Home
- Live Active
- Social Prescribers
- Dementia Friendly Walking Initiative

This enhanced support within the Integrated Care Teams will provide a common competency framework across a range of pathways. The competency framework will enable the identification and development of a comprehensive education and training plan across all disciplines from Social Care Officers to Advanced Nurse Practitioner level.

These enhancements to community services will be an integral part of the plans being developed as part of the Review of Inpatient Rehabilitation beds. The plan is to go out to the wider public to inform and engage on the future delivery and model of care and the support available for the adult population of Perth and Kinross. Local events will be held to provide an opportunity for open and transparent conversations around the need for change, the developing future model of care, how these changes will affect people living within Perth and Kinross and to gain feedback to develop the proposed model.

4. CONCLUSION

The enhancement to the Locality Integrated Care Service (LINCs) will complement and support the intention of the 2018 GMS Contract for Scotland. The contract introduced significant changes to the way in which Primary Care Services are delivered in our communities. Through closer working with a wider and strengthened multi disciplinary team, General Practitioners are to be supported in becoming expert generalist medical practitioners to more comprehensively support people and enable avoidance of unnecessary admission to hospital or premature entry into residential care.

It is anticipated that this enhancement to our Locality Integrated Care Service will commence in April 2020.

Implementation of this model will deliver improved outcomes for patients, service users and carers and will support the HSCP's key strategic priorities by providing;

- Timely access to community rehabilitation for early intervention/prevention
- Alternative options to hospital admissions/crisis placements in a care home
- Reductions in readmission to hospital
- Improved opportunities for self-management
- Opportunities for people to live at home for longer, safely and independently
- Improved care experience and person centred care
- Enhanced support for unpaid carers

This in turn will support shifts in the balance of care and improved performance in relation to the Ministerial Strategic Group's (MSG) key indicators in relation to;

- Unplanned admissions
- Occupied bed days for unscheduled care
- Emergency Department performance
- Delayed Discharges
- End of Life Care; and
- The balance of spend across institutional and community services.

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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.

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