PERTH & KINROSS COUNCIL

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G/16/193

PERTH and KINROSS INTEGRATION JOINT BOARD

26 AUGUST 2016

STRATEGIC COMMISSIONING PLAN - UPDATE

Report by Chief Officer

PURPOSE OF REPORT

This report provides an update on the action plan of the Strategic Commissioning Plan 2016-2019, as part of the regular progress reports to the Board. It covers one key priority, the development of locality working through locality planning and integrated teams.

1. BACKGROUND

1.1 The Board approved the health and social care Strategic Commissioning Plan at the meeting of 23 March 2016 and agreed that the Chief Officer would provide regular updates on progress.

1.2 The plan has a number of actions based around its 5 priority areas:

1. Prevention and early intervention
2. Person centred health, care and support
3. Work together with communities
4. Inequality, unequal health outcomes and healthy living
5. Making the best use of available facilities, people and resource

1.3 For the purposes of monitoring, the detailed actions have been condensed and prioritised so that the critical areas for 2016/17 in particular are monitored by the Chief Officer Group and reported to the Board. There are 19 of these and they will be reported on a cyclical basis to the Board, unless the Board asks for more regular updates on certain priorities and actions.

2. PROPOSALS

2.1 The first update on the strategic plan, which was discussed at the meeting in May, which identified a number of key priorities. This report covers one of these, the development of local integrated working, the details of which are included in the appendix.

3. CONCLUSION AND RECOMMENDATION

3.1 The strategic plan has a clear vision and an aspiration to transform services to meet future needs and challenges. It is about working together, with people, communities, the third and private sectors, to deliver innovative ways of meeting people's needs and enabling them to live healthy lives at home or in a homely setting.

3.2 The plan emphasises the need for services and support to intervene early to prevent later, longer term issues arising, and enabling people to manage their own care and support by taking control and being empowered to manage their situation. Where this is not possible, resources should be targeted where they are needed most, reducing ill health and deterioration and ultimately reducing health inequalities.

3.3 This report focuses on a key way of delivering this vision and these priorities through joining up knowledge, skills and resources for the greater benefit of the individuals and communities.

It is recommended that the Board:

(i) Approves the report on integrated locality working
(ii) Requires the Chief Officer to submit progress reports on the implementation of integrated locality teams.

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Perth and Kinross Health and Social Care Partnership

Plan for Integrated Locality Working

Appendix to the Strategic Commissioning Plan

Introduction

Perth and Kinross Health and Social Care Partnership (the Partnership) is committed to improving outcomes for people and their communities. Health and social care integration will mean changing the way we deliver health and social care services, focusing on the important role individuals, communities, the third and independent sector have in supporting healthy and independent lives. Seeking their involvement in decisions about the design and delivery of services that will have an impact upon people in Perth and Kinross is essential.

Integration recognises the positive experiences that people have when communities, services and support connect effectively. The partnership is committed to delivering more effective and joined-up approaches by sharing knowledge, skills and resources for the greater benefit of the community. Integration should promote empowerment, supporting and inspiring staff, individuals, partner organisations and communities to participate, influence and be part of solutions for the future.

The plan for locality working is aligned to the scheme of integration and will support the implementation of a number of Perth and Kinross Health and Social Care Partnership strategies including the:

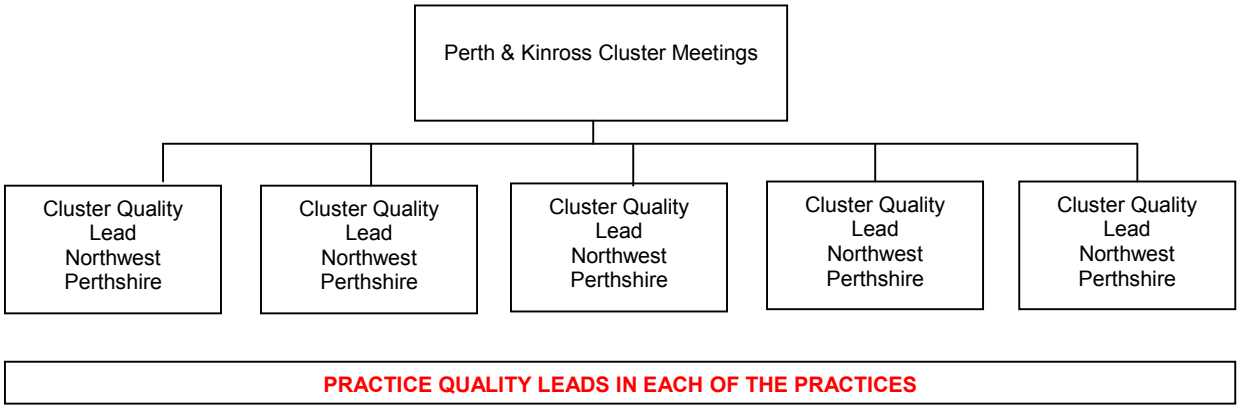
- Joint Commissioning Plan
- Workforce and Organisational Development Strategy
- Engagement, Participation and Communications Strategy
- Transformation Plan
- Financial Plan

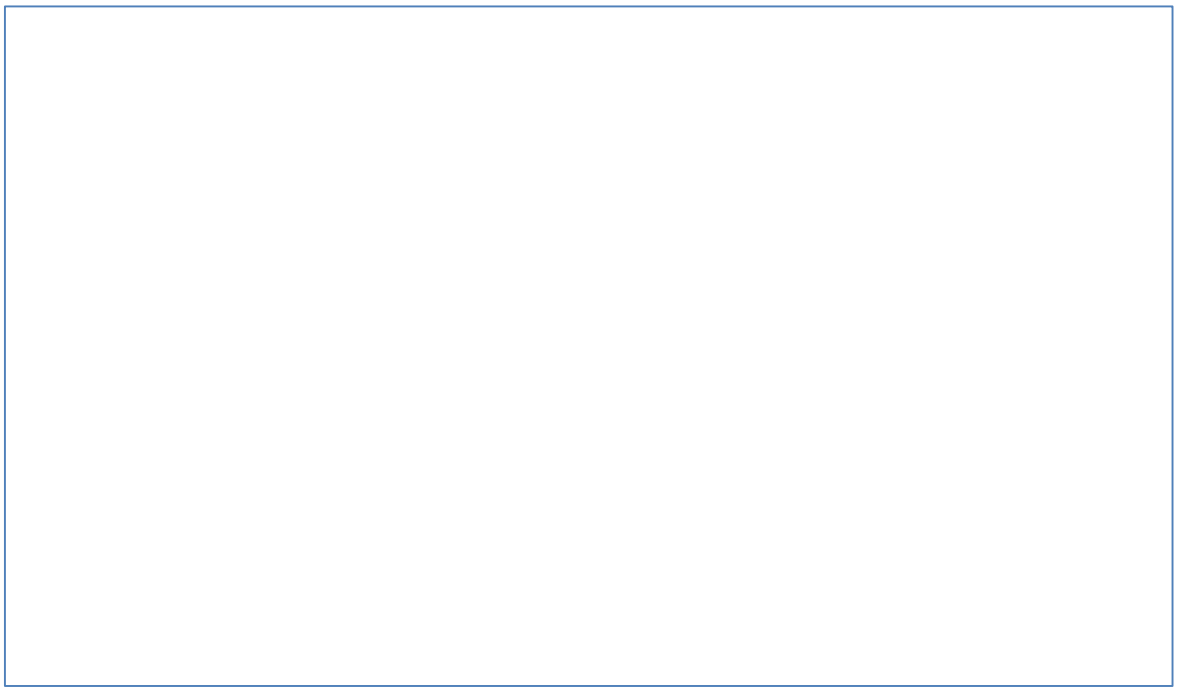
The Integration Joint Board is one of the statutory partners in the Perth and Kinross Community Planning Partnership. While the focus of the Health and Social Care Strategic Commissioning Plan is to improve health and tackle health inequalities, sustainable changes will require effective and joined up working with other partners such as Housing, Education, Fire and Police.

The Scottish Government has designed a number of pre-requisites for Localities in consultation with local professionals and local communities:

- Localities should relate to natural communities and take account of GP clusters.
- Localities must support collaborative working principles.
- Localities must support a proactive approach to capacity building in communities.
- Localities must cultivate better integrated working between primary and secondary care.

Perth and Kinross Integration Joint Board has defined 3 localities, Perth City, North Perthshire and South Perthshire and have also approved the 5 sub locality structures based around GP Clusters.





These Localities provide an organisational framework to enable planning, leadership and delivery of local services. Locality leaders will be accountable to the Integration Joint Board for delivery of the strategic commissioning plan through the Heads of Health and Social Work/Social Care and the Chief Officer. This plan sets out how we will integrate health and social care services to meet the objectives of the strategic commissioning plan.

In developing the plan for integrated locality working, we have taken into account the views of service users and carers from 'Join the Conversation' and they are reflected throughout the document.

"Being connected with our community helps to increase confidence building, personal responsibility and make people feel valued"

Our Aims

The plan for integrated working aims to reflect the vision and principles of our strategic plan.

People are supported to lead independent, healthy and active lives and live their lives as independently as possible in their own homes, or in a homely setting with choice and control over the decision they make about their care and support

Our aim is to improve the wellbeing and outcome of people living in Perth and Kinross, To intervene early and work with the Third and Independent sectors and communities, to prevent longer issues arising

- Support effective local implementation of the Strategic Commissioning Plan and provide assurance to the Integration Joint Board
- Prioritise safety and quality standards in all aspects of integrated/joint working.
- Ensure equity of care across Perth and Kinross while allowing for local variation to meet the needs of local people
- Respond to the message that people say they would prefer to receive care and support in or as near to their own home as possible
- Recognise the positive experiences that people have when services and support are joined up and connect effectively
- Put people at the heart of service design; to involve the community, service users and local professionals in the planning and delivery of care and support
- Recognise the reality of the wider challenges in society, such as increased demand and expectations, and reducing public finances and promote a culture that encourages open-minded, creative collaboration to develop solutions
- Make best use of available facilities, skills and resources and create a culture of best value
- Innovate and prioritise services that anticipate people's needs before a crisis, intervene early and prevent longer-term issues arising
- Minimise delays in care; provide appropriate support earlier to help people better manage their own needs
- Support people with disabilities, long-term conditions or frailty to receive care and support to live as independently as possible and avoid unnecessary hospital or residential care
- Provide support and training for all those working within integrated health and social care to make best use of their skills and resources to deliver high quality, improved outcomes for people using services
- Provide support and training to families and carers to allow them to safely and effectively continue their significant contribution to the people they look after

Our Approach to Integrating Services

Principles - Designing an integrated model of service delivery

The Strategic Commissioning Plan outlines the scale of redesign and transformation required to develop locality-based, integrated services. It is only through this transformation that services will be able to fulfill the vision of the Integrated Joint Board and meet current and anticipated population, workforce and financial challenges.

The guiding themes for transformation set out in Diagram 1 provide the basis to support change. Only through engagement with communities can we create the opportunity for transformation, to sustain high quality health and social care provision that responds to local need. All changes to models of care must deliver improved outcomes and demonstrate value for money. At the same time, we recognise that smaller, more specialist services may be more sustainable if they are managed across Perth and Kinross or even wider, across neighbouring partnerships.

Diagram 1

An effective, integrated model of service delivery requires:

1. Establishment of an effective management structure to deliver on the Strategic Plan
2. Establishment of Locality Managers to line manage all delegated services.
3. Implementation of clear health and care pathways around early intervention and complex care
4. Alignment of activities with other members of local community planning partnerships
5. Active engagement with local communities and communities of interest in planning and service delivery.

Framework for Locality Governance

Principles for Management and Leadership

Individual members of the Chief Officer Group are aligned with localities.

The Head of Health and Head of Social Work and Social Care will provide Strategic, Operational and professional leadership across Perth and Kinross.

Locality Managers from Health and Social Work Services will be co-located in localities where possible and will be responsible for leadership and management of operational service delivery.

All managers will build strong working relationships with public health to support the anticipatory work outlined in the strategic plan. Prevention and early intervention are essential in supporting healthy communities.

Integrated Care Teams will develop around neighbourhood settlements, GP practices or GP clusters depending on population demand across Perth and Kinross. They will be consistent in their functions.

It is the ambition of the partnership to work with Social Work team leaders, Heads of Nursing and AHP's towards locality and sub-locality leadership and management.

The Strategic Plan explains the need to work differently to achieve our transformation agenda; outlining a shift from a focus on institutional care to community based care with much emphasis in service user choice, self-monitoring and self-caring. In future this shift will increasingly be supported by rapidly advancing technologies such as Telecare, Telehealth and mobile communications.

"**Joint working between both services and the community would create better use of resources**"

Health and Social Care Management Arrangements

The Health and Social Care Organisational Structure was outlined in a report presented to the Integrated Joint Board in February 2016 – **reference G/16/47**

A review of existing management structures at both second and third tier management roles is being undertaken across Health and Social Work and Social Care Services which will support locality working. The second tier management for the partnership will be completed by October/November 2016. The proposed structure will support locality working and ensure professional leadership across the three localities and sub-localities. Services will be redesigned with the person at the centre of all that we do.

The Locality Manager will provide line management for all delegated services within that locality. The role of the Locality Manager will be to ensure that services are provided to meet the local needs and priorities while working effectively with CPP and other Partners.

The Chief Officer Group along with the Locality and Professional Managers will:

- Demonstrate measurable improvement in outcomes for people and communities
- Demonstrate effective professional accountability for staff
- Provide opportunities to recruit, retain and develop staff to their full potential
- Protect the public through adherence to regulatory standards for professional practice and statutory roles
- Drive current transformation programmes in health and social care at pace

Locality Managers from Health, Housing and Social Care will form Management Teams who work together at Locality and sub locality and GP Cluster boundaries. Membership of the Locality Management Teams include operational locality managers and clinicians.

- The role of the Locality Management Team is to plan, deliver and monitor the best possible care and support by the right person in the right place at the right time

- Ensure multi-agency teams promote independence and well-being at home and in the community as appropriate, so people can avoid unnecessary admissions to institutional care as safely as possible
- Improve the multi-disciplinary care of people with complex needs
- Ensure resources are delivered more effectively and efficiently
- Integrate staff team in local areas to Implement an Integrated Care Team approach i.e. around GP cluster groups
- Manage and allocate health and social care resources
- Ensure the delivery of Care co-ordination and embed person centred care

"Information sharing between services, patients and community groups should better support people"

Locality Steering Groups

Locality Steering Groups have been established in the three areas with representatives from Health, Social Work, Housing, Third and Independent Sector to provide strategic support to plan and commission local services. These groups will:

- Prepare locality plans to underpin our strategic priorities
- Engage with community groups and representatives to deliver these local plans
- Ensure that there is a focus on prevention and early intervention to support people including carers to maintain their independence
- Implement transformation and change programmes

"**More localised services so we can get to know staff better**"

Integrated Care Approach

The approach to develop integrated care will be consistent across institutional (including hospitals) and community services.

Transformation of long established services will require strong strategic leadership and collaboration from Lead Professionals from the Health and Social care partnership. The implementation of an integrated care model will require cooperation and collaboration across all sectors. Eventually, this will enable realignment of services and spending patterns at locality level through the strategic commissioning powers of the IJB. The scale of transformation required to deliver comprehensive integration will require openness to further change across the wider public sector.

Integrated Care Teams will improve people's outcomes through the joint working of local partners.

Partners include:

- GP's and Primary Health Care
- Acute Hospitals and Community Health
- Social Care providers
- Third and Independent Sector providers
- Health and Social Work professionals
- Housing Providers
- Ambulance Service
- Community Safety Partners

The journey for individuals

By shifting the focus away from specialist services and placing Health Promotion and Universal Care as a top priority we will ensure that the investment and focus of our resources (both in terms of financial and workforce capacity) is primarily on maximising independence and choice for those living in Perth and Kinross.

By people having access to a wider range of preventative services earlier on, it should be more possible to maintain health, fitness and independence. This person-centred approach will also lead to a reduction in the need for access to more acute care and support in the future.

"Other local services could support and provide advice around minor ailments to overcome and relieve some of the stress"

At any stage of the journey the person will be able to access care and support through a single point of contact and will receive the following:-

- **Prevention and Anticipatory Intervention** promoting wellbeing through social care and health contributions to early anticipation and prevention.

- **Early and Rapid Intervention** providing rapid access to services where the need arises and ensuring clear and effective pathways to minimise the inappropriate use of institutional care.
- **Complex Care** – A similar approach to early intervention and prevention as described above allowing for a more complex array of needs. Anticipatory care planning for those who require ongoing interventions to manage long-term and complex health conditions and the associated social, cognitive and functional barriers to independent living.
- **End of Life Care** – This is a national priority. People approaching the end of their lives should be supported to die in a place of their choice with assistance from a comprehensive range of services relevant to their needs

Third Sector

The partnership has a diverse network of commissioned and non-commissioned third sector groups and organisations that play an important role in improving health and wellbeing outcomes for local people. Some operate across Perth and Kinross, while others are targeted within specific communities. The third sector has an important contribution at different stages of the care pathway, providing preventative interventions, targeted services, complex and end of life care.

Integrated Care Fund commissioning has enabled locality-focused changes, for example with third sector support for Carers and physical activity, while nurturing projects in communities experiencing higher levels of deprivation and health inequalities. As integrated locality working takes shape, connections with the third sector into locality management arrangements will be essential. For example, connecting with local people as volunteers and with creative initiatives such as Time Banking.

Clinical, Care and Professional Governance Arrangements

The Clinical, care and professional governance framework will support professional integration. Examples of key features of professional integration:

- Joint Care Planning
- Assessment processes
- Shared records
- Care guidelines and protocols
- Technologies
- Peer review
- Standardised eligibility and diagnostic criteria
- Standardised risk stratification/ case finding

The Clinical and Care and Professional Governance Framework *(Getting it Right for Everyone)* has been agreed by all three Tayside IJBs. All Strategic plans, priorities and Locality Plans must be aligned to the 6 Clinical and Care Governance domains:

- Professional Regulation and Workforce Development
- Information Governance
- Patient, Service User, Carer and Staff Safety
- Patient, Service User, Carer and Staff Experience
- Regulation, Quality and Effectiveness of Care

- Promotion of Equality and Social Justice

So, what will a successful Perth and Kinross health and social care system look like in future?

The Swedish and Torbay examples demonstrate that, in spite of the challenges, it is possible to improve outcomes for people through changes in services and the way we work together. A greater focus on multi-disciplinary working, on primary and community care with the statutory, third and independent sectors will support the transformation of our health and social care system. In summary we want:

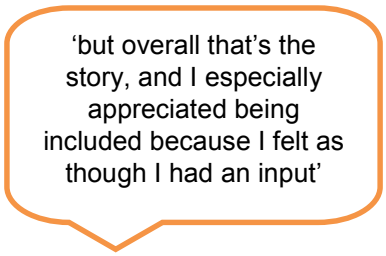
- ✓ Varied and responsive community-based health, care and support services that enable people to live as independently at home as possible with a better quality of life
- ✓ High numbers of people supported through reablement and recovery, with no further need for care
- ✓ Better use of inpatient hospital facilities
- ✓ Fewer unnecessary unplanned hospital admissions
- ✓ Fewer people delayed unnecessarily from hospital
- ✓ Fewer new admissions to residential care, and none from acute hospitals
- ✓ Reduced health inequity and increased health and well being

Making Locality Working a Reality

Delivering integrated care is essential to improving outcomes for people who use health and social care services. We recognise that integrated care is not just about creating structures, we are committed to adopting common principles of person centred care to develop an approach which put patients and service users at the heart of care. It is our priority to reduce the fragmentation that people experience and provide coordinated care.

Locality teams will ensure that we work with individuals and/or their carers. People have told us that they want Health and social care professionals to work together to provide person centred, co-ordinate care the care to enable people to live healthy, independent lives.

Join the conversation captured the views of service users, who want to be listened to, to get good explanations from professionals, to have their questions answered, to share in decisions, and to be treated with empathy and compassion.



Locality Integrated Care success indicators for the people of Perth and Kinross:

- ✓ If someone needs support for themselves or someone they care for there will be a single point of contact for advice and support.

- ✓ People will have access to a range of local non-statutory supports to help them maintain their independence in their community.
  Examples of care and support interventions at this level: self-management, community based education and social prescribing, digital platforms with better access to information, co-production.

- ✓ If someone has a long term condition, the Partnership will support them to manage this in a way which prevents the need for future hospital admissions.
  Examples of care and support interventions at this level: Telemedicine, local treatment centres, early intervention, prevention and reablement (12 week model), anticipatory care planning, local diagnostic and joint assessment for planned care/ care planning.

- ✓ When someone has a sudden deterioration in their health or injury they will receive rapid co-ordinated support to enable them to regain their health.
  Examples of care and support interventions at this level: Enhanced Community Support, step up prevention of admission, telecare, hospital at home models, housing with care, step down, speedy discharge and prevention of admission

- ✓ We will provide effective and appropriate access to excellent palliative/end of life care.
  Care home admission, criteria driven admission and discharge to assess, appropriate hospital admission for unplanned care and palliative and end of life care.

- ✓ People will get the right support from the right people in the right place at the right time.

Implementation

Key objectives, milestones and timescales 2016-2017

OBJECTIVES	MILESTONES	TIMESCALE
Support effective local implementation of the Strategic Commissioning Plan and provide assurance to the Integration Joint Board	Establishment of Chief Officer Group and lead officers identified to support locality management groups	complete
	Establishment Joint Senior Management Team (core group)	complete
	Engagement, Participation and Communication Strategy (EP&C) completed and ratified by Joint Integration Board	complete
	All Strategic Plans, priorities and Locality Plans aligned to the Clinical and Care and Professional Governance Framework with regular reviews against domains undertaken	March 2017
	Development of Joint Performance Frameworks	Sept 16
	Development of joint risk management	August 16
	Outline paper on devolved budged finalised for partnership discussion and agreement at Chief Officer Group around how locality budgets will be managed and supported in localities	01/03/17
	Develop an outcome focused commissioning framework in place to support the implementation of person centred care	01/03/17
Locality Steering Groups established in 3 localities in Perth and Kinross to deliver on the Strategic priorities within Commissioning Plan	Establishment of Locality Steering Groups to enable locality level multi-disciplinary discussion across Health, Social Care, Third Sector and Housing	Complete
	Locality Plans in place to implement strategic locality priorities	31/08/16
	Second tier Locality Management and Professional Leads in place	30/11/16
	Locality learning plans in place to support the commencement of delivery of OD and Workforce Strategy outcomes	31/12/16
	Locality Joint Performance Framework in place to inform population profiles	31/12/16

	Locality Risk Profiles and Registers developed with reporting and monitoring arrangements in place	31/12/16
	Locality Engagement, Participation and Communication Plans in place to support the outcomes within EP&C Strategy.	31/12/16
	Mechanisms will be in place across localities to ensure that communities, service users and carers play an active role in the decision making taken at Locality Steering Group	01/03/17
Locality Management Teams will be established at locality and sub locality level to ensure multi agency working, local service provision and targeting of appropriate resources.	Health and Social Care third tier management implemented. Community Care managers appointed and in place in October16.	March 2017
	Joint working arrangements between partners, teams and communities in place to enable future long-term shift to integrated care team working in localities	01/03/17
	Locality Plans established by Locality Management Groups	01/03/17
	Processes and systems in place to monitor, report and ensure quality assurance is embedded within Locality Management Teams	01/03/17
	Reporting arrangements in place which enable Locality Management Groups to review population profiling data to support appropriate targeting of resources for those most at risk	01/03/17
	Health and Social Work resources aligned to support delivery of Locality Management Teams	Dec 2016
	Partnership third tier co-located management arrangements implemented	31/3/17
Ensure that new models of delivery enable people to access support at the right time and in the right place in line Prevention, Anticipatory and Early Intervention	Enhanced Community Support piloted, reviewed and lessons learned identified and shared	complete
	Full roll-out across Perth and Kinross GP practices of Enhanced Community Support complete	Nov 2017
	Core processes identified and put in place to support person centred approach within assessment and care planning	01/01/17
	Volunteering programmes in place at locality level to encourage and develop alternatives ways to support people to live independently	01/10/17

	Anticipatory care planning mechanisms to be reviewed	01/03/17
	Joint assessment and care planning in place to enables individuals with multiple conditions to have access to key professionals	01/03/17
	Staff and service user peer support and champion groups in place to embed person centred care	01/03/17
	To plan for the appropriate community based diagnostic and treatment services to be in place in localities to reduce the requirement for admission to hospital	01/12/17
	Intermediate Care implemented to align Rapid Response, Reablement and Rehabilitation	01/03/17
	Modelling of single point of contact for adult health and council services undertaken and agreed	01/03/18
	Working arrangements in place to align health, social care and third sector staff to accident and emergency	Commenced
	Joint protocols and procedures agreed and in place to implement an in-reach service to acute hospitals to prevent admission or facilitate discharge	March 17
	Housing solutions incorporated into prevention, early intervention pathways to reduce the numbers of delays awaiting adaptation	March 17
	Market place implemented to enable effective alternatives to hospital admission	01/03/18
People approaching the end of their lives should be supported to die at home with assistance from a comprehensive range of services	Palliative and end of life Education and Training for Health and Social Care staff implemented across localities	01/03/17
	National end of life standards implemented across localities	01/12/17
Ensure continued support to people with multi morbidity and long term complex needs in local communities	Integrated Care Teams based around GP Practices/Cluster/ neighbours are established	01/12/17
	Co-location opportunities for Integrated Care Teams are identified and in place where appropriate	01/03/17
	Telecare and telehealth solutions reviewed to ensure best use and people are supported longer in the community	01/03/17