ITEM No …11……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 19TH JUNE 2024**

REPORT ON: **STRATEGIC SHIFT TO ADVANCED NURSE PRACTITIONER LED FRAILTY PATHWAY**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB23-2024**

1.0 PURPOSE OF REPORT

1.1 To seek approval to progress the development of the leadership model required to support the ongoing development of a clinically robust Advanced Nurse Practitioner workforce.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the transformational nature of this proposal and its contribution to the strategic aims of Continuous improvement of unscheduled pathways and process as outlined in this report.

2.2 Approves the release of funding from ring fenced IJB Transformation Reserves to the value of £92k to support the proposal (as detailed in section 3.1 of this report).

2.3 Instructs the Chief Officer to issue the direction as attached at Section 8 of this report to NHS Tayside.

3.0 FINANCIAL IMPLICATIONS

3.1 The proposals to create 1 additional Lead Advanced Nurse Practitioner post and associated project support resource to support implementation and to provide robust data management as outlined in this report will require £92k of additional investment for a 12-month period. It is proposed that the IJB utilises ring fenced Transformation Reserves to support this test of change which will be reviewed with further recommendations put to the IJB in due course as to future funding options should the change be successful.

4.0 MAIN TEXT

4.1 Work has been progressing to develop a seamless whole system frailty pathway. This has focussed on aligning professional staff from all disciplines to patient pathways, and wherever possible around GP cluster groupings.

Most of the progress so far has been with the Medicine for the Elderly (MFE) patient and professional groups, although we would aspire to spread this work across the wider frail population as we stabilise and embed the model.

Aims:

- promote early intervention and prevention
- Contribute to NHS Tayside's Annual Delivery Plan target of reducing front door presentations by 5%

- Prevent admission and therefore promote better outcomes
- Support primary care and General Practice
- Provide alternative pathways for Scottish Ambulance Service, Flow Navigation Centre, and Out of Hours General Practice Service
- Support early discharge with minimal risk of readmission
- Reduce cost of clinical service over time

4.2 The ethos behind the development and expansion of the frailty model is that this type of intervention promotes early discharge from hospital, and the delivery of care closer to home. Early discharge prevents the dependence created by longer admissions to hospital, as well as reducing the number of bed days used.

4.3 The effectiveness of this is evidenced through the impact of implementation of the frailty model in Oct 2017, and the subsequent strategic positioning of targeted social care resource within the model to support early discharge and prevention of admission.

4.4 As our integrated partnership working across Dundee Health and Social Care Partnership and NHS Tayside has developed and matured, we have continued to focus on developing this approach in order that the growing numbers of frail older (and increasingly younger) adults can receive care, treatment and support from the right person at the right time in the right place.

4.5 We are now at a stage where the Dundee Enhanced Community Support Team (DECAHT) has realigned into multiprofessional Advanced Nurse Practitioner (ANP) led cluster teams with a single point of access for GPs. This enables each referral to be triaged appropriately within the cluster teams and the appropriate type of assessment undertaken, therefore increasing efficiency within the service. Patients receive a comprehensive geriatric assessment, based on the principles of realistic medicine, and accompanied by realistic and sensitive conversations with patients and their families about their wishes in order to develop robust anticipatory care plans.

4.6 The MFE medical team has been realigned against the cluster model as much as possible across both Ninewells and Royal Victoria Hospitals (RVH) to promote care continuity, with the cluster DECAHT teams linking with their cluster consultant when necessary for additional advice. This promotes the formation of virtual multidisciplinary teams and communication across the system and is aimed at reducing inappropriate treatment decisions.

4.7 As the ANP workforce grows and the system develops trust in the efficacy of the competence framework, we anticipate less medicalisation i.e. fewer polypharmacy issues, fewer unnecessary tests and fewer admissions.

4.8 The next stage in this transformational process involves 2 key actions:

- Shift a further 18 beds from the MFE acute bed base to the frailty model with the aim of discharging more patients within 72 hours into community settings. This will involve further realignment of medical staff to strengthen the cluster model across the whole pathway i.e. wherever possible within job planning, cluster consultant will see the patient in acute and follow either to RVH or into community
- Expand the ANP workforce across the inpatient setting therefore reducing the MFE medical spend over time

4.9 Agreement has been secured to transfer money from the MFE medical budget to fund 1 additional WTE ANP to work within the RVH site and plans are in discussion for further potential transfer over the next year should this model create the anticipated efficiencies. This will enable us to develop an ANP led model across the cluster MFE wards, thereby reducing the need for medical input, and driving the practice and culture changes required to reduce length of stay in line with the Urgent & Unscheduled Care Optimising Flow Workstream.

4.10 This will require some initial investment as the growing ANP workforce requires a leadership infrastructure to ensure the necessary governance is in place, and to support the supervision of the competence framework for the ANPs.

This workforce currently comprises:

13 ANPs within DECAHT providing senior clinical assessment for urgent GP referrals in community and care homes

1 ANP in RVH

4 ANPs in Community Mental Health Team for Older People (2 in training)

2 ANPs in Community Nursing

2 ANPs in 2C practice, Maryfield with a plan to provide more leadership support as practices develop their ANP workforce

4.11 The model already includes 2 Lead ANP posts banded at 8A, funded partly from the previous management structure within the service, with additional investment from MFE budget. In order to continue to support the ANP workforce adequately as the model becomes embedded, a further Lead ANP post is requested. This will secure the continuing strategic development of the model, and ensure excellence is maintained across all 4 pillars of practice, while crucially continuing to develop the model proactively in a way which supports the demographic demand.

5.0 POLICY IMPLICATIONS

This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

6.0 RISK ASSESSMENT

Risk 1 Description	Inadequate professional and managerial structure to support growing workforce
Risk Category	Workforce
Inherent Risk Level	Likelihood 5 x Impact 4 = Risk Scoring 20
Mitigating Actions (including timescales and resources)	Introduction of this management structure will support ongoing development of advanced practice workforce
Residual Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9
Planned Risk Level	Likelihood 3) x Impact 3 = Risk Scoring 6
Approval recommendation	Recommend risk is accepted due to the mitigating actions put in place

Risk 2 Description	Inadequate management resource to develop and manage emerging governance structure
Risk Category	Governance
Inherent Risk Level	Likelihood 5 x Impact 4 = Risk Scoring 20
Mitigating Actions (including timescales and resources)	Introduction of proposed management structure to support governance structure, both in terms of development of governance and the measurement of service performance against the framework
Residual Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9

Planned Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9
Approval recommendation	Recommend risk is accepted due to the mitigating actions put in place

7.0 CONSULTATIONS

The Chief Finance Officer and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	Direction to: N/A	
	1. No Direction Required	
	2. Dundee City Council	
	3. NHS Tayside	X
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

None

DATE: 21 May 2024

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Acting Chief Officer, Dundee IJB

Lynne Morman
Associate Locality Manager, Acute and Urgent Care

DIRECTION FROM DUNDEE CITY INTEGRATION JOINT BOARD

1	Reference	DIJB23-2024
2	Date Direction issued by Integration Joint Board	19th June 2024
3	Date from which direction takes effect	19th June 2024
4	Direction to:	NHS Tayside
5	Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s)	No
6	Functions covered by direction	Dundee Enhanced Community Support Team
7	Full text of direction	Dundee Integration Joint Board directs NHS Tayside to create and recruit to 1 additional Lead Advance Nurse Practitioner and associated project support in the Dundee Enhanced Community Support Team for an initial 12-month period
8	Budget allocated by Integration Joint Board to carry out direction	£92k
9	Performance monitoring arrangements	Service review process
10	Date direction will be reviewed	June 2025