Appendix 1

HOSC March 2012

Briefing on Integrated Primary Care Teams

1.The Development of Integrated Primary Care Teams – Background and Rationale for Change

The purpose of this paper is to outline the work that has taken place to implement new Integrated Primary Care Teams to support patients with a range of long term conditions and the frail elderly within the community.

Following previous information regarding this work presented to HOSC in June and November 2011, this paper is intended to provide an update of progress since the implementation of the new teams in January 2012.

The reconfiguration of these community teams was included within the Long-Term Conditions (LTC) commissioning plan and is one of the key Priority Transformation Programmes supporting the delivery of QIPP. The new service model is based on stakeholder feedback and examples of national best practice.

Previously, there were many different teams, supporting patients within the community. These teams had been commissioned at various times and had not developed in an overall coherent way.

- District Nurses;
- Community Matrons;
- Care Home Support Team;
- Medical Review Pharmacist;
- Community Phlebotomy (Phase 2 of the development);
- Community Physiotherapy

These teams have now been reconfigured into new multidisciplinary teams aligned to small clusters of GP Practices (Integrated Primary Care Teams) able to manage the full spectrum of needs patients with long term conditions have. The teams will also support the frail elderly and provide the same level of care to those in care homes or who are housebound. These teams are providing flexible, appropriate and tailored levels of support to patients in conjunction with primary care to enable the patient to develop, establish and achieve their own goals. Dedicated carers support will also be included within these teams from April 2012.

This new model was developed by a clinically led project board with patient and LINK representation. It was supported by a stakeholder event in July 2011, previous HOSC meetings, locality meetings and by the Clinical Commissioning Executive and Board. It was approved for implementation at the Integrated Delivery and Governance Committee in November 2011.

Further background information and detail on the model are included in Appendix A

A briefing and diagram outlining the service model is attached in Appendix B

2. Consultation

This new model was developed by a clinically led project board with patient and LINK representation. It was supported by a stakeholder event in July 2011, previous HOSC meetings, locality meetings and by the Clinical Commissioning Executive and Board. It was approved at the Integrated Delivery and Governance Committee in November.

Sussex Community Trust carried out a full staff consultation process in October 2012 which included all staff affected by the service change, prior to the recruitment process.

3.1 Implementation – March 2012 Update

The new Integrated Primary Care Team service went live on 23 January 2012 with the previous community teams outlined above (current exception of Community Phlebotomy which is to be included in Phase 2) forming new Integrated Teams aligned to small clusters of GP practices.

Locality meetings were held in December 2012 to enable representatives of the new community teams to meet with their aligned practices to begin to build relationships and establish effective ground rules for working.

Since January the focus of implementation has been

- Team formation and development
- Establishment of relationships, agreements on working practices and communication methods
- Alignment of patient caseloads and agreed approaches to patient prioritisation developed
- Patient and public information leaflets regarding the changes
- Stakeholder communication plan regarding the changes
- Establishment of weekly teleconference with Sussex Community Trust to track implantation and address issues arising
- Transformation of the Project Board responsible for development of the model to one with responsibility for overseeing implementation
- Agreed performance management and data collection framework developed
- Draft evaluation framework developed to enable determination of future commissioning intentions.
- Finalisation of pathways to specialist services to enable effective and streamlined referral processes
- Effective alignment with Adult Social Care to improve the interface between health and social services, reducing duplication and improving patient outcomes.
- Following a tender process for provider of the carer service which did not result in a successful bidder, work is taking place to develop an alternative approach to appoint Carers Support Workers from Adult Social Care who will be aligned to the practice clusters to increase the resource and support available to carers. This additional element of the service will build on the carer support work already carried out by Adult Social Care, ensuring best use of resources, management time and avoiding duplication by both the IPCTs and social care.
- Training is currently taking place with practices and members of the teams on the use of the Urgent Care Clinical Dashboard which will support the proactive identification, prioritisation and effective management of patients at increasing risk to prevent avoidable admissions.

- Staff within the Integrated Primary Care Teams have completed training in motivational interviewing techniques and behaviour change to enable them to better support patients in a more proactive way.

3.2 Implementation- Issues

A detailed risk register has been developed and is reviewed at each Project Board meeting for the implementation of the project with risks addressed and escalated as required.

Since the start date in January there have been a number of issues identified which are currently being addressed

- The difficulties of large scale change which includes the different community teams coming together and these teams establishing effective working relationships with their practice clusters. To progress this, meetings are taking place between teams and their cluster practices to start to build effective relationships and agree processes for ongoing communications and an organisational development plan supports staff training and development.
- Some capacity issues within teams, notably across the West. Whilst most of the posts within the teams across the city have been filled, there are a number of vacancies which are being recruited to currently. Combined with staff sickness, this has on occasion led to capacity gaps and a reduced level of service by the teams. To manage this, staff are being deployed across the service to ensure optimum cover, vacancies are currently being recruited to and ongoing communications with primary care are taking place to advise them of any capacity issues and management plans.
- It has been identified that further work needs to take place to ensure clear and effective pathways, referral processes and communications between the new Integrated Primary Care Teams and specialist, urgent care and hospital discharge services. This is being addressed to ensure that patients are able to move seamlessly between these different services, as appropriate.

4. Next/Future Steps

2012-13 is a transitional year towards the full implementation of the service from 2013 onwards. Learning from this transitional year will inform the final service and specification.

Dedicated carers support will be available within the teams from April 2012. Community Phlebotomy will also be included within the scope of the teams. Data collection and monitoring will commence in March 2012 to ensure that the service is meeting agreed outcomes and key performance indicators.

The Prevention sub group which sits under the Project Board will develop pathways into prevention services to further support the service by September 2012 and the end of life services review which is due to conclude by autumn 2012 will improve access to effective and tailored end of life services.

The project board which has overall responsibility for implementation will continue to meet monthly throughout the implementation of the service and will oversee the evaluation of the service. A draft evaluation framework is currently in development and a full evaluation of the service will take place by autumn of 2012 to inform future commissioning intentions and the final version of the service specification.