Brighton and Hove Integrated Primary Care Teams (IPCTs)
Update Report – September 2013

1. Summary and context

This paper is to update the HWOSC on key themes from the year 1 evaluation of the Integrated Primary Care Teams and the work that has is progressing to continue to develop these teams.

2. Relevant background information

2.1 The HWOSC were last provided with an update on the Integrated Primary Care Teams in March 2012.

2.2 Historically a range of different (predominantly uni-professional) community teams provided support and care for people in the community. Whilst these services individually provided a high quality care, in terms of an overall care system it tended to be reactive, episodic and fragmented rather than being co-ordinated around the needs of the individual patient. There was also a relatively high rate of emergency hospital admissions for acute conditions that should not usually require hospital admission indicating scope to improve community based preventative care.

2.3 Alongside this the local population is growing and complexity of need and the prevalence of long term conditions is increasing[1]

3. Service Model

3.1 There is a range of national and international evidence that integrated, coordinated and preventative care system for people with long term conditions can provides better outcomes and better use of resources. Delivering care with a single point of coordination can improve patient and carer experience, supports care at home and may prevent avoidable hospital admissions.

3.2 Holistic assessments and user and carer participation is the first step in developing appropriate care and support plans. Regular discussions at multi-disciplinary team (MDT) meetings within GP practices enable health and social care practitioners to reassess individual care plans, address any gaps in a collaborative way and make more effective use of local services. Instead of reactive or crisis care, people and their carers will receive an improved service through a more proactive assessment and care planning approach.

3.3 In light of evidence and best practice as well as the growing needs of the population, multidisciplinary teams (MDT's) aligned to small clusters of GP Practices - the Integrated Primary Care Teams were developed in Brighton and Hove to provide pro-active care & support to the frail housebound

[1] Long-term conditions are defined on the Department of health website as "those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies. The life of a person with a LTC is forever altered – there is no return to 'normal'." Among the most common of these conditions are hypertension, asthma, diabetes, coronary heart disease, chronic kidney disease, stroke and transient ischaemic attack, chronic obstructive pulmonary disease, heart failure, severe mental health conditions and epilepsy.

population with long term conditions. The IPCT service is provided by Sussex Community NHS Trust and the organisation has worked collaboratively with the Clinical Commissioning Group and other partners to deliver the model.

3.4 The IPCT's went live in January 2012. Key features of the new model:

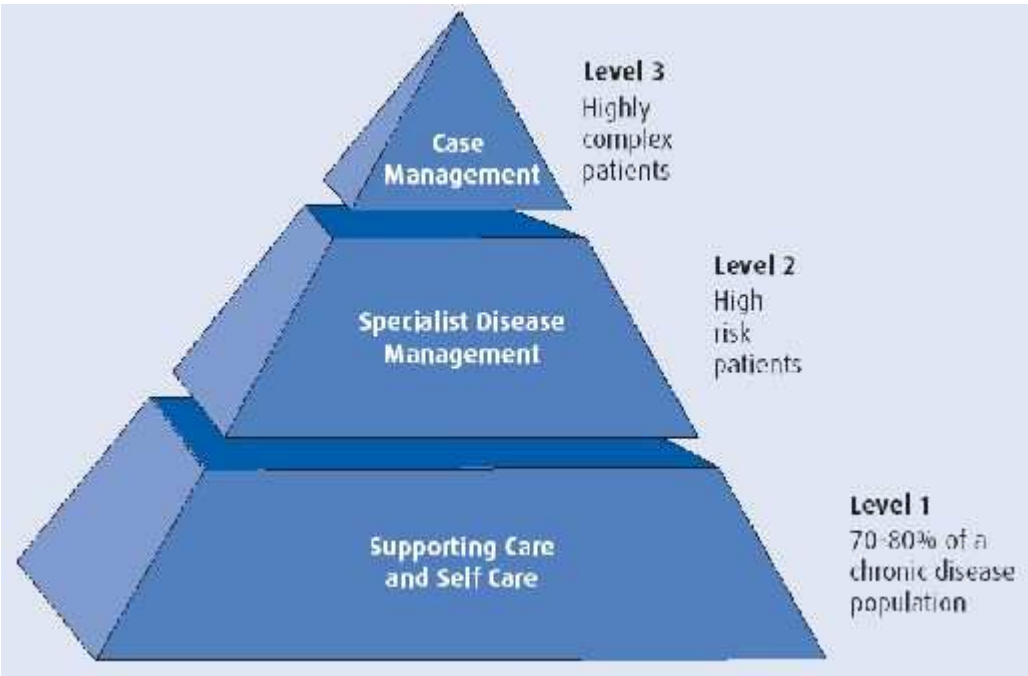
- The teams operate 7 days a week, providing care between 8am and 8pm.
- The GP practice remain the hub of care for the IPCT's
- The IPCT's consist of nurses, occupational therapists, physiotherapists, pharmacist & carers support.
- There is a pilot social care worker in the East Locality .
- Approximately 6,000 patients were cared for and supported in one year

3.5 Key principles of IPCT's

1. Planned and proactive preventative care intended to keep people as well as possible in the community
2. Co-ordinated care using team based approaches
3. Support for self -management
4. Increased support to carers
5. Case management for high risk patients.
6. Reduce avoidable demands on acute health care

The IPCT model of care is shown diagrammatically in Figure 1.

Figure 1: IPCT Model of Care



4. Key Themes From the Year 1 Evaluation

4.1 An evaluation of the first year of the IPCT service delivery was completed in April 2013. The overall key theme from the evaluation was variability in the success of the model. In some parts of the City it was working well but in others the benefits had not been fully realised and pro-active care is not yet being delivered consistently across the City.

4.2 The evaluation included structured feedback from stakeholders. There was wide

variation between different stakeholders with patients being most positive, and GP practices identifying the most need for further improvement of the service.

4.3 A patient survey (with 159 responses) was conducted in September 2012 which showed positive results:

- **91%** felt treated with dignity and respect
- **85%** agreed there was sufficient time to discuss their problems
- **87%** felt they received clear explanations of their treatment
- **88%** satisfied with standard of care

4.4 The GP practice survey conducted in October 2012 (with 105 responses) showed that the pro-active care model was not yet being delivered as intended as there was room for improvement:

- **61%** reported that they had frequent MDT meetings.
- **Over half** felt the teams were too busy or not adequately resourced to meet demand.
- **70%** did not feel there had not been an improvement in management of housebound.

4.5 IPCT staff feedback was obtained via focus groups which showed a more mixed views. Positive comments included: "*Significant benefits working in an integrated team with shared learning, better access to therapy and better patient care*". Staff also highlighted areas of variability. Comments included:

- GP engagement is variable
- Case manager role is variable and further development is needed.

4.6 Key themes from the evaluation and the actions agreed as part of the subsequent Development Plan are detailed in Figure 2

Figure 2: Key Themes and Development Plan Actions

	Issue	Action
1	**Variable GP engagement and MDT Working.** MDTs have been a success in some areas but in other's meetings had not taken place. Regular discussions is essential to enable care to be planned for patients in a collaborative way and is fundamental to the model of IPCT care.	• An "Enhanced Service" for Risk Profiling and Case Management has been launched which provides funding and a consistent framework for General Practice to work with their IPCT's • Service delivery started from July 2013 and 91% of Brighton and Hove GP Practices have signed up to deliver this new Enhanced Service. • Progress will continue to be closely monitored.
2	**Increasing Patient Complexity coupled with Insufficient Staff Resources & high levels of staff turnover in the IPCT's has hindered full delivery of Pro-active Care**	• Funding for 12 additional nursing and therapy posts has been agreed. Recruitment has been undertaken and most posts have been recruited to. These additional new staff will start in post form from September 2013 • Pilot funding for occupational therapy to IPCT's in Year 1 has now been made permanent • A plan has been agreed to transfer some "re-active" activity from the IPCT's to the Community Rapid Response Service – freeing up the IPCT's to concentrate on pro-active care • The impact of the additional resources will be closely monitored.
3	**Gaps in Service Model**. The IPCT model has integrated a range of physical health care services and two key gaps were identified in the model of care through the evaluation: • Mental health • Social Care	**Mental Health** • Plans are in place for Sussex Partnership Foundation Trust (the main local provider of mental health services) to provide training for IPCT's on the range of mental health services available and to ensure streamlined referral routes. • A pilot has been agreed for two mental health workers to be embedded within two IPCT's one focusing on mental health and one on dementia) to test out whether this enhances the model of delivery. The pilot will commence in Autumn of 2013 and will be evaluated in 2014. **Social Care** • The pilot Social Worker in the East Locality has provide successful and this been extended to Central and West localities increasing the amount of social care support available across the City. Recruitment to these additional posts is underway.

4.	**Scope to Improve Self-Care**	• A plan is being developed to introduce volunteers into the IPCT's providing increased support with practical tasks to support frail people at home and to enable independence. • The Public Health Promotion Team has delivered health promotion training sessions in May & June 2013. The training includes details of services they could refer on to promote self-care. • Further plans are being developed to ensure opportunities for IPCT's to promote self- care are maximised
5	**Lack of clarity about Support Available to Care Homes with Nursing**	• Discussions are taking place between the Clinical Commissioning Group, IPCT's, and Nursing Home Managers to ensure: o Clarity about role and support available from IPCT's o Clarity about responsibilities of Care Homes with Nursing Homes • Written information about support available from IPCT (and other specialist community services) is being produced to share with Care Homes • A networking event is being organised by Sussex Community NHS Trust and Care Homes with Nursing to promote IPCT's and other more specialist community services

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5. Summary

5.1 The development of IPCT's has been a large scale change and in common with any transformational change programme it takes time for the full benefits to be delivered. The evaluation and feedback from stakeholders is that the IPCT model of care is about right but there are gaps and it could be developed further. Ability to successful delivery of model in first year has been affected by Increasing patient complexity and difficulties in recruitment and retention of IPCT staff.

5.2 A Development Plan has been produced following the Evaluation and Brighton and Hove Clinical Commissioning Group meet on a monthly basis with SCT to oversee the delivery of the plan. In addition there is an IPCT Project Board which includes representation from stakeholders including other care providers and Healthwatch meet to ensure that the IPCT's develops with reference to the overall system of care.