TEST AND LEARN: WORKING TOWARDS INTEGRATED SERVICES

As part of the government’s drive for seamless care, 14 pioneer sites are piloting different approaches. Louise Hunt visited one in Greenwich, south east London.

Abstract

By 2018 the government expects integrated health and social care to become the norm in England. From next April a £3.8 billion pooled budget called the Better Care Fund will be launched to support service redesign for integrated care.

The overall aim of the integration policy is to shift more care into the community to address the challenges of an ageing population by preventing delayed discharges and avoiding emergency hospital admissions.

Across England, there are as many different approaches to attaining this holy grail as there are interpretations of the word integration. Nursing Older People visited one pilot site in south east London to explore how integration works in practice and what effect it is having on community nursing services.

Keywords
Community nursing, co-ordinated care, health and social care, pioneer sites, service integration

THE GREENWICH Co-ordinated Care (GCC) model is one of 14 Department of Health (DH) integration pioneers (see box, page 18) that are piloting and showcasing different best practice approaches to co-ordinated health and social care.

A number of integrated services have been developed under the umbrella GCC model run jointly by Oxleas NHS Foundation Trust and the Royal Borough of Greenwich Council. One service is ‘Eltham Test and Learn’, as it is known by staff, which was launched in January to wrap health and social care teams around GP practices to manage complex patients. While it is open to all adults with an Eltham GP, the average age of patients is 76, as the area is home to a large older population. Test and Learn will soon be trialled in another part of the borough with a different demographic.

Under the service, patients have a shared action plan called an ‘I statement’ that is agreed by them and the professionals identified as being relevant to their care pathway. These professionals may be from a core team, which includes the Greenwich community assessment and rehabilitation team, and a wider network of tertiary, council and voluntary services.

The service is delivered by the Test and Learn hub, which comprises specialist integration lead Wendy McDermott, and three care navigators, who work directly between patients and professionals to deliver the shared action plans. Monthly multiprofessional meetings are held in each surgery to discuss patient progress.

Ms McDermott, an occupational therapist by background, explains the service’s ethos: ‘We are moulding services together to try to help patients feel there are no barriers. This is not a medical model. If the patient has issues around housing, or isolation or pain we would bring in the correct professionals.’
**Integration pioneers**

- **Barnsley**: a new centralised monitoring centre assesses emergency patients in one of three categories – individual, families and communities – to help ensure the right help is dispatched.
- **Cheshire**: integrated health and social care with a focus on older people with long-term conditions and families with complex needs.
- **Cornwall and Isles of Scilly**: 15 organisations across health, social care and voluntary sector have formed one pioneer team. Prevention of falls and injuries in the over-65s is one measure of success.
- **Islington**: Islington Clinical Commissioning Group (CCG) and Islington Council have established an integrated organisation introducing a single point of contact and individual care plans.
- **Kent**: county and district councils, CCGs and NHS trusts have been brought together to provide patients with access to 24/7 community-based care and introduced patient-held care records.
- **Leeds**: 12 health and social care teams now co-ordinate care for older people and those with long-term conditions. A new joint recovery centre provides rehabilitation.
- **North Staffordshire**: five CCGs have teamed up with Macmillan Cancer Support to form one principal organisation responsible for the overall provision of cancer care and one for end of life care.
- **North West London**: two million residents now have a single point of contact as health and social care is integrated across eight London boroughs.
- **South Devon and Torbay**: expanded its integrated services to include GPs, mental health and severe alcohol problems.
- **Southend**: health and social care partners are focusing on commissioning new services to support frail older people and those with long-term conditions to reduce demand for acute care.
- **South Tyneside**: new services to support independence including increased use of the voluntary sector and technology.
- **Waltham Forest, East London and City**: older people have a single point of contact to co-ordinate their care.
- **Worcestershire**: all local NHS organisations, the county council and voluntary sector have united to tackle avoidable hospital admissions.

**Care navigators**

Pivotal to the service are the care navigators – a relatively new role being trialled in several of the pioneer sites. ‘They act as a single point of contact, so they have to be able to tap into lots of different services and advocate for patients,’ says Ms McDermott.

‘We say to the patient: what do you want to be able to do? What’s going on? We record that in the “I statement”, which forms a shared action plan and that is what drives the whole thing, so we are working totally from the patient’s perspective and what they want to achieve. What we do know is that we shouldn’t work in an imposing way.’

One of the most skilled aspects of the care navigator role is to tease out the underlying issues that are making patients’ problems so complex.

Ms McDermott explains: ‘A key aspect to the care navigators’ role is to make sure they get everybody around the table, monitor the plan and go through the progress that has been made and if goals have changed. It’s quite a dynamic process.’

**Patients with multiple needs**

One of the main advantages of the Test and Learn service is the opportunity to work directly with GPs. ‘The main thing is getting GPs on side,’ Ms Nash says. ‘Historically, they are always hard to get hold
of for advice. This has made it a lot simpler. We feed back to the GP anything we have identified through our advanced clinical assessment.

‘The GCC is a one-stop shop so if you’ve got someone with multiple needs you don’t have to keep putting them on all sorts of waiting lists, it’s a much more seamless service,’ she adds.

The Test and Learn service is also helping to pick up patients who might have been missed, in particular, those coming through social services that GPs may have been unaware of. ‘The whole system is based on the idea that two heads are better than one, so if something gets missed out it’s picked up by someone else,’ says Ms Nash.

Healthy ageing nurse Kumba Doherty explains how the approach is enabling the team to identify multiple needs.

‘One lady, for example, kept presenting to A&E with hyperventilation and when we saw her we found she was clinically depressed. It presented as a physical condition but it was more as a result of depression.

‘Another gentleman was presenting with falls. We arranged to visit with a continence nurse to see if he had a urinary tract infection (UTI). A bladder scan showed he had residual urine, which was why he was having recurrent UTIs. We worked together to highlight problems and think of ways they could be managed to reduce hospital admissions.’

Previously, Ms Doherty says it was difficult to get professionals together to discuss patients with multiple needs. ‘We would arrange case conferences, but they were not as effective,’ she says, adding that the new integrated approach is ‘fantastic’.

‘We work very well with other services, such as district nursing and mental health teams looking at the whole picture of holistic care. If you don’t know what’s wrong with a patient you have other professionals linked in who you can go to and say “it’s not health, what do you suggest, what else can we look at?”’

More concordance

Patients, too, are responding well to the opportunity to express their needs through ‘I statements’. Ms Doherty says: ‘Patients are more concordant if you are working with them to achieve their goals rather than imposing your ideas on them.’

The positive response from patients is helping the team to achieve its mission of avoiding unplanned hospital admissions.

Adds Ms Nash: ‘We have just done an evaluation that predicts that in a year our service is saving £80,000 on acute admissions that can be managed in the community.’

For community mental health nurse Adrian Dassrath, the new approach is broadening his perspective on physical health and how it affects mental health.

Working predominantly with Greenwich older people’s service, Mr Dassrath says previously he would have referred patients with complex physical needs for further assessment, but now these issues can be discussed and often dealt with in the multiprofessional meetings before referral.

‘We look to see if we can improve their general wellbeing by offering physical assessments and social input and whether the mental health and psychological issues can be improved,’ he says.

He often encounters patients with complex physical needs who are on a multitude of medications but are not following the complicated regimen, which affects their mobility as well as mental health. ‘Before we might have thought they were not taking their medicines because of memory loss, but it turns out that it has nothing to do with dementia. They have just got fed up and don’t know why they need their medications and don’t understand their effects and side effects. What I can do now is tell them what the medicines do, their side effects and the impact of not taking them.’

He adds: ‘As a psychiatric nurse, it’s made me consider conditions like hypertension, diabetes, chronic obstructive pulmonary disease, and read more about them so I can understand the impact on the patient and come to specialists for advice.’

Lynne Fitzpatrick, community forum lead for district nurses, says the shared action plan means visits can be planned more efficiently. ‘The “I
The nurses feel strongly that Test and Learn has improved staff morale and is breaking down professional barriers

The Care Act 2014 sets out that the Better Care Fund will be allocated to local areas, where it will be put into pooled budgets under joint governance arrangements between clinical commissioning groups (CCGs) and councils.

A condition of accessing the money in the fund is that CCGs and councils must jointly agree plans for how it will be spent, and these plans must meet certain requirements.

In April 2014 every health and wellbeing board, in collaboration with local health and social care providers, submitted a plan for how they would deliver more integrated services through pooled budgets. On July 25 the government published revised planning guidance to support the resubmission of local Better Care Fund plans by September 19. These will need to demonstrate how emergency hospital admissions will be reduced as payments to the boards will be linked to achieving set targets.

The revised plans will be reviewed in the autumn to ensure they are on track to begin in April 2015.