Item No: 11

Meeting Date: **Wednesday 15 February 2017**

Glasgow City
Integration Joint Board

Report By: **Alex MacKenzie, Chief Officer Operations**

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TRANSFORMATIONAL CHANGE IN OLDER PEOPLE'S COMMUNITY BASED HEALTH AND SOCIAL CARE SERVICES

Purpose of Report:	To inform the Integration Joint Board of further transformation of Older People's Services.

Recommendations:	The Integration Joint Board is asked to: a) note the contents of the report; b) approve the programme of transformational change activity outlined in section 3; and, c) direct the Health Board and Council to implement the change programme.

Implications for Integration Joint Board:

Financial:	This reform programme will achieve £450,000 of efficiencies in the Older People's Budget through release of posts following natural turnover.

Personnel:	There are a number of personnel implications in this proposal and a programme of consultations has begun with Trade Unions and staff.

Legal:	N/A

Economic Impact:	N/A

Sustainability:	N/A

Sustainable Procurement and Article 19:	N/A

Equalities:	An Equality Impact Assessment will be completed on these proposals.

Risk Implications:	The achievement of the efficiency target is dependent on the movement of staff to new posts.

Implications for Glasgow City Council:	As per HR implications.

Implications for NHS Greater Glasgow & Clyde:	AS per HR implications.

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	
	2. Glasgow City Council	
	3. NHS Greater Glasgow & Clyde	
	4. Glasgow City Council and NHS Greater Glasgow & Clyde	✓

1. Background to the Programme

1.1 One of the key aspects of the Scottish Government's Policy on Health and Social Care Integration was to ensure that the needs and expectations of increasing numbers of people living into older age, with complex and multiple needs receive joined up and integrated services.

1.2 Glasgow City Health and Social Care Partnership continues to face the challenge of providing safe and effective care to an increasing elderly population while supporting them to live longer and more independently in their community.

1.3 Integrated Management arrangements have now been established across the Health and Social Care Partnership in relation to Older People's services and a programme of review of the current level and effectiveness of services is currently being progressed.

2. Current Service Arrangements

2.1 There are currently a number of service arrangements in place to deliver older people and physical disability health and social care services across the City. These range from:

- Area based Social Work teams
- Hospital interface Social Work Teams
- Social Work Occupational Therapy Teams
- GP cluster based District Nursing Teams
- Locality based Rehab Teams
- Locality based Older People's Mental Health Teams

- Locality based specialist nursing teams
- Citywide Specialist Nursing Resources
- Professional Nursing Support

2.2 These services are not all co-terminous and cross over in terms of location and service provision. There are also a number of direct access points and duty systems for each of these services which do not relate to each other. Some but not all of the teams have direct connections to GPs and there are a varied set of arrangements in place in relation to the interface with acute.

3. Proposals

3.1 There are a number of pressures which will have an increasing impact on how we deliver health and social Care services for older people across the city. These include increased demand for services; financial pressures, and the pressures on the Acute system in relation to admission avoidance and delayed discharge.

However, there are emerging opportunities to make these services more efficient at the point of referral and to streamline pathways for service users/patients to reduce duplication and improve interventions.

In order to improve service delivery and service user/patient outcomes it is clear that we need to better organise our services so that they are more responsive to local need and link more closely to our key partners in Primary Care and the Acute sector. The emerging work around GP clusters will assist with the development of a wider system of care for older people and the work in partnership with the Acute sector will assist in improving our performance in relation to admission avoidance and delayed discharge.

3.2 Health and Social Care Direct Access Hub

Across the city there are a number of access routes to health and social care services for older people. Initiatives and service developments such as Single Point of Access (SPOA) for District Nursing services, Social Care Direct and Single Point of Access for Rehab Services and Social Work duty systems have all realised efficiencies in relation to service user access and experience. In line with the broader review of front door services and HSCP Out of Hours Services, it is appropriate that Direct Access Hubs for older people’s services are developed ensuring that service users/patients get the right support at the right time. These Hubs will provide a single point of contact for all Community Health and Social Care Services ensuring that service users/patients are directed to the right service or are given appropriate support and advice at the first point of contact.

3.3 Integrated Community Teams

The city is currently divided into to 3 localities all with a network of health and social care services, partner agencies and community and third sector services and carer and community supports. It is appropriate in the context of integration that the new arrangements for delivery of older people and physical disability services adopt a community/neighbourhood model which will reflect the development of the GP cluster arrangements and link to natural communities.

Twenty GP clusters across the City (7 in South, 7 Northwest and 6 Northeast) have been established in recent months and in broad terms these clusters are geographically based although a number of cross boundary issues still exist with GP patient lists. It is considered appropriate that ten neighbourhood teams (4 South; 3 Northwest; 3 Northeast) be established that will link to the broad geographical area that the clusters cover. The teams will comprise of co-located Social Work, District Nursing, Rehab and Older People's Mental Health staff and where possible perhaps other disciplines and sectors. The teams will have links to a broad range of partner services including Acute; the Third and Independent sectors and the Housing sector.

This model will consider the ongoing development of the Treatment Room Service in Health Centres and the broader Primary Care Support to this service. There currently is no equitable access to this service for many Primary Care contractors. A review is underway to ensure there is better access to this service and greater efficiency of the current model.

3.4 Home is Best Service

This proposal is to develop an integrated approach with the Acute sector in relation to admission avoidance and delayed discharge. A dedicated HSCP resource will be aligned to the acute hospitals in the North and South of the City and will:

- Support the redirection of avoidable admissions by supporting 'front door' work. The 'team' will have access to telecare, homecare, supported accommodation, carers assessment & support, daycare and Intermediate Care beds
- Enable shared ownership of a whole system, person-centred care
- Improve relationships with ward staff and wider teams as HSCP staff will be part of an integrated service
- Improve communications with patients, carers as staff will be more available

3.5 Development of a Professional Nursing and Support Structure

There are currently a mixture of arrangements in adult community nursing in relation to management, professional leadership and practice development. It is proposed that the professional nursing and practice development agenda is strengthened and separated from the general management arrangements. The team will be managed via the Professional Nurse Advisor for Adult Community Nursing and will have direct responsibility to deliver on a programme of robust professional governance; effective practice development and support arrangements.

4. Recommendations

4.1 The Integration Joint Board are asked to:

a) note the contents of the report;
b) approve the programme of transformational change activity outlined in section 3; and
c) direct the Health Board and Council to implement the change programme.

Glasgow City IJB Integration Joint Board

DIRECTION FROM THE GLASGOW CITY INTEGRATION JOINT BOARD

1	Reference number	150217-11-a
2	Date direction issued by Integration Joint Board	15th February 2017
3	Date from which direction takes effect	15th February 2017
4	Direction to:	Glasgow City Council and NHS Greater Glasgow and Clyde
5	Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s)	No
6	Functions covered by direction	All function associated with the delivery of Older People's services as outlined in section 2 of this report
7	Full text of direction	Glasgow City Council and NHS Greater Glasgow and Clyde are directed to implement the change programme for Older People's services as outlined in section 3 of this report
8	Budget allocated by Integration Joint Board to carry out direction	As advised by the Chief Officer: Finance and Resources
9	Performance monitoring arrangements	In line with the agreed Performance Management Framework of the Glasgow City Integration Joint Board and the Glasgow City Health and Social Care Partnership.
10	Date direction will be reviewed	15th February 2018