PERTH & KINROSS COUNCIL

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G/16/190

PERTH AND KINROSS INTEGRATION JOINT BOARD

26 August 2016

Chief Officer Update

Report by Chief Officer

PURPOSE OF REPORT

This report provides an overview and update of work across the Health and Social Care Partnership. The report is intended for information and to allow Board members to remain aware of the progress of the major projects and any issues arising in between formal reports. Comments and advice from board members will be noted and fed back to Lead Officers

1. RECOMMENDATION

The Board is asked to note progress on each of the projects listed.

2. MAIN ISSUES

2.1 Tranforming District Nursing – Sandra Gourlay

The Lead Nurse and the Associate Nurse Director are leading a project on Transforming District Nursing in Perth and Kinross. In 2014, NHST Tayside issued a paper proposing a new vision and model citing reasons including: demographic shifts; policy changes; the economic outlook; service variance; and key strategies such as Health and Social Care Integration, the 2020 Vision, and shifting the balance of care to the community.

An NHS Tayside Transforming District Nursing steering group was created to guide this transformation. A Perth and Kinross steering group is being set up to deliver a District Nursing transformation programme in line with the above and those that address more local needs. The local group has representation on the Tayside-wide steering group and is further supported by the Perth and Kinross Joint Transformational Board.

The challenge is to transform the service *"To provide the best evidence based District Nursing Service to meet the needs of the population across Tayside. Delivering safe, clinically effective, person centred care, focusing on the health care quality strategy and ensuring a contemporary care model that meets Scotland's Health care and workforce 20/20 vision"*. based on *support and care for patients who are unwell, recovering at home and at end of life*; and a widened service scope to include: *population and targeted proactive management*; and *support and care to maximise peoples' independence*.

Significant foundational work has taken place during 2014/15, including:

- scenario planning and gap/SWOT analysis to explore current and perceived future challenges and capabilities;
- workforce activity analysis and audit of clinical team leader role to support a programme baseline;
- District Nursing intervention and complexity mapping against the new model and the full prevention and care continuum to further identify service deliver gaps;
- utilising the PRECEDE-PROCEED framework as a basis for engagement and holistic programme planning and evaluation;
- Contribution from Head of Nursing and Team Leaders to NHS Tayside Transforming District Nursing sub-groups to ensure NHS Tayside approach to education, the District Nursing (B6) role, IT and assessment tools;
- Gap analysis and development of improvement plan against the Clinical and Care Professional Governance Framework.

This has lead to a recently developed programme initiation document. This document acts as the launch platform for the programme, defining the programme in term of its management and the assessment of its overall success once completed. The PID describes a set of interdependent workstreams to take place over the period 2016-2020: (1) Reshaping the workforce; (2) Prevention and care in partnership; (3) Improved clinical pathways; (4) Person-centred outcomes; and (5) Quality, improvement and governance.

2.1.1 Proposals

The programme is to transform District Nursing into a service that:

- Embodies the Tayside vision, the Triple Aim and the NHS Scotland Healthcare Quality Strategy;
- Delivers services in line with the Tayside model, achieving a measureable shift in the balance of prevention and treatment towards a more proactive, preventative approach to activities and person-centred outcomes;
- Operates in harmony with the national and local integration strategy and developing integrated locality service delivery structures.

2.1.2 Progress

The initial draft of the programme plan is complete and out for consultation with the Chief Officer Group, Staff Partnership and the Nursing Directorate.

A formal paper will be presented to the November meeting of the Integration Joint Board

2.1.3 Financial Implications

Board members should note that this work stream will deliver less than the predicted savings in 2016-17 but it is anticipated that the remainder of savings will be achieved in 2017-18

2.2 Dalweem Integrated Care Facility - Audrey Ryman

The communities of Aberfeldy and surrounding area have been involved in an extensive consultation process on a future model for health and social care. As part of the community generated solutions, the combining of both Dalweem Residential Care Home and the patient services delivered from Aberfeldy Community Hospital are being progressed to provide a single health and care facility in the area.

The initial proposal to transfer health services to Dalweem included 4 inpatient beds, 4 enhanced respite beds, the current 16 residential care beds, outpatient clinics and day case provision, whilst allowing free movement and flexible use of staff across the whole facility to ensure effective and efficient use of our joint resources and improve the care pathway. The Care Inspectorate and Health Improvement Scotland have collaborated with PKC and NHST to support the development but different requirements and standards for health and care facilities have created additional challenges in delivering the model of care agreed with the local community. The Care Inspectorate has been very supportive and helpful throughout the development of this model and continues to provide guidance and advice. The different regulatory standards have been raised with the Scottish Government by the Chief Officer. The Aberfeldy Community also wrote expressing their concern at the practical barriers to progress. There has been considerable interest from Scottish Government as the proposed model may be relevant to many similar communities across Scotland. We now have plans for further engagement with the community as we seek to overcome these obstacles. A meeting is being arranged with the Health & Social Care, Integration and Reshaping Care Business and Integration Policy Support Officer to discuss further.

At the beginning of July 2016, Support staff working in Aberfeldy were transferred on an interim basis, to work from Pitlochry Community Hospital. This again was due to recruitment and retention challenges. An agreement has been reached to continue to provide outpatient clinics from Aberfeldy Community Hospital until the Dalweem Integrated Care Facility is open.

The refurbishment of the communal areas within Dalweem Care Home will soon be concluded. The health works are anticipated to take approximately 3 months. They will commence as soon as possible following completion of the care home refurbishment and on conclusion of the tendering process.

The Partnership continues to inform and engage the local community and key stakeholders on the progress and the challenges faced in providing the approved integrated model of care. As part of this process a press release

has been issued on behalf of the Partnership in early July to keep the community informed of progress, the work ongoing to resolve the challenges faced, and the commitment of the Partnership to continue to provide high quality inpatient and community based services in Northwest Perthshire. In addition the Community Planning Group has been re-established and will meet on a regular basis to ensure their continued involvement in the development of the model of care.

The Partnership is committed to delivering an integrated model of care in Dalweem, working with partners and the community in finding solutions to any remaining challenges.

2.2.1 Progress

The Partnership has agreed to proceed under option 1 and is recruiting registered nurses.

To ensure the continued provision of inpatient services in the area, all remaining nursing staff were transferred to Pitlochry Community Hospital.

An extensive innovative recruitment drive commenced in June 2016 to attract trained nurses to work in this rural area. The first round of advertisements has attracted 4 applications. Further work will be done to ensure the project has an appropriate professional profile, that all methods of recruitment are explored and that the skill mix and job arrangements are in line with the intention for a much more integrated model of service within the community

2.3 Perth & Kinross Third Sector Interface – Helen MacKinnon

In March the Chief Officer Group was updated on three current health and social care impact and evaluation projects involving PKAVS as the Third Sector Interface (TSI) and the wider third sector in Perth & Kinross. This report provides an update on key learning and recommendations following the completion of the first of these projects in June 2016.

Perth & Kinross was selected by Voluntary Action Scotland (the national network body for TSIs) to take part in the final phase of a Scottish Government project that seeks to ensure integration authorities can access the assets of the health and social care third sector.

The project aimed to demonstrate how in practice the TSI role can ‘connect, enable and develop’ the role of the totality of the third sector to contribute to opportunities in health and social care. Nationally, learning will be presented to a project steering group and shared with the TSI network, and locally, with the Perth & Kinross Health and Social Care Partnership and third sector. Our approach was, over a period of 3 months, to collate, evidence, evaluate and review the various strands of PKAVS’ TSI work that support the Third Sector’s role in health and social care integration in Perth & Kinross. Broadly, we defined these as supporting the third sector’s role as:

- professional partners and leaders
- innovators and drivers of change
- holders of intelligence
- joint strategic commissioning partners
- and as enabling coproduction.

The project considered the TSI's contributions towards progressing these five themes, with a key focus on the work undertaken with our Third Sector Health and Social Care Strategic Forum (hereafter referred to as "the Forum"), which was established in 2014. Key learning and recommendations have been identified by TSI staff and shaped with the Forum. A full project report will be available shortly; points from the Executive Summary are shared below.

2.3.1 Learning:

- The Third Sector Health and Social Care Forum is enabling effective strategic engagement with commissioned providers.
- Third sector colleagues are comfortable representing their own organisation but not yet fully-confident in adopting roles where they reflect wider views.
- The partnership's approach to leadership is forging a deeper sense of partnership that spans sector and is enabling a sense of shared accountability and responsibility.
- There is a need to increase understanding of the totality of the third sector and the quality assurance, regulatory and other good practice that exists within the sector to ensure safe, robust and quality services.
- The third sector's involvement in determining Integrated Care Fund Year 1 priorities took us closer to exploring joint strategic commissioning. There is an opportunity to better understand the innovations and transformations taking place within the third sector and how these sit alongside and support the Strategic Plan.
- The potential for third sector data and intelligence to be used for profiling, planning and commissioning is significant, but this requires a long-term commitment and distinct resourcing to harness this effectively.

2.3.2 Conclusions

- The Forum needs to strengthen its profile and formal connections so that partners at all levels recognise it as the main conduit for strategic engagement and proactively connect with it. These mechanisms must evolve to support leverage into localities and community groups with local interest.
- The Forum will explore local leadership development opportunities for third sector leaders, including the possibility of a third sector leadership network.
- We need time as different sectors to explore our professional perspectives together.
- There is an opportunity to increase the pace around maturing conversations relating to joint strategic commissioning and resourcing with

the third sector to support sustainable models for the future. We should strive for a collaborative approach that engages with the third sector during the formative stages and empowers the sector to play a key role in designing and delivering creative solutions.
- We need a vision for the use of third sector intelligence to better inform profiling, planning and commissioning.

2.4 Capacity and Flow

Perth and Kinross HSCP was facing a very challenging problem with delays to discharge in the latter part of 2015. This reflected a number of factors including rising demand, workforce challenges, communications, culture, variations in priority, existing patterns of joint working, system capacity and financial constraints. Avoidable delays at any point in the patient journey should be eliminated to reduce clinical risks, the adverse effects of institutional care on frail older people and to ensure best value.

With the complex, multi-agency and multi-professional array of factors identified for attention, a rapid improvement event was organised over one week in April. While this was focused upon flow through PRI, the learning demonstrated the close inter-dependency between different elements of health and care services. The learing from this event has been significant, identifying a number of areas for improvement. An action plan has been developed and project plans are in place.

The transformation programme is within the responsibility of the Health and Social Care partnership, but will be aligned with the NHS Tayside Transformation programme for other aspects of performance on the PRI site. Agreement in principle has been reached that PRI services for which the IJB is not directly accountable will be managed with the P&K programme where there is commonality. This will minimise duplication and gain the benefits of joint working between the P&K and NHS Tayside transformation programmes.

A number of factors outwith PRI will require attention and transformation. There is variation across Scotland in the length of time lived in residential care. As part of the improvement programme, we will be investigating the impact of delay on the level of care required . Private providers of home care in Perth and Kinross can experience varying levels of success in recruiting care workers to meet the level of demand. At times, some people experience delay in the start of a care package. A range of actions are required to address this situation. Further information will be provided by way of update at Future Board meetings.

2.4.1 Progress

In Perth & Kinross there were 15,769 bed days lost in 2014/15. Using the Expert Group methodology this had a full year gross cost to the NHS of £3.9m. In the eleven months to February 2016, there had been 17,622 bed days lost, a large increase on last year at a time when nationally there has been a 10% year-on-year reduction. This equates to an average of 53 beds

being unavailable every single day, a level that is likely to be much higher at the moment. Since May 2016 the average number of beds unavailable on a single day has been reducing. In July the average number of unavailable beds has been down to 36. This may in part, be due to seasonal variation, however officers will continue to monitor this closely.

A visit by the Improvement Service illustrated that Perth and Kinross may be facing a scale of challenges unique in Scotland. The age profile of our population is such that a higher proportion of resource may be required and there will be limited scope for internal efficiency alone to reverse the trend. Perth and Kinross data is considered to be relatively advanced and may provide evidence to inform future service planning.

A Performance and Resources panel now meets weekly to drive progress for every person in delay. Resources available to the panel are utilised efficiently and effectively. In starting these initiatives and through investment of approximately £1.7 million of the partnership's resources, the average number of delays has dropped as described above. The challenge will be to maintain this performance as winter approaches. In time, a weekly meeting will be insufficient. We will be devolving responsibility to localities and decisions will need to be made in real time.

Several small but significant initiatives have been introduced in changing the models of care. P&K will now offer to support applications for welfare guardianship where there is a delay of more than 21 days. Enhanced community support is demonstrating a significant impact on reducing the risk factors known to lead to hospital admission. A deep dive on people delayed has demonstrated learning to support the change process at a number of points on the patient journey.

A new initiative – "Assess to Admit" will meet people being brought into hospital and determine any other suitable method of managing their needs before they are admitted to hospital. Similarly "Discharge to Assess" will support people to return home and provide the support and assessment at home rather than awaiting the same process to be completed in Hospital.

Finally, plans are in place to implement locality working. A number of technical and legal issues remain as barriers to fully integrated working, however the approach in P&K is such that frontline integrated service delivery will be achieved early and the infrastructure that supports such working will be introduced over time and at a pace that is culturally, professionally, practically and legally achieveable within current regulatory frameworks.

2.5 Mental Health In Patient Services – Val Johnson

Mental Health In patient services include General Adult Psychiatry (GAP), Learning Disability (LD) and Substance Misuse Service (SMS) beds. These services are Hosted by Perth and Kinross IJB on behalf of Angus and Dundee City IJBs. There is an important and on-going relationship with NHS Tayside, which hosts a number of regional specialist Mental Health services

Community GAP/LD and SMS services are delegated to the three IJBs across Tayside and will be delivered in localities as part of the integrated portfolio of services required to meet the health and social care needs of communities. Perth and Kinross will have three localities in which these services will be based.

NHS Tayside initiated a Mental Health Improvement Programme (MHIP) prior to Integration under the "Steps to Better Healthcare" initiative. This work continues under the NHS Tayside Transformation Board. The acute issues facing Mental Health Services result from the build up of several factors over the past 10-15 years.

The NHS Tayside Board requested a further public consultation process be undertaken to determine the most appropriate model for in-patient services taking account of the need to make the most complex services safe and sustainable in the long term.

There is significant public interest in the success of community based mental health services. In-patient facilities will always be required by people with the most complex needs for a defined period of time. These specialist must be safe and sustainable into the future.

2.5.1 Progress

- The Chief Officers for the three IJBs in Tayside and the Interim Director of Mental Health are working to ensure that community services will remain safe and that clear lines of operational accountability can be demonstrated including strong connections to the professional line. This will allow the Head of In Patient Mental Health (IPMH) Services to take up her role. We have agreed in principle that we will work to a 1st September 2016 deadline for transition to the new accountability arrangements. The Chief Officers will be working with the Head of IPMH and the Associate Nurse and Medical Directors to ensure this transition can be achieved safely.
- Mechanisms for Clinical Care and Professional Governance in Mental Health Services will remain effective. The performance review process in place for Mental Health Services will continue in the medium term, to provide assurance to the NHS Board and the IJB about the safety and effectiveness of the service. This review process will transition over time as the review process is brought into alignment with the Joint Clinical Care and Professional Governance Framework "Getting it right for Everyone."
- It will be vital to maintain high standards of clinical practice and to retain a Tayside wide expertise in Mental Health Services. For this reason a Tayside Mental Health forum is being established in line with the R3 grouping described within the Clinical Care and Professional Governance framework.
- A formal update will be brought to the November Board.

2.5.2 Financial Implications

The level of expenditure on premium agency staffing across Mental Health is one of the most significant financial challenges facing Perth and Kinross IJB as the Host IJB for these services. Shortages of expert staff combine with a requirement for service reconfiguration to drive an unsustainable pattern of over-spending. Pereth and Kinross IJB will inherit a significant role in achieving the objectives of the Mental Health Improvement Programme that was initiated by NHS Tayside in 2014. This programme has recently concluded another round of public consultation and an Option Appraisal process has begun.

3. CONCLUSION

Further updates will be presented at each meeting of the Integration Joint Board.

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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.