



Joined-up care
delivering seamless care

Case Studies

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Torbay Care Trust - Making a bigger difference

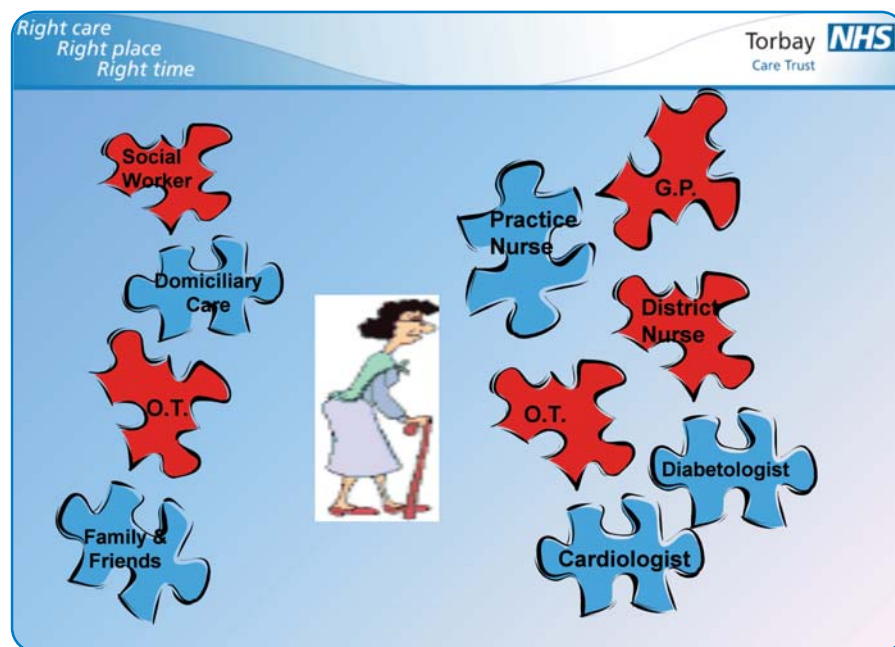
As far back as 2005, the Chief Executive of Torbay Care Trust, Peter Colclough, recognised that community services were not joined-up. Torbay has a population of around 140,000 people and nearly a quarter (23 per cent) are over 65. Patient feedback indicated that older people were unhappy about being visited by lots of different healthcare professionals and having to answer the same questions over and over again.



Peter Colclough framed the problem by creating a fictional character, Mrs Smith. 85 year old Mrs Smith was represented pictorially using a simple graphic. The myriad of different specialist services with which she interacted on a regular basis was represented by scattered jigsaw pieces. These included: social workers, domiciliary care, occupational therapy, practice nurses and cardiologists. The aim was to join up the pieces to make a complete picture, with Mrs Smith at the centre of it.

Torbay Care Trust's Chief Operating Officer, Mandy Seymour explains:

"Although we carried out our initial pilot in Brixham, improving the whole experience for Mrs Smith was everybody's business. We created an environment where everyone felt empowered to make a difference and everyone knew that we were working towards shared values and a shared vision."



The trust discovered that, no matter how effectively healthcare teams worked together to improve the patient journey, a completely integrated service was impossible without the involvement of social services. Following discussions with Torbay Council, it was agreed that Torbay Care Trust should become a co-terminus authority, providing adult social care services alongside healthcare. The chief executives of Torbay Hospital, Torbay Care Trust, Torbay Council and Devon Partnership Trust met regularly to discuss how the new arrangement would work and set out their visions for a seamless service. A Partnership Agreement was established between the NHS and Local Authority and the budgets for all NHS and adult social care services were combined. Two nominated councillors joined the Care Trust Board and the chief executive of the trust became Director of Adult Social Services.

Five 'zones' were established, based around groups of GP practices in Torquay, Brixham and Paignton. Multidisciplinary teams were set up and the team introduced Health and Social Care Co-ordinators, whose role was to co-ordinate responses and liaise with the different professionals in order to make the right referrals behind the scenes. This meant that GPs and patients had a single point of access.

Council staff were transferred to the NHS using the TUPE (Transfer of Undertakings and Protection of Employment) process, which protects employee rights. Each team was given the autonomy to make things better for their own 'Mrs Smiths', rather than being given set targets and objectives.



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 The trust used the Plan, Do, Study, Act (PDSA) methodology widely as they implemented the changes, as it was practical and very simple, reducing risk and ensuring that the changes being made were owned by staff and could be easily improved and amended. The constant baseline was *“what difference are we making for Mrs Smith”*

 Health and social care teams came from very different backgrounds and the challenge was to integrate them into a single, unified team. One general manager was appointed with responsibility for the whole team. The manager enabled the team to begin thinking about how they could create a new identity for themselves. They held monthly meetings and agreed team objectives (such as improving waiting times and access to care). This helped different professionals to start to see their shared values: they all wanted to do the right thing and take a more holistic approach. This common ground and shared values brought people together, generating the synergy to continue building relationships.

This was reinforced by training and development. All members of the team attended training courses together, even if the course was directed more towards health or social care. The idea was for the whole team to learn together, so that they were aware of the bigger picture. Multidisciplinary shadowing was encouraged - for example, nurses shadowing physiotherapists - to reinforce the ethos of team working. In the trust's monthly newsletter,


a 'day in the life of...' feature gave everyone a wider understanding of the work of other members of their team.

 An exercise entitled "Know Your Population" asked all of the health and social care professionals involved in the pilot to identify and analyse caseloads in Brixham. The team devised criteria for categorising individuals' needs, based on the amount of support required. As well as enabling the teams to identify caseloads and build closer relationships within the team, this exercise gave them a more realistic idea of how many local people are working with more than one professional. This meant that different professionals could co-ordinate their visits and discuss care with one another, helping to formulate a more joined-up care plan.

 In order to make sure that every body within the organisation knew that they had a personal responsibility to do this, and making sure Mrs Smith received exceptional care the chief executive led some organisational development work, entitled Leading Improvements in Torbay. Its aim was to engage frontline staff to make a difference and one of the key drivers was to understand how the staff were feeling. Staff were asked a range of questions such as *“What does it feel like to work for this organisation? Do you feel empowered to make a difference?”*

The staff feedback was encouraging. One person said: *“I've devoted my career to doing the right thing and now I feel able to do so.”*

Another said: *“Yesterday, I got all of the background I needed from the social care OT to take back direct to the patient. We reckoned this saved about five hours of our time.”* This point of view was echoed by a social care colleague who said: *“A nurse can just have a discussion with me and find a solution, which prevents what would have been a referral.”* One summed up his feelings by saying *“Buck-passing is dead in this building.”*

 Equally important was the involvement of the local community. Regular discussion sessions invited patients and the public to share their experience of the health service and asked what they would like to see changed. The community hospital league of friends, schools, residential homes and nursing homes were all involved and kept informed of developments. The aim was to foster a sense of enthusiasm and a desire to get involved, and to understand from their point of view what would make their experience better?



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 Strong leadership has driven this process from the outset, starting with the original vision that was powerfully articulated by the Chief Executive, through to the joint leadership established with partner organisations. Clinical leadership at all levels championed the changes and kept the focus on patient benefits.

 Information and measurement has been the key to the improvement process. Obtaining good baseline data – including activity, financial flows and risk – helps the teams to understand fully the potential benefits of what they are doing, to measure improvement outcomes and realise these benefits.

The team used an external evaluator to give credibility and momentum to the project. Initially, the editor of the Journal for Integrated Care, Peter Thistlethwaite, was invited to examine the available data. He discovered that it could take anything from five to 81 days to deliver services. Peter talked to GPs and other members of staff to try and identify delays in the system. He asked questions like *“who do you know in social services? How do you access a therapist?”* A pro forma was used to reveal information such as the number of visits made to patients and to try to identify whether the care provided was 1) co-ordinated 2) collaborative and 3) integrated.

This data was reviewed within three months. It provided tangible evidence that multidisciplinary working was bringing about improvement. GPs indicated that the biggest improvement was the introduction of the Health and Social Care Co-ordinator, who provided a single point of contact and co-ordinated care.




Crucially, this evaluation also enabled the team to see where significant progress hadn't been made, so that it could refine some of its objectives.

The integrated structure has made a real and lasting impact. “Mrs Smith” now only has to make one telephone call and answer one set of questions during a comprehensive health and social care assessment. The health and social care team then signposts her towards the specialist care she needs. The vision has continued to grow, now encompassing a much wider group of professionals and services, with the focus being on the whole family, not Mrs Smith in isolation.

From being rated as a poor performing authority, Torbay Care Trust is now judged to be performing well. The number of residential and care home placements has reduced by 300 since February 2006, down from 1,298 to 984, and direct payments increased to 12 per cent by the end of 2009.

Ninety five per cent of care packages are available within 28 days and 99 per cent of equipment within seven days.

 Mandy Seymour says that having a vision and being able to articulate it is the key to the integrating services: *“Talk of reducing costs by 20 per cent instils fear, but a vision of making things better for patients creates a different energy. It is important to tell a compelling story and by personalising it to an individual patient, it makes it easy to present the message. The vision of our chief executive was the driver for change - it ignited the passion and belief of staff in making things better for patients. The premise was that if we made things better for the most complex patients, then everything else would fall into place.”*

What next?

Torbay has now become one of 16 national Integrated Care pilot sites identified by the Department of Health. Its next challenge is to improve the interface between primary and secondary care and create a culture of joint working and ownership of care - tackling the "them" and "us" culture. At times complex patients were referred to A&E because effective and coordinated care could not be set up. This has now radically improved, the Integrated Care team have pioneered a consultant hotline for GPs in Brixham and Paignton, enabling doctors to discuss individual patient cases and ascertain care options and in particular if there is an alternative to emergency admission. It held workshops, bringing GPs and consultants together, and built on its previous experience by playing a video of a local woman recounting her mother's experience of care.

It has taken some time to establish the precise needs within the community, but GPs and consultants have embraced the pilot as an opportunity to tackle the challenges they face with older people who have complex needs in a different way.

Early indications suggest that alternatives to A&E admission are being explored. For example, a number of acute hospital initiatives are being utilised such as an Acute Physicians' Rapid Assessment Clinic, and the Community Hospital and Intermediate Care team arranging visits by a consultant. The pilot is now being rolled out across Torbay, alongside a rapid assessment clinic and the acute physician model, so that patients can receive a diagnosis without having to go to hospital.

Productivity levels continue to improve - Torbay now has the lowest emergency admission rates for over 65s compared to other South West PCTs and is rated the fourth best in England for the use of acute hospital beds. For patients, the move towards integrated services means they receive the right care in the right place at the right time.

Top tips for success:

- Create a really clear vision and express in a really simple way
- Communicate your vision to everyone in the organisation
- Begin from the ground up. Empower people to be able to make a difference 'tell us what we can do and we'll help you make the difference'
- Really strong leadership is crucial – make a statement that this is what the organisation is all about
- Spread the news – be relentless in sharing everything – in every format available. You need to articulate a strong and compelling vision that connects everyone - nothing motivates staff like patient stories
- Be clear about what you are trying to achieve.



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NHS Bolton - Leaving Nothing to Chance




Lesley Doherty, Acting Chief Executive, Royal Bolton Hospital NHS Foundation Trust comments:

"Ensuring a bottom up approach in influencing the culture of the new organisation was, and continues to be, something both Tim and myself want in order to support, create and sustain the future of health in Bolton"

Transforming Community Services was a policy initiative introduced by the Labour Government in 2009. It stated that Primary Care Trusts (PCTs) should move away from being providers of community services and concentrate instead on their public health and commissioning role. As a result, PCTs have to shed their community services by 1 April 2011 and there are a range of different options available to them to achieve this.


For NHS Bolton, the options were: vertical integration with a local hospital; horizontal integration with another community services provider; integration with the Local Authority, becoming a community foundation trust or becoming a social enterprise. In May 2010, following extensive consultation with staff and patients, a decision was made to integrate community services with Royal Bolton NHS Foundation Trust.

Royal Bolton Hospital NHS Foundation Trust. NHS Bolton is taking a multi-layered approach to the change to make sure that the integration is smooth and seamless, and that patient care remains the primary focus.

 From the outset, NHS Bolton Chief Executive Tim Evans has been very visible, talking frankly with staff, making it clear that senior leaders do not have all the answers and asking staff to share their views and insights. A series of panel discussions for staff and a provider event in February 2010 explained what the benefits and opportunities of integrating the two organisations were.



 Building on its partnership foundations with staff a number of "Conversations" have been held with Royal Bolton Hospital and PCT provider staff. The aim is to give staff the opportunity to shape what the new organisation will look and feel like. In addition, managers and senior leaders from the PCT provider and hospital have taken part in their own "Conversations", giving everyone at every level a chance to have their say.

 The issues and views raised during these conversations will be fed into a vision and strategy event which took place in November 2010. This two-day workshop was attended by senior level staff and stakeholders from both organisations and beyond. Its aim is to determine the vision, values and culture that the new organisation should embrace. The model of care will then be decided on the basis of what patients need and how best this can be delivered. The Trust is doing this through a variety of methods: Patient members from across Bolton will be asked directly for their opinion and patient representatives will be invited to all events. The Trust engages with patient organisations such as the LINKs, asking for feedback, thoughts and comments. In addition to this, both organisations are undertaking Experienced Based Design (www.institute.nhs.uk/ebd), and the learning and themes, from that have been fed into events and communicated with staff.



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Heading up the integration process are the Royal Bolton Hospital's Director of Service Development, Ann Schenk and NHS Bolton's Interim Director of Nursing and Integration, Helen Clarke. Commenting on progress towards integration, Ann says: *"The integration of community services is about giving the foundation trust an opportunity to do things differently in the future and providing better care for our patients and our community. We are very pleased with progress and the way staff have engaged in the process, but all the time, we need to remember that this process should not distract us from the day job – of providing safe and quality care for the people who need our services."*

Helen adds: *"NHS Bolton is not new to the integration process. Bolton Diabetes Service is a model of good integration, as is community-based paediatrics. We are building on our past experiences and using the integration of community services as an opportunity to create a better service. Our discussions with staff are about giving clinicians an opportunity to tell us what they are most proud of and to look at the aspects of care they might like to change. This is not about one culture being subsumed into the other. It is about taking what is best in the two cultures and combining them to get the best of the best."*



While many of the workshops and events have focused on the bigger picture, understandably, for staff many of their concerns are to do with the detail of the transfer. A monthly newsletter, *Better Care Together*, keeps staff informed about progress and addresses some of these concerns. For example, the October 2010 issue explained the TUPE (Transfer of Undertakings and Protection of Employment) process, which protects the rights of individual staff members.

The Human Resources departments have been early adopters of integration principles. While the two departments are not yet fully integrated, they have begun working together on a range of workforce issues and the collaboration is going well. Currently, the two departments are looking at integrating the recruitment process and the Electronic Staff Records (ESR) system. Senior members of both teams meet regularly, as do individual members working on joint projects.

At the same time, reviews of all speciality services are taking place at the Royal Bolton Hospital, examining how each clinical speciality looks to the future and considers the impact and opportunity of an integrated organisation. There will be three waves of reviews, which will look at current clinical performance, financial viability, opportunities for more services to be provided outside hospital, improvements in patient experience and outcomes, the efficiency of the service and competition from other providers. Feedback from these reviews, which will involve commissioners and providers as well as GPs, will help with positioning and improving services over the next three to five years.



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The integration process is complex and NHS Bolton and the Royal Bolton Hospital are taking the utmost care to ensure that nothing is overlooked. The fact that both organisations are involved with High Impact Pathways and QIPP means that the improvement process does not feel revolutionary. Staff are familiar with the concept of Lean with community teams undertaking Productive Community Services, and acute teams undertaking Productive ward via the exemplar programme, with the language and methodologies of improvement and integration being already familiar.

NHS Bolton Quality Improvement Lead (Provider Arm), Elizabeth Ashall-Payne concludes: *"There are undoubtedly challenges. We face some significant cultural differences but by adopting an honest and open approach and by focusing on what is best about particular pathways for patients and what could be improved, we are moving forward in a positive way. I am particularly proud of the myriad of different approaches we are taking, giving everyone an opportunity to contribute and learn from the process."*

Top tips for success:

- Start early
- Engage as many people as you can in the consultation process and ensure staff have an opportunity to be heard using every possible medium
- Focus on the clinical benefits that the integration will deliver
- Strong, brave leadership is critical, even if leaders don't have all the answers.



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Camp Hill - Towards a Healthier Community

Camp Hill in Nuneaton is one of the most deprived areas in England and the health of local people is poor. 39% of adults smoke, compared to 25% nationally and 29% are obese (compared to a national average of 21.9%).

In 2009, the George Eliot Trust became the first acute trust to be awarded an APMS (Alternative Provider of Medical Services) contract. APMS contracts are designed to be responsive to local needs and increase patient choice, so the trust set out to determine exactly what local people wanted. It was keen to turn things around on the estate by focusing on prevention and health promotion. In line with the national agenda, the trust's priority was to reduce dependence on hospital beds and move care closer to where people live. However, it knew from previous experience that local people would not readily access GP services, so a more radical approach was needed.

Chief Executive, Sharon Beamish explains: *"We needed to design services around communities and individuals rather than around our functions and organisations, which is how we deliver them now."*

Under the tongue-in-cheek banner of 'Mission Impossible', staff from the Trust who live in Camp Hill visited local community groups to talk to them about what they want from local healthcare. on how to ask the local community what services they needed, and got back together to discuss their findings and to start to

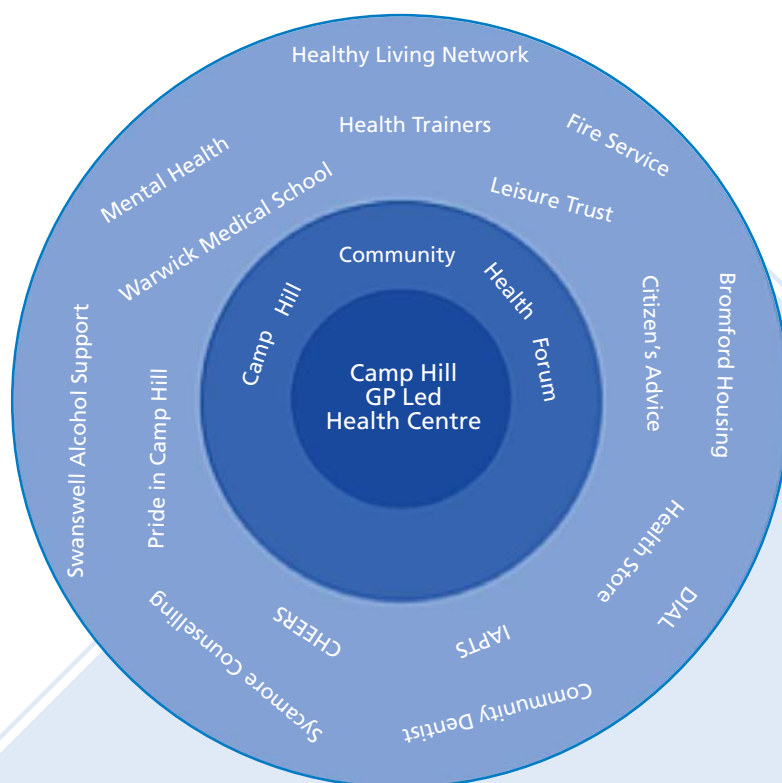
design the new services based on their insights. No sector of the community was neglected, staff worked with youth groups, nursing homes and churches, and attended the Camp Hill Festival. The feedback provided really useful information about what people wanted locally, for example evening and weekend appointments, local screening services and being able to see a doctor or nurse quickly.

With a clear vision of what local people said they wanted, the delivery team, led by Associate Director of Primary Care, Julie Whittaker, set about building an integrated model of care, breaking down traditional boundaries.


The idea was to create a walk-in centre where patients could access lifestyle advice in addition to conventional healthcare. The new centre would bring diverse organisations together under one roof, including healthcare, citizen's advice, housing organisations, and mental health services.

Since being involved with the programme, the local fire service reported a reduction in the numbers of arson incidents. The local fire service are also based at the walk-in centre and offer a free fire alarm service to local residents, and have been able to build positive relationships within the community.

Figure 1: The services provided at the Camphill




They feel that this has significantly altered young peoples perceptions of the Fire Service.

 The team used data from the Quality Outcomes Framework (QOF) along with other access data to set Key Performance Indicators. Strong leadership was critical. Chief executive, Sharon Beamish articulated the vision throughout the trust on numerous occasions, building support and enthusiasm at all levels. This helped to engage staff from across the workforce.

Julie engaged the chief executives of every partner organisation to ensure that the core messages were communicated and that any concerns could be raised. Obtaining this strategic support was crucial, as it enabled staff to progress the changes that needed to be made once the project was being implemented.

While it has not been without some teething problems, the Camp Hill Health Centre has become a focal point of the local community. The integrated model of care is working well – for example, family turnaround sessions are organised by whichever organisation has the best rapport with the family. Sessions involve multiple organisations and on-the-spot advice and support can be provided by partner organisations within the centre.

 Anecdotal evidence suggests that the centre is making a real impact. Incidents of Arson have reduced; families are offered free fire checks, helping to build good relationships with the local fire service. It is difficult to measure the full impact that the centre has made as

public health data is slow to consolidate, but early figures show that the uptake of childhood vaccinations has increased to around 40%, and cervical screening, which stood at around 15%, is now up to 76%. Julie says: *“It is apparent that health behaviours on the estate are changing – one woman hadn’t had a cervical smear for 15 years, another came to the centre after her teenage grandson made her an appointment for a long-term health condition.”*

Figure 2:
A poster developed by local youth



 The culture of listening to the community has continued. A health forum was established, which now has more than 200 members. Around 30 of them meet regularly to discuss ideas for improvement and act as a link between the centre and local community. Julie comments: *“The health forum is what I am most proud of. It is truly owned and operated by the community and even the GPs run their new ideas past it. There is a large Polish and Nepalese community so the health forum has been involved in developing marketing and information material that uses pictures instead of words so that it is clear and accessible to all.”*

There has also been a shift to a more “can do” culture among staff and a willingness to work together in different ways. Challenges between teams and organisations are worked through at whatever level is needed. This new approach is helping patients to access whichever service they need quickly and with minimal bureaucracy.

The workforce is growing and staff are given opportunities to rotate between primary and secondary care, resulting in the development of new skills and new opportunities and a constant flow of new ideas.

Sharon Beamish concludes: *“This project was about giving local people information and access to services so they could consider changing their lifestyle to improve their health long term. It supports local communities tackling local issues and holding Public Sector Services to account. The challenge is waiting for the results and keeping faith with your overall aims to improve the health and wellbeing of local people”*

Top tips for success:

- Spend lots of time planning and talking to people
- Engage the local community at a very early point
- Treat all partners equally
- Work with whoever is there - at Camp Hill the local high street pharmacy provides private consulting rooms, and the supermarket supplies fruit
- Involve the heads of all partner organisations.

NHS Barking and Dagenham - Commissioning for Long-Term Conditions



"It was one of the most astonishing things I've ever seen. The patients' stories had a profound effect on staff"

Gareth Howells - Deputy Director of Nursing

"The highlight of this was the fact that we had so many disciplines and patients coming together in such a short time, willing to make changes and suggestions at every level."


Dr John Jagen - GP Lead for the heart failure workstream

Barking and Dagenham has a population of 168,900 (2008, National Office of Statistics). Nearly 16,000 children in the borough live in poverty and early death rates from cancer, heart disease and stroke are higher here than elsewhere in England.

NHS Barking and Dagenham is a Spearhead Primary Care Trust. That means it is in the bottom fifth nationally for: male and female life expectancy, premature mortality from cancers and cardiovascular disease, and the Index of Multiple Deprivation.

In 2009, NHS Barking and Dagenham became aware that people with long-term conditions in the borough, such as COPD, were experiencing high levels of hospital admissions. The trust set out to change the way it procured care for people with conditions like these to reduce the number of admissions to acute care and shift the focus towards promoting self-care and maintaining independence.

It began by looking at four long-term condition pathways - COPD, heart failure, diabetes and stroke - which were a major cause of ill health and premature death in their community. The PCT wanted to develop a set of specifications that would enable a focus on the patient pathway, increase self confidence and self care, reduce unplanned admissions and deliver any care needed closer to the patients home.

 Work streams were created for each of the four pathway areas and each was lead by an appropriate clinician. These appointments were crucial to the success of the project and followed a comprehensive recruitment process which led to the appointment of three GPs and one Hospital specialist. Each of the work stream leads were able to access a special development course which provided detailed training and support for their new roles.

Dr John Jagen is the GP lead for the heart failure workstream.

He comments: *"As a GP with special interest (GPWSI) in cardiology, working in a local community service, I would get feedback and understanding of various issues from our patients. By breaking down the patient journeys, it was easy to see the pitfalls, issues and good points. This has an impact on our true understanding of quality, efficiencies, patient experience and access. It was the desire and drive to improve the patient journey that made me take this project on, to focus the pathway around patient experience and improve patient outcomes from the very beginning of the journey to the end. The highlight of this was the fact that we had so many disciplines and patients coming together in such a short time, willing to make changes and suggestions at every level."*



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 A robust project management approach enabled this programme to move forward quickly and efficiently, and has been the key to maintaining momentum. The project had four distinct phases.

- Phase one was to assess existing services and provide a baseline against which any future improvements could be measured. The team looked at the way services interacted with one another and how patients moved from one service to the next.
- The next stage was to represent this process pictorially so that the team could prioritise improvement areas.
- Phase three focused on designing the future pathway - patient input was crucial for this process.
- Finally came the production of a set of outcome-based commissioning specifications. These specifications were based on best practice, in line with national and regional guidance. They are outcome-based in order to encourage innovation in the way services are delivered. Patient experience is one of the main Key Performance Indicators.

  Over a period of just three months, more than 300 stakeholders, 30 clinicians and 50 patients took part in a comprehensive programme of workshops and events. Each workstream held five separate workshops and there were two overarching summit events, involving representatives from across health and social care. More than 70 people attended each summit.



Deputy Director of nursing Gareth Howells said: *"The rationale for holding a regular programme of workshops and events was to build momentum and involve as many people as possible from primary and secondary care. We wanted local people to own the process and, in between workshops, participants were asked to prepare for the next one. The aim was to get a clear picture of the current situation, to identify service gaps, to articulate clearly the need for change and to see what we could build upon locally."*

 Listening to patients and their carers was crucial, particularly when it came to working out how the new pathways should look: *"It was a shot in the arm for the project,"* explains Gareth. *"We used existing patient networks and support networks for people with long-term conditions, recruiting people who were not afraid to give their opinions to groups of professionals."*

The Experience-based design (ebd) methodology was used to help staff to understand what it felt like for patients experiencing the services. The principle of ebd is to listen to patients telling their stories and then to involve them in co-designing improved services.

The team at NHS Barking and Dagenham produced a video of patients telling their stories. *"You could have heard a pin drop when we showed the video,"* comments Gareth, *"It was one of the most astonishing things I've ever seen. The patients' stories had a profound effect on staff. This was the essence of what the project was all about; we wanted to make that experience better for patients."*

Challenges

There have been some tough challenges to overcome and some important lessons have been learned along the way. The process involved GPs, secondary care, social services and community care. All of them are culturally very different and this made finding common ground very difficult. However, the one thing that united them all was wanting to improve the experience of patients and this proved to be the common thread running through everything. The ambitious three-month timeline also proved challenging and it was not always possible to ensure consistency of staff over time and between the different workstreams. This led to some inefficiencies and duplication of effort.



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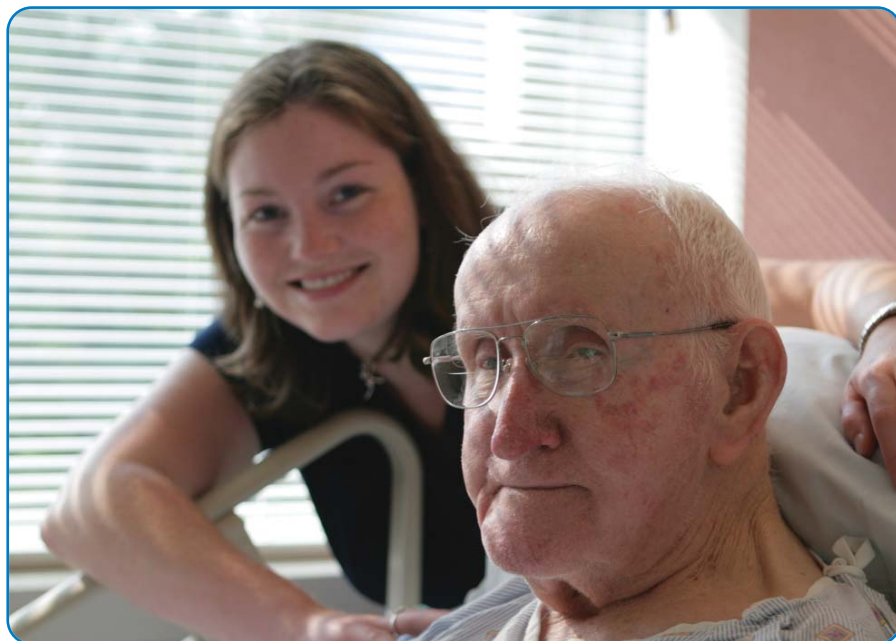
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Top tips for success:

- Patient stories are the key - they cut across barriers. We must have faith in the message we get from our patients, that's the reason we are here. I think it would be good to reorder like this
- Strong leadership - particularly clinical leadership - is essential for success, not just at the top of the organisation but at many different levels. These leaders need development and support
- You need to be able to articulate a compelling vision to lots of different audiences.

The team admits that there was a tendency to want to develop a wish list of quality standards and performance indicators, which risked making the process unduly onerous and unattractive for prospective providers. It also found it difficult to come up with a meaningful way of measuring outcome-based Key Performance Indicators.

Successes

Despite these challenges, the team is hugely proud of what it has achieved.

"Patients have never really had a voice in these types of projects before, we always assumed we knew what they wanted. Hearing them articulate for themselves how it feels to be on the receiving end of our services and what would be better for them has made a massive difference," concludes Gareth.

The future

Having completed the evaluation and service redesign, NHS Barking and Dagenham is now in the process of compiling a business case for the proposed changes and developing an implementation strategy.

A performance management process is being introduced for commissioners so that they continue to work with providers and allow them to influence the change process.



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Ashton, Leigh and Wigan - From professionally-centred to patient-centred care

Before we joined-up care:

"patients might see up to 10 separate professions and be asked the same questions again and again- community services needed to change to become more patient-centred"

After we joined-up care:

"The new structure is making a significant difference to patients. They are dealing with fewer people and there is a seamless transfer of information between different specialisms"

One of our highlights:

During the last 12 months the Hospital at Home service has saved an estimated 9,688 hospital bed days by avoiding hospital admission and a further 735 bed days by facilitating safe early discharge.

One Hospital at Home patient said: *"Everyone helps each other all the time and this is what I noticed with them (Hospital at Home)... especially when two of them come. They work like a team."*

Wigan is the largest Borough in Greater Manchester, with a population of around 305,000 residents. Ninety per cent of Wigan's electoral wards are classed as being in the most deprived 20 per cent in the country. The health of local people is significantly worse than the UK average and there are high levels of cancer, stroke, obesity and smoking-related diseases.



Ashton, Leigh and Wigan Community Healthcare NHS Trust (ALWCH) employs around 1400 staff, including community nurses, health visitors, dietitians, physiotherapists, occupational therapists and speech and language therapists. It serves the entire population, from newborn babies to elderly people, and is committed to improving local healthcare and helping to prevent instances of poor health.

ALWCH took a good look at its service provision. It recognised that services were provided in a way that suited professionals rather than patients. The process was very fragmented with lots of duplication; patients might see up to 10 separate professions and be asked the same questions again and again. Community services needed to change to become more patient-centred.

Deputy Managing Director of ALWCH, Linda Agnew says: *"There was a level of anxiety amongst the teams and some guarded behaviour, but we overcame this by emphasising that the work they all do is valued but that it could be made better... and that it was up to them to tell us how."*

Consultation sessions were held with staff to discuss the ideas and to ask for their input.

Chair of Staff Side Peter Walker said: *"Along with other Staff Side representatives, I was fully engaged in the consultation process to establish a care group structure within Ashton, Leigh and Wigan which marked a significant move away from traditional profession specific management structures. This was a challenging process which involved a large amount of commitment from both Staff Side and managers to ensure that the final structure was the most appropriate for delivering seamless patient care."*



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 Following these discussions, all of the input was synthesised and it was clear that there would be a great benefit to reorganise services based on care pathways ensuring that the patient's needs and experience were paramount. During this process it became clear that professional boundaries needed to be removed and instead of separate groups of professionals with their own managers, six multi-disciplinary Care Groups were created as follows:

- health and wellbeing
- acute care closer to home
- complex community care
- independent living
- children, young people and families
- long-term conditions.

In some cases, it was obvious where professional groups should fit into the new pathways, while others took more working out. Teams have worked on the fine tuning to ensure that everything works in the optimum way for patients. Each team has its own targets and access to its own budgetary and staffing data, so it is responsible for its own service delivery.

 Linda explains: *"The new pathway structure is making a significant difference to patients. They are dealing with fewer people and there is a seamless transfer of information between different specialisms"*

The whole care pathway is now configured in a more efficient way and referrals to other services can be made much more easily. A good example of this multidisciplinary approach is the Hospital at Home service which is a partnership with the local acute trust and local authority.


It offers community nursing and therapy care in patient's own homes to provide services that would previously only have been available in hospital. The service caters, where appropriate, to the increasing preference for treatment at home with patients spending as little time in hospital as possible.

Local analysis of the service data indicates that during the last 12 months the service has saved an estimated 9,688 hospital bed days by avoiding hospital admission and a further 735 bed days by facilitating safe early discharge.

A research project in conjunction with Salford University also illustrates, from a patient perspective, the benefits of the multidisciplinary approach within this service.



One Hospital at Home patient said: *"Everyone helps each other all the time and this is what I noticed with them (Hospital at Home)... especially when two of them come. They work like a team."*

 Despite initial concerns that they would lose their professional identity, this has not been the case and many staff now prefer the new structure and would not go back to their professional groupings. ALWCH Macmillan Cancer Lead for Nursing and Therapy Services, Julie Atherton, said: *"The re-organisation from professional groupings to care groups has been pivotal in enabling us to provide care with a whole team approach, addressing patient pathways in a cohesive multi-professional way."*

Chief Executive and Medical Director of ALWCH, Dr Kate Fallon, adds: *"This is a better way of managing services and utilising resources. We have been careful to ensure that people have retained their job titles and they remain up-to-date with their professional skills and registrations, so they continue to meet their professional standards. In essence, we took what was best about the professional structure and protected it, while ensuring that our specialists work at optimum levels in a patient and clinical setting."*

ALWCH was one of the community healthcare providers selected by the Department of Health to pilot the concept of Community Foundation Trusts (CFT). On 1 November 2010, as a necessary part of its bid to become a CFT, ALWCH was established by the Department of Health as an NHS Trust - one of a new type of community trusts with a focus on delivering care closer to home. These developments are part of a national Transforming Community Services programme which aims to deliver substantial



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improvements in healthcare services by separating out provider services from the Primary Care Trust (PCT), leaving the PCT as a commissioning-only organisation. The idea behind this is that commissioners can consider a range of providers, including CFTs, with a view to securing the best possible option for patients and local people.

 The decision in Ashton, Leigh and Wigan to aspire to CFT status followed months of consultation with staff, patients, residents and other stakeholders. The organisation held dozens of roadshows and consulted face-to-face with staff to make sure that everyone's views could be heard. Staff were presented with a range of options for the future structure of the organisation and CFT status emerged as the preferred choice. The rationale for this was that being a Foundation Trust would: enable the organisation to reinvest savings in improving services for patients; make it more accountable to the local population; and enable it to be more accessible to patients and respond more quickly to their views.


Peter Walker adds: *"Staff Side was involved from the very outset in looking at developing a CFT model. As NHS employees we were extremely pleased that the senior management's vision was to retain our services within the NHS structure and this full engagement has enabled us to inform our members about benefits of becoming a CFT. We are happy that we appear to be progressing down that route."*

Challenges

One of the main challenges of the change process was in managing the business priorities of all organisations involved and keeping politics separate from what was best for patients. Professional groups were particularly concerned about losing their professional identities and skills. These fears were allayed by developing professional advisory networks so that individuals are able to maintain their professional support and development.

The future: more joined-up care

The integration of services and the drive to become more patient-centred fits perfectly with Ashton, Leigh and Wigan's new role as an NHS Trust and aspiring CFT. Having successfully integrated community healthcare, ALWCH is now turning its attention towards integrating health and social care services. Driven by the same desire to eliminate duplication and improve the experience for patients, health and social care colleagues are working together to scope out options. The trust is also working closely with the third sector to improve services for patients. For example, it has recently trained volunteer staff from Age Concern in caring for the feet of elderly people to enable them to help patients remain more active and independent.

 Linda Agnew stresses the importance of strong leadership and good communication when undertaking an integration process on this scale:

"Leadership is all, and it is a different skill set from management. There have been anxieties both within community services and the hospital. The way we have tackled these anxieties is by talking face-to-face, via a partnership board with representatives from each organisation. Strong leadership is critical. Management is one thing – it's what professionals are good at – but leadership is something else entirely. It is about having key members of the executive team who can articulate the vision so that people feel inspired, and who have the tenacity to keep people's enthusiasm up. We celebrate achievements every step of the way and nurture the leaders of tomorrow, who have the qualities we need to drive the process forward."

Top tips for success:

- Don't be deterred. Integrating community services is all about delivering a service that is fit for the community, culture and patient experiencing it. Keep the politics separate from what's best for patients
- Listen to your patients. Always have them at the centre of your thinking – that's what makes the big difference. Ask yourself *"Would you want this done to you?" "How would you want this to be?"*
- Ask for people's opinions and then show them how these ideas have been taken forward and acted upon.



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Northamptonshire Integrated Care Partnership - Pioneering a New Way Forward



"We are breaking down unhelpful barriers and turned "it's not my business" attitudes into "it's everybody's business".

Charlie MacNally - Corporate Director of Health and Adult Social Services, Northamptonshire County Council

"We found that aligning the services around the patient can sweep away the differences".

Richard Alsop, the Director of Strategy and System Management at NHS Northamptonshire

"This is the most exciting thing that has happened locally for 15 years".

Staff member


Northamptonshire has a population of almost 700,000. The population is similar in characteristic to England as a whole, but with particular areas of deprivation. The county is served by two acute hospitals, Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust.

The Northamptonshire Integrated Care Partnership (NICP) was established to transform the management of long-term conditions in the county. It helps older patients remain independent for longer and offers them more and better choices at the end of life.


It is a revolutionary approach that is unprecedented locally in its size and scope.

The partnership brings together health, social care and third sector partners working towards a single vision. It has led on the development, commissioning and delivery of new end of life services, a new community care of the elderly service and a case management system for people at high risk of emergency admission. The NICP also serves as the Urgent Care Network Board for Northamptonshire.

Prior to the development of the Integrated Care Partnership, health and social care organisations in Northamptonshire worked largely in isolation, with no shared objectives and little collaboration. Patient pathways¹ were disjointed, particularly for people with long-term conditions. Healthcare spend was inefficient and patient outcomes were sometimes poor.


 Working together with NHS Northamptonshire, a range of partner organisations in health and social care began to recognise that working in a more integrated way was essential to improve the care of patients with long-term conditions.

Driven by clinical commissioning, these organisations began introducing small scale changes. However, in 2009, the opportunity arose to become one of the Department of Health's Integrated Care Pilots², offering the chance for change across the health and social care spectrum.

 Northamptonshire Integrated Care Pilot (NICP) is the largest of 16 Integrated Care Pilots across England. The NICP Board is clinically-led and chaired by a GP Chair, and Commissioning. Decisions are made by senior clinicians to ensure the best outcomes for patients. Each organisation used its existing patient networks to gain patient input into the design and delivery of the six priority work streams. The work of NICP is supported by an Urgent Care Delivery Group, whose role is to drive implementation of initiatives developed through the NICP.


¹ The 'patient pathway' is how we refer to the route that a patient takes from their first contact with the NHS (usually their GP), through to the completion of their treatment. Pathways also cover the period from entry into a hospital or a treatment centre, until the patient leaves. You can think of it as a timeline, on which every event relating to treatment can be entered. Events such as consultations, diagnosis, treatment, medication, diet, assessment, teaching and preparing for discharge from the hospital can all be mapped on this timeline.

² The two-year national pilot scheme aims to drive improvements in local health and wellbeing by encouraging health and social care services to work in a more integrated way. The idea is to offer personalised, flexible and high quality services, where the individual is at the centre and is engaged in service organisation. Integration can refer to partnerships, systems and models, as well as organisations, crossing boundaries between primary, community, secondary and social care.

 The aim of NICP is to improve the health and wellbeing of people with long-term conditions by working in a new, more integrated way.

Irrespective of organisational boundaries and vested interests, partners are working to achieve the NICP's shared aims of reducing emergency admissions and readmissions, cutting hospital length of stay and the number of care home placements, and increasing the number of people who can die at home.

These goals have inspired an unprecedented level of commitment and enthusiasm among stakeholders - board meetings are well attended, partner organisations are actively involved and there is a powerful willingness to co-operate.

 Northamptonshire County Council Corporate Director of Health and Adult Social Services, Charlie MacNally comments: *"We are breaking down unhelpful barriers and turned 'it's not my business' attitudes into 'it's everybody's business'".*

Everyone involved with that older person's wellbeing wants them to receive care in the most appropriate setting. An example of how they are commissioning differently is where they are commissioning a local voluntary agency to support vulnerable elderly people in practical ways during their first three days post-discharge.



"Being part of a partnership allows us to move away from an institutional need to prove our performance to being our own regulator. We all look at the whole system and see what needs changing. That can require organisations to make compromises that may disadvantage them but it balances out."

The Board reviewed and synthesised all of the inputs from patients and staff and local groups and developed six priority workstreams based on what was felt to be important to these groups.

1. Pro Active Care (PAC) - is a model of case management that delivers services to those patients at highest risk of admission to hospital. A bespoke care plan is co-produced between clinicians and patients/carers, with interventions that are designed to keep patients safely at home. NICP's Pro Active Care model is the largest case management service of its kind in the country, covering 62 GP practices. The initiative began in primary care,

but it has now become a whole-system approach and PAC patients will soon be tracked across the acute sector as well. Work continues to refine the approach to PAC and to integrate this work fully with core community nursing services. We are beginning to see impressive result. For example there has been a 53 per cent reduction in the number of hospital admissions amongst the patients being cared for in this way.

2. End of Life Care - New services have been commissioned to offer greater choice to people at the end of their life. Currently, more than 50 per cent of patients in Northamptonshire say they want to die at home but only around 20 per cent achieve that. To help change this, a 24-hour a day, seven day a week care co-ordination centre has been set up, along with a rapid response service to support patients and carers in their own homes and a link nurse based in the acute hospitals. The pilot has already saved around 380 bed days as a result of patients' timely discharge to their home.



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3. A new approach to urgent care for frail older people

- offers a comprehensive geriatric assessment and treatment in the community. The service is consultant-led, with multi-disciplinary support. Initial figures suggest that up to 30 per cent of the county's frail elderly people could be cared for in the community using this approach.

4. Improved medicines management

- A comprehensive action plan has been developed to improve the quality of medical information on admission and discharge.

5. Better management of depression

- is being achieved by GP Practices and Community Pharmacists working together to help patients to take their anti-depressants correctly. Evidence showed that only 30 per cent of patients were doing so previously.

6. An application to become a Personal Health Budgets pilot

was approved in October 2009. The Northamptonshire Pilot will provide individuals with a continuing healthcare or mental health need, or those who have health needs after suffering a stroke, with an opportunity to choose the services that best meet their needs according to their personal lifestyle.

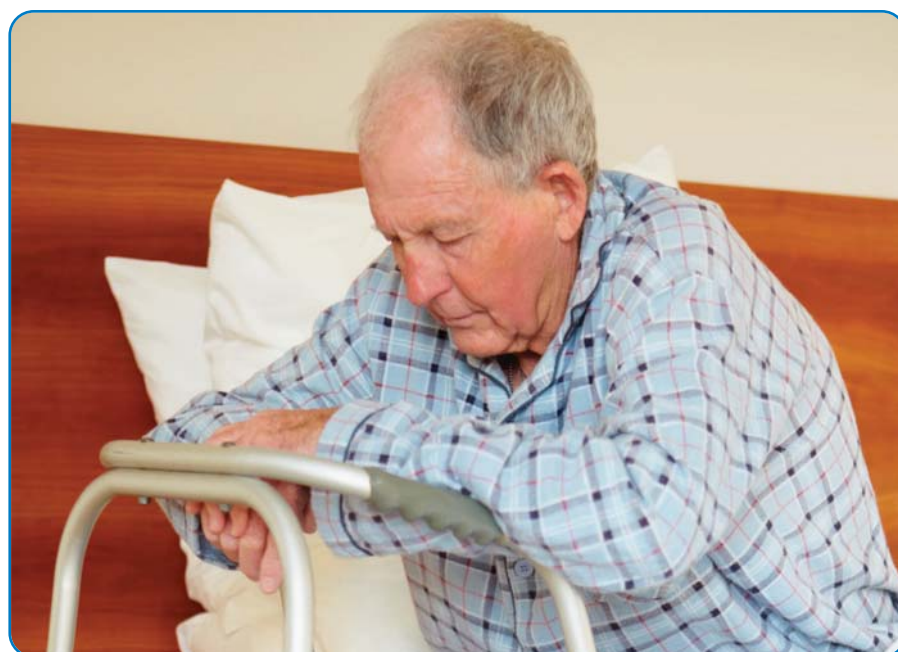


Achieving the widespread cultural change that is needed to become an Integrated Care Partnership has been a challenge. Recognising and addressing these cultural differences was crucial and Richard Alsop, the Director of Strategy and System Management at NHS Northamptonshire acknowledges that there is more work to be done in bringing the different teams together:

"This is an ongoing process, central to the success of the programme and we've only just begun. Changing clinician behaviour is always complex. However, we found that aligning the services around the patient can sweep away the differences. We are making sure we provide step-by-step support to help clinicians to take on and deliver the changes. This proves invaluable."



The Board has developed a long-term workforce strategy, based on providing the right services in the right place and staffing these services appropriately. This means providing more services in the community, with fewer hospital beds. Partner organisations are encouraged to align their own strategies with the partnership's long-term plan, as well as with each other's strategies.



Making sure that there is a lot of face-to-face communication with staff so that they can make suggestions and ask questions is essential, in addition to this we also supplement the communications with written updates throughout the whole change process.



The partnership realised at the outset that having clinicians leading the programme was essential as they are pivotal in delivering care and have the expertise to ensure better outcomes for patients. Teaming these expert clinical leaders with committed senior managers has been the key to driving the process forward.



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 The implementation process began by supporting the identification of local data that would be used to measure the impact of the work to improve services for patients. This focus on baseline and on going measurement was vital to demonstrate to all stakeholders how the partnership was moving towards its objectives.

Baseline data included analysing referral rates and hospital admissions, which will be used to calculate reduced admissions and consequent savings on bed days. As the process develops, patient satisfaction surveys and statistical process control are being used.

The results to date are impressive. Staff are enthused and inspired by the fact that their skills, experience and knowledge of "what will work" is acknowledged and acted upon. One comments:

"This is the most exciting thing that has happened locally for 15 years."

Having the freedom to work with other organisations who share common aims is proving to be a liberating experience. The fact that ideas and new models are developed and implemented rapidly demonstrates how effectively this new approach is working; for example, it took just nine weeks for the business case for the new end of life service to be developed, including engagement with stakeholders and carers.

It is too early for a detailed evaluation of the benefits to patients, but initial process measures are extremely positive:

- The Pro Active Care system has now been rolled out across all 62 GP practices, covering a patient population of 615,000. Over 1,750 patients have been admitted onto the scheme and there has been a 53 per cent reduction in the number of hospital admissions amongst these patients.
- The introduction of a Shared Care Form for PAC patients provides the first personalised care plan shared between patients, GPs, Out of Hours services, hospitals, intermediate care and the ambulance service. This proves invaluable in providing seamless care across organisational barriers.
- During the end of life nurse link pilot scheme, 59 patients were referred. Seventy one per cent of these patients achieved their preference for place of death. The pilot also saved around 380 bed days as a result of patients' timely discharge.



The future

Given the changed economic environment, it is critical that the work of the NICP actually reduces demand for acute services. Therefore, the partnership is now moving into a different phase, with the emphasis very clearly on implementation and effective delivery.

Top tips for success:

- Articulate a clear, agreed vision, allied to mutually beneficial outcomes, and share it amongst all your partners
- Engage all partners and gain commitment from the right people to create a culture that encourages innovative, long-term solutions to old problems
- Strong clinical leadership is essential.



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NHS Oldham -

"Get it right for patients and you get it right for everybody."

"I used to believe that the Dr knows best and that patients with a strong opinion were a bit of a pain. Over the years, I've come to realise that that is far from true. It is patients who need to help redesign pathways, not just clinicians". The days of patients asking "what would you do, doc?" and the GP proffering an opinion are gone. If asked that question, we should be saying "what else can I tell you to help you make a decision?"

Dr Alan Nye


"All patients with long-term conditions will have a personal care plan that encourages self-care and enables them to self-refer"


"I saw a consultant within a surprisingly short time and I have been very impressed by the whole service. You are treated like a human being and not a number."

Brenda Iles (Patient)


Figures for 2008/9 showed that Oldham was in the top 20 per cent for spending on musculoskeletal (MSK) conditions. The average spend per 100,000 population nationally was £7,986k, in Oldham it was £9,394k. NHS Oldham recognised that it needed to redesign services to make savings and improve the clinical pathway.



 In 2010, the Commissioning for Oldham Group (COG) and Pennine Musculoskeletal Partnership (PMSKP), in conjunction with NHS Oldham, took over responsibility for commissioning the entire MSK pathway, covering orthopaedics, rheumatology and chronic pain. These organisations are currently working in "shadow" with the PCT commissioner and will take over the actual MSK budget in April 2011.

 Nine years previously, in 2000, a local GP, Dr. Alan Nye, had begun work on commissioning drug services. In 2002 he and Anne Browne, a nurse consultant in rheumatology, led a project to set up a tier 2 triage service for rheumatology referrals. The plan was to reduce demand on the hospital service and to manage variation in referral thresholds from primary care. The service used an electronic triage of all GP referrals, and on the basis of the referral letter, either saw the patient in the tier 2 clinic or passed the patient directly on to the hospital. The project was successful in reducing GP referrals needing a consultant opinion by 50

per cent. At the same time, it recorded high levels of GP and patient satisfaction.

 An opportunity arose in 2004 for the tier 2 service to take over the running of the rheumatology service from the PCT using a Specialist Personalised Medicine Services (SPMS) contract¹. The primary care trust agreed, but also asked them to include a tier 2 orthopaedics and musculoskeletal pain services. Following 18 months of negotiation, the Pennine MSK Partnership (PMSKP) went live in March 2006. Rather than just being a triage service to filter GP referrals, it became an Integrated Clinical Assessment and Treatment Service (ICATS), handling all patient treatment up to the point of hospital admission and, where possible, replacing traditional hospital outpatients. Consultants in rheumatology, liaison psychiatry and orthopaedics work within the service. There are currently three rheumatologists, two psychiatrists and eight orthopaedic surgeons employed and over 20 extended scope nurses, physiotherapists and podiatrists.

¹ Personal Medical Services (PMS) were first tried in April 1998 and became a permanent option in April 2004. The health care professional/health care body and the Primary Care Trust (PCT) enter a local contract. The main use of this contract is to give GPs the option of being salaried.¹



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 In March 2010, PMSKP put a bid to the PCT to take over the programme budget for MSK services (orthopaedics, rheumatology and chronic pain). This was using a "Prime Vendor Model" developed by local GP and public health consultant, Dr. Steve Laitner. It was backed by the GP practice-based commissioning group - Commissioning for Oldham Group (COG) - and was approved by the PCT board in September 2010. From 1 November, PMSKP started working in shadow with the PCT and GP commissioners. It will take over the commissioning entirely on 1 April 2011. PMSKP will provide the complete non-admitted patient pathway and is working with local acute trusts to provide community-based consultants in specific specialisms. The team's initial aims are to bring overall spending in line with regional averages (representing efficiencies of £2.1m). Further efficiency savings (£3.2m) will bring Oldham in line with national benchmarking and, ultimately, the region aims to be among the most efficient in the country.



  Currently, the team is renegotiating all MSK pathways with partners, including social care, to ensure 18-week compliance and best practice. Rather than concentrating on balancing demand with capacity, there is a new focus on increasing patient choice and encouraging best value clinical decision-making. All patients with long-term conditions will have a personal care plan that encourages self-care and enables them to self-refer. Treatments with low clinical value will be eliminated, reducing waste, and stronger clinical commissioning will ensure that the most appropriate services are provided for the local population.

Dr Alan Nye admits he is a complete convert to the idea of involving patients in redesigning services: *"I used to believe that the Dr knows best and that patients with a strong opinion were a bit of a pain. Over the years, I've come to realise that that is far from true. It is patients who need to help redesign pathways, not just*

clinicians. We are involving patients in every aspect of the service redesign and helping to drive out unwarranted variation in services by empowering patients. This stuff is not fluffy; it is about driving change in the most effective way possible."

Medical director Dr Hugh Sturgess adds, *"We know we have to design the service around the people who use it, without their input and feedback we won't get it right."*

One of the ways that the new service is empowering patients is by taking part in a pilot, led by the Department of Health to develop **Decision Aids**. These electronic aids prompt patients to make informed decisions about their care, based on the pros and cons of each treatment option. The service is working with a proactive patient group and recently was awarded the Customer Service Excellence Award. This has taken over from the charted mark and is award by the Cabinet Office².

² <http://www.cse.cabinetoffice.gov.uk/homeCSE.do>



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Alan points out: *"Patients don't always make the decisions you expect them to make. The key is to give them all of the information and allow them, with the support of the clinician, to reach their own conclusions. The days of patients asking 'what would you do, doc?' and the GP proffering an opinion are gone. If asked that question, we should be saying 'what else can I tell you to help you make a decision?' This is about educating patients but it's also about educating clinicians that the best decisions are shared with patients and clinicians as equal partners."*

Decision Aids will be an important tool to tackle healthcare inequalities, driving up conversion rates where they are too low and driving them down where they are too high. Overall, they are shown to reduce conversion rates by between 20 and 30 per cent.

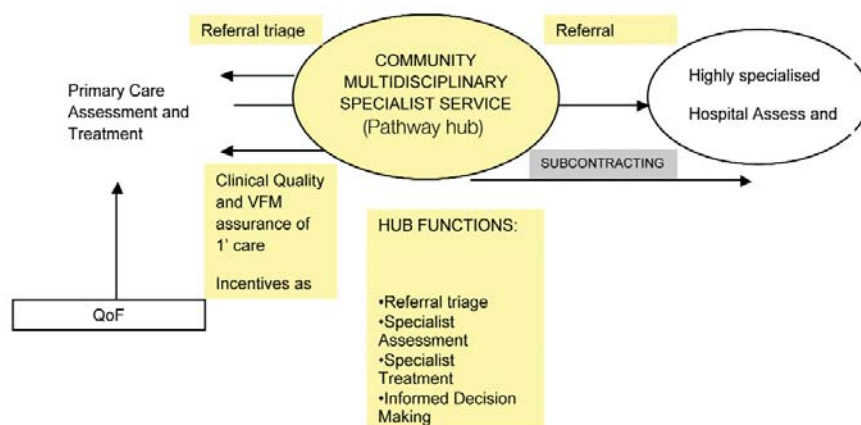
"I needed an operation and was referred here. I thought I was just coming for an assessment and I was surprised to see both the surgeon and anaesthetist."

"They were brilliant. The anaesthetist spent nearly an hour with me explaining what would happen and taking my history."

"It all happened very quickly, I had the operation within weeks and the care I had both before and after was brilliant. It was as if I had been in a private service and paid for treatment. I couldn't have expected more."


Margaret Collins (Patient)


Fig 1: Pathway Hub model




The model is expressed where the yellow levers for demand management are clinically driven, the responsibility of a single organisation and aligned for both clinical and financial accountability.

Dr Steven Laitner, March 2010

 The process of developing a clinically-led pathway service in Oldham has faced major challenges along the way. The acute trust initially regarded the new service as a competitor and relationships broke down in the first year of negotiations, but good leadership has enabled great progress to be made. Alan admits that PMSKP may not have articulated the benefits of the new service as clearly as it could have done to the acute trust and he stresses the importance of having a communications strategy, a compelling story to tell all of your stakeholders, which keeps the benefits to patients at the centre. Each group has different priorities and the message needs to spell out what the specific benefits are for them. Recognising their problems and showing them how you can help is the key. Alan says that it was a mistake to fall out with colleagues in the acute trust, as that just delayed things.

 Alan advises getting clinical champions on board and giving them the freedom to make their own decisions, without micro-managing them. The redesign of the rheumatology pathway was led by a consultant rheumatologist, while a consultant physiotherapist is currently leading on the redesign of back pain services. *"Consultants are the best people to lead the process as they understand the service best and have day-to-day contact with patients,"* explains Alan. *"We agreed a generic way of working using a Project Initiation Document, and then allowed them to develop their own approaches."*

 The process of culture change is a gradual one. Most GPs in Oldham are supportive of the new approach to commissioning but some colleagues resent the idea of no longer being able to refer patients directly to their chosen consultant. Similarly, the majority of consultants recognise the benefits of the new approach but a few resent the idea of working for a GP-led consortia. The key is in developing relationships and keeping the focus on the benefits to patients. This takes time and won't happen overnight.

Alan concludes: *"This model of working will only increase as the concept of programme budgeting becomes more widespread. The driver has to be about making things better for patients. If it's just about the money, you will get it wrong. Most clinicians want to do what's right for patients. If that's not at the heart of your proposal, they won't buy into what you're offering. Get it right for patients and you get it right for everybody."*

The future

PMSK is not the only primary care-led provider service in Oldham. Primary Care Oldham LLP (limited liability partnership) is a partnership of 40 GPs and it recently won a bid to work as a federated partner with the local mental health trust for Transforming Community Services in Oldham. The LLP will provide expert clinical advice on redesigning services. The lesson learned in Oldham will be applied across the North East sector of Manchester. The focus is similar to what is has achieved in the musculoskeletal pathway - it will be helping to move from an acute-based care model to one where care is delivered as near as possible to patients' homes. The team is increasingly working with Local Authority partners to develop pathways of care, recognising the importance of wider integration.

Top tips for success:

- Have a different marketing message for different audiences - patients, GPs and consultants. Recognise their issues and demonstrate how you can help.



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NHS Trafford - Nothing about me without me

Two patients have been recruited to each of the six pathway panels and there is a very active patient focus group with more than 100 members, whose views are regularly sought

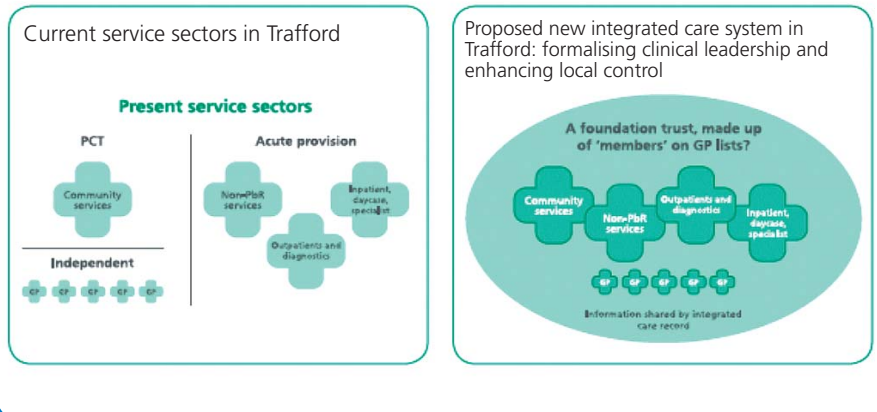
Building strong clinical and managerial relationships is viewed as a critical success factor, "White coats and grey suits sitting alongside each other

It is critical that the staff delivering services are involved in their design

Trafford is a densely populated borough of Greater Manchester. It has a population of around 214,000 people.

NHS services have come together to develop a health system embracing primary, community and secondary care services. Dr George Kissen, Medical Director, Trafford PCT, talked about how a 'burning platform' of unsustainable local services in Trafford, led the local PCT, provider trusts, and general practice colleagues to work together to try and develop a whole system health system based on new models of care (See Figure 1)

Figure 1



The approach is built around the concept of 'office medicine', which means that the focus of care is community-based and focused, offering outpatient specialist services and diagnostics. This is primarily to address the challenge of supporting patients with long-term conditions more effectively. One of the biggest changes will be a shift in the relationship between GPs and hospital-based doctors. The model is being rolled out gradually via nine 'vanguard' practices.

These practices have a remit to:

- develop a population risk management approach
- identify and focus on caring for those people identified as being at high risk of hospital admission
- oversee the implementation of telehealth
- implement new models of care.

The programme aims to:


- tackle health inequalities
- improve the experience of patients and staff
- reduce admissions to hospital
- improve cost-effectiveness.


The integrated care team, headed by Samantha Nicol, is developing a programme management approach that will be used to develop and implement an Integrated Care Services Strategy (ICS).

Central to the philosophy of the ICS is the role of clinical leadership. There have been a number of clinical congress meetings, where clinicians from community services, primary and secondary care have met to explore, develop and design the service model.

- Initially, twenty four disease areas that would benefit from an integrated approach were identified. Six of these have been prioritised as the focus for 2010/11. These are:
 - unscheduled care;
 - end of life care;
 - ENT;
 - mental health;
 - respiratory care;
 - diabetes.


Six clinical panels will lead the change from an outpatient acute-based model to an 'office medicine' approach. It is hoped that they will eventually hold a programme budget to allow them greater flexibility to continue to develop these services.


 Whilst much work has already taken place to remove the boundaries between primary, secondary and tertiary care and move towards closer integration, there has been less clarity about which processes to follow to actually implement the programme: Samantha Nicol points out that *"We are very strong on ideas, now we need to make sure that these are translated into effective and sustained change. We have gone back to basic change management principles so that everyone is clear about their roles and responsibilities, using a programme and project management approach"*.


 One of the key aims is to develop a culture of continuous improvement, and to that end, the organisation has invested in an Advanced Training Programme to give people the skills and competencies that they will need. The aim is that eventually all staff will participate in this programme.

Building strong clinical and managerial relationships is viewed as a critical success factor, "White coats and grey suits sitting alongside each other" and whilst there are many obstacles and challenges, this focus on building positive relationships around improving the patient experience is central to success.


George Brandreth, MD of Trafford provider services believes that it is these relationships that are driving the process forward.

 To lay the foundations of the ICS programme, the PCT is investing £2m for 2010/11. It has agreed a whole health economy approach to delivering cost improvement programmes through closer working between primary, community and acute care.

 NHS Trafford recognises how challenging such large scale change will be for staff, and has developed an Advanced Training Programme to give people the skills they need to manage the changes. To date, a number of directors, senior clinicians and GPs have completed the training programme, which will be rolled out more widely in the coming months.

 Patient involvement is regarded as a critical component of the integration process. Two patients have been recruited to each of the six pathway panels and there is a very active patient focus group with more than 100 members, whose views are regularly sought. A survey is underway of 1,600 patients to provide a baseline measurement of patient experience. This survey will provide quarterly reports so that the impact of any changes can be monitored. There are plans to hold regular patient congresses throughout the change process to enable patients to see what the surveys are saying and offer their views.



 Involving staff is also seen as a priority but there is more work to be done to achieve full staff engagement. It is critical that the staff delivering services are involved in their design. Good communication is essential and a communications plan is being developed, using multiple methodologies to ensure that staff are engaged and have the opportunity to contribute to the new developments.



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 As well as carrying out surveys to find out about the patient experience, other baseline measures have been set, such as length of stay, readmission rates, non-elective admissions and so on. These revealed that, while length of stay is comparatively high, readmission rates are low. Each of the six pathway panels aims to reduce hospital admissions. They are using GP registers to identify key risk factors in certain patient groups and measure particular risk factors against the number and type of hospital admissions. Having identified core risk factors, each team can then come up with a set of aims, articulating what they want to change and how much difference this will make. The next step is to map the processes patients currently go through to identify duplication and waste.

Samantha explains: ***"This is vital groundwork and it takes time. Sometimes staff can underestimate how long it will take, but you need to be thorough or you might miss something crucial. Ultimately, we are aiming for a process of continual improvement to existing pathways, based on the actual experience of patients here in Trafford."***

Successes

The team has already reached many significant milestones. All project managers are now clear about their roles and responsibilities and they have project initiation documents and implementation plans to steer the process. There are training plans in place to help people to develop the skills they need. Clinicians and patients are working well together and each pathway panel has a set of measurable aims and objectives, which will be tested from December onwards. Senior level relationships are also developing and clinicians now have a clearer understanding of each other's positions and priorities. Productive discussions are also underway with the Local Authority which is very supportive of the initiative, and positive about including social care within the ICS at a later stage of development.

Sam concludes: ***"To achieve transformational change, you need to make transactional changes in the right way, involving staff and patients. I am confident that we have now laid the groundwork well and, from here, we can proceed to build a truly integrated care service that benefits everyone in Trafford."***

What we have learned from this process so far:

- You need to have a clear vision and set of values, and to be able to articulate these clearly
- Everyone needs to be clear about their roles and responsibilities and what the governance arrangements are. Executive sponsors need to be held accountable for the delivery of their programme. Senior clinicians need to cascade information down to their staff
- Culture change is a gradual process, it doesn't happen overnight
- You need a performance management framework so you can demonstrate the changes that are taking place. Staff and patients need to be able to see the difference this is making



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North Tees and Hartlepool NHS Foundation Trust - A Steep Learning Curve



"The driver for change has been to improve services for patients, "right care, right place, and right time", but the financial climate is demanding that the financial savings made by reducing the waste in services are realized as quickly as possible. It's important to get the pathways right for patients, if the focus moves away from that the risk is that transformational change will not happen."

Chris Willis, Chief Executive of NHS Stockton on Tees and Hartlepool

"It was very important to fully involve staff every step of the way when we were going through the integration process.

"Our advice to others undertaking vertical integration would be to take your staff with you on the journey, involve them at every stage, listen to them and encourage their good ideas. For community services to join with an acute trust is a huge change for the staff and the impact should not be underestimated."


Linda Watson Clinical Director of Community Services



North Tees and Hartlepool NHS Foundation Trust provides healthcare to 400,000 people in Easington, Stockton, Hartlepool and Sedgefield. It has two major hospital sites in Stockton and Hartlepool and has been hosting community services since 2008, with 38 separate community sites. Around 5,500 staff are employed by the trust, including 1200 in the Community Services Directorate.

North Tees and Hartlepool became a Foundation Trust in December 2007 and in November 2008, the PCT transferred community services to the FT, so the PCT could concentrate on becoming a world-class commissioning organisation.

The vision

 The Foundation Trust has a five year strategy, with one of its strategic objectives - to provide more care closer to home outside the hospital setting. This is in line with the Transforming Community Services agenda and the Trusts Momentum Strategy - Pathways to Healthcare. A new hospital is due for completion by 2015, which will reduce the number of available beds. This makes it imperative that there is a focus on prevention of ill health, avoiding emergency admissions and promoting early discharge.

Integrated care

Hartlepool's first integrated care centre became a reality in May 2010 with the opening of the £20m **One Life** facility. One Life houses a pharmacy, respiratory unit for chronic chest problems, three GP practices, an assessment area for musculoskeletal conditions,



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a podiatric surgery unit, dedicated dental suites and an audiology clinic. Later this year, a new wing will be launched containing a day surgery unit and the facilities to house a minor injuries unit. One Life is part of the Momentum Pathway to Healthcare project, which is a series of projects to redesign services and move more care from hospital into the community, or even into people's homes, along with two further integrated care centre's in Stockton and Billingham and the new hospital, which plans to be open in Wynyard.

Chief Executive of NHS Stockton on Tees and Hartlepool, Chris Willis comments: *"Already, the vast majority of healthcare is provided in or close to people's homes, but we will see this increase to meet the needs of our population. We are living longer, but with more complex needs. The health service we are building will respond to these needs and will result in a much more accessible and responsive service for everyone."*

"The driver for change has been to improve services for patients, "right care, right place, and right time", but the financial climate is demanding that the financial savings made by reducing the waste in services are realized as quickly as possible. It's important to get the pathways right for patients, if the focus moves away from that the risk is that transformational change will not happen."

Culture

 Integration brought about a 'step change' in both the culture and processes of teams in North Tees and Hartlepool. However, this degree of change does not happen overnight, it took six months to start to see how integration could make a difference, and much longer to begin actually realising the benefits.


Involving staff

 Linda Watson Clinical Director of Community Services says:

"It was very important to fully involve staff every step of the way when we were going through the integration process. We held regular workshops and used intensive written information. The CEO and senior executives regularly shadowed staff, to ensure they really understood the services. Staff were also fully involved in redesigning the pathways – that's where the really good ideas came from. Staff forums allowed staff to share their innovations, and the message about developing the best possible services for patients was reiterated in lots of ways."

"Our advice to others undertaking vertical integration would be to take your staff with you on the journey, involve them at every stage, listen to them and encourage their good ideas. For community services to join with an acute trust is a huge change for the staff and the impact should not be underestimated."

Baseline measurement

 The Foundation Trust admits that the integration process has been a steep learning curve and such was the enthusiasm to implement changes that insufficient time was dedicated to establishing baseline measurements at the outset.

Nicholas McDonaugh Assistant Director Community Services says: *"In retrospect, it would have been better to establish meaningful systems of measurement that measure outcomes rather than just contacts. I would advise any organisation undertaking a similar process to bring providers and commissioners together at the beginning to establish baseline measurements and agree what the outcomes measures should be. Too much focus on financial savings shifts the focus away from getting pathways right for patients towards transactional issues alone. You need to allow time for the real benefits of service improvements to be felt."*



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Patient-centered pathways

 Taking services forward under TCS means that community and acute services were already vertically integrated in North Tees and Hartlepool, making it easier to communicate the vision across the organisation and helping to facilitate the development of patient-centered pathways.

Nicholas explains: *"The fact that we are a provider-only organisation is a big advantage. It means we can place more emphasis, at a strategic level, on patient safety, effectiveness and experience of care."* There are now 53 separate pathways and many, such as Musculoskeletal services, employ staff in flexible roles that cut across organisational boundaries. This is backed by supportive training to develop modern, transferable skills.




Strong, visible leadership

 Highly visible leadership was vital to the process of integration, with a clear and sustained vision championed from the top of the organisation. For the CEO and senior team, getting out with staff to understand the services and issues was a priority. Strong relationships at a senior level have been forged with partner organisations, particularly with practice based commissioners and the local authority. These are key to the future development of joined-up care.

Lessons learned

Initially, there was a lot of fear that community services would simply be subsumed into the acute hospital directorates and staff were wary of integrating with one another. However a new Community Services Directorate was formed within the FT, regular meetings and workshops, as well as newsletters and updates helped to allay fears and keep staff informed about what was going on. All staff were transferred using the Transfer of Undertakings and Protection of Employment (TUPE) process, which protects individual employment rights.

Improvement methodologies

 The team has used a range of improvement methodologies, including those within the NHS Institute programmes of the Productive Community Services, Productive Ward and Lean Rapid Process Improvement Workshops (RPIW) in podiatry and dentistry. It recently introduced the Productive Prisons programme for its 2 Offender

Healthcare establishments services. Because the productive methodology is understood by both acute and community teams, they already speak a common language and have developed improvement skills which they are using to implement the new pathways of care.

Positive impact... for patients

 Despite facing many challenges, the integration of community services in North Tees and Hartlepool is having a hugely positive impact for patients. There is now a seamless transition between different specialisms along the care pathway, with patients getting the care they need when and where they need it. There are some great examples of services using telemedicine to monitor and support patients. For example; telehealth is used to keep a daily check on the condition of a 75-year old woman who suffers from a respiratory condition.



She comments: *"Every morning, from the comfort of my own home, I use the machine to check my oxygen levels, blood pressure, pulse and temperature. Before I started using telehealth, I was regularly admitted to hospital, but this hasn't happened since I started using it."*



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Another service user praises rapid response care, saying: *"Each one of the team is friendly, professional and very caring. They have been able to administer the required medication on signs of infection. This has prevented the need to have my mother-in-law taken into hospital."*

...and for staff

 Staff, too, recognise the benefits that the integration process has brought. A member of the podiatry service says: *"Staff have been supported to do the training necessary to carry out their role. This has led to an improved patient journey, referrals to other practitioners have been minimised and patient satisfaction has increased."*

Almost half of community staff have either been introduced to, trained in or have become certified leaders in lean techniques. To date, five Rapid Process Improvement Workshops have been completed and two more are planned.

Top tips for success:

- Improving the experience of patients is what will drive the change and inspire staff. Transactional improvements should be secondary to that aspiration
- Take staff with you on the journey - involve them at every stage, listen to them and encourage their good ideas
- Good leadership at every level of the organisation needs to happen continuously, not just as you are going through the change process
- This is about understanding how services operate, what their individual contribution is and how they all hang together
- Don't underestimate the impact on staff. Joining an acute trust is a huge change - new organisation, new employer, new processes, new culture.
- Don't expect too much too soon, it takes time for integration to start to deliver results and for people and processes to settle down.



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Coventry City Council, NHS Coventry, University Hospitals Coventry and Warwickshire NHS Trust

A project run by older people for older people: An example of working with patients and carers to understand their experience of services

Around 45,800 people living in Coventry are over the age of 65, accounting for around 15% of the city's population. In 2008, prompted by the opening of the new University Hospital Coventry and a powerful desire to improve the experience of patients, Coventry City Council's Health and Overview Scrutiny Committee commissioned a study into the experience of older people being discharged from hospital. Extensive public consultation confirmed that this was a subject that local people felt strongly about and anecdotal evidence suggested that hospital discharge was not always a positive experience for patients

The committee was keen to discover what was good, what was bad and what could be done to improve the experience of older people. It asked Coventry Teaching PCT to carry out the survey, in collaboration with the City Council's Community Services Directorate and the University Hospitals Coventry and Warwickshire.

Esther Peapell, Head of Patient and Public Involvement at the PCT was the project lead. She explains: *"In 2005, the PCT successfully used service users as researchers for an intermediate care project. Feedback from this project suggested that patients felt more comfortable talking to peer researchers than to health professionals and were more likely to engage in honest dialogue without fear of*



repercussions, however misplaced these fears. The older people who worked with us on the previous project were keen to be involved again and we approached them to assist us with interviewing older people. This was a review of patient and carer experience, rather than a survey or clinical care or quality, so it was really important that we got open and honest feedback."

The survey had two distinct stages. The first was to interview older people who were waiting to be discharged from hospital and stage two was to interview patients six weeks after discharge. Families and carers were also interviewed. It was important to ask the right questions in the right way, avoiding any jargon, so consequently older people's groups and partnerships were asked for their input. Three separate questionnaires were devised: one for patients pre-discharge;

one for patients post-discharge and one for families and carers.

16 older people between the ages of 55 and 78 were recruited as user researchers via the city's various older people's boards and consultation forums. They received extensive training in interview techniques and recording information, and they were fully briefed on issues such as infection control and health and safety. Esther acted as project co-ordinator and was on hand throughout the interview process to debrief interviewers and deal with any issues that arose. For example, there was one instance where a diabetic patient had not been given a diabetic menu and another where a female patient was concerned as the hospital had been unable to contact her family. In both cases, the interview team took immediate action to remedy the situation.



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The project received funding of £10,000 most of which was used to fund a part-time administrator whose role was to co-ordinate the interviews and arrange for back-up in the event of queries relating to the interviews. To ensure synergy and empathy with the project, the administrator recruited was also an older person. In total, more than 150 older people were involved in devising the questionnaires and conducting the research. There were 132 patient interviews across six wards and patients' homes.

The research findings were revealing. There was a widespread belief amongst older people that their GP, or another health professional, would contact them after their discharge from hospital. This belief led to a feeling that they couldn't take proactive steps to address any problems that arose and, on occasions, this resulted in their readmission to hospital.

There were also some discrepancies between what patients thought and what their carers thought. For example, 100 per cent of carers praised the hospital food, compared to only 70 per cent of patients - clearly, while it looked good, it didn't necessarily taste good. Overall there was a high degree of praise for the dignity and respect with which older people were treated. 75 per cent of responses were positive.

The raw data was sent to the City Council analysts and correlated with Healthcare Commission patient and carer statistics. 40 separate recommendations had been identified by the research team.



Using the Grounded Theory Method, Esther helped them to pinpoint three core improvements identified as significant by patients and carers, with a range of additional issues which will be valuable as services are developed:

- There was a need to improve communication and information for patients and carers about care packages and post-discharge support
- Staff needed to develop a better understanding of how services are experienced by older people
- Discharge planning needs to be improved.

Project staff and user researchers jointly presented the research findings to the Overview and Scrutiny Committee. The findings were also sent to the PCT Board, the Local Authority, the Hospital Board, the Ambulance Board and to local GPs.

These organisations worked together to develop a joint action plan to address the issues. They formed a

steering group with the aim of giving older people a more holistic, joined-up service.

The timing of the project was crucial to its success, in that a new hospital had just opened and people wanted to understand what patients and carers thought from the outset.

There was a shared approach and collaborative working across organisations and, throughout the process, the working group was performance managed by older people's representatives.

To date, improvements have been made to the information provided to patients and to implementing infection control. A survey has just been completed, the results of which will be compared against baseline data to measure the effect of improvement measures on the patient experience. Interim surveys have also been conducted to test that recommendations were being implemented correctly.



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Esther comments: *"It would have been very easy to do this badly. We took a long time over the planning - almost a year - and made sure that our user researchers were thoroughly prepared. We ensured that all of the different stakeholders were involved in the steering group to get them accustomed to working together from the outset."*

In 2008, the project was recognised by the National Scrutiny Awards, winning the best Health Scrutiny Award. Judges praised the innovative way that older people were recruited and trained as researchers and also the clear, practical recommendations that resulted from the survey.

It was described as an effective model for scrutiny that could be easily replicated and the multi-agency action plan was also singled out for praise. Judges said: *"The scrutiny review demonstrated excellent partnership-working in practice and shows what can be achieved through a collaborative, but challenging, approach to scrutiny. In particular, it illustrates perfectly the immense value that can be added through the direct and active involvement of users."*

Following the success of the 2008 project, discussions are underway with Coventry and Warwickshire Partnership to support a similar review of mental health services.



A review of the experience of individuals with physical and sensory impairments is underway, using the same methodology, and there are plans to use peer research to assess the experience of black and minority ethnic communities.

Esther concludes: *"This model works exceptionally well, providing that the planning is robust and researchers are given a high level of support. By involving different organisations in the planning and development of the project, you encourage partnership working, which is essential when it comes to implementing recommendations."*




Top tips for success:

- Plan, plan and plan again
- Test the questions by doing a small number of interviews and reviewing the results
- Don't underestimate the amount of work involved in a project of this sort
- Make sure you provide plenty of support to your researchers. The project co-ordinator should be on hand to debrief researchers and provide an immediate response to any urgent issues that are identified
- The part-time administrator was an invaluable resource and it helped that she was also an older person as she had empathy for the project aims
- Training your researchers in interview technique and working in a hospital environment will give them the confidence they need.
- Ask questions in a way that older people will understand. Use appropriate language.



Joined up care: Step by step in Northern Ireland


"The hardest thing about being sick is being sick... you leave it until the last minute before you ask for help and by then it is too late... it's the hospital for you !... now my nurse gets me to call her when I start feeling sick and she comes, gets me sorted with tablets or the doctor and so far I haven't been back into hospital..." (male aged 68)

 In 2005 The Northern Health and Social care Trust (NHSCT) started on a journey to modernise their community services to better meet the complex health needs of an increasingly frail and elderly population. The aim was to join up the whole system so that it worked well for patients and carers, was cost effective and efficient.

Although this was a Health and social care organisation, the services provided were far from being joined up, as Marina Lupari, who has led this initiative, describes:

"Although healthcare and social care workers at NHSCT were employed by the same organisation, the care they provided was fragmented, with lots of duplication. Nurses were aligned to GP practices, whilst social workers were geographically aligned."

"On the surface, the organisation appeared integrated. In reality, it was far from joined-up and virtually every patient with multiple chronic conditions would end up in secondary care."

 The Trust has taken a step wise approach to Joined-up care, starting in just one area and building on the initial success achieved.



Step One: Redesigning Nursing Services

The first step was to improve the efficiency and effectiveness of the District nursing team, who were not, at this time, providing services that, met the needs of patients with long term conditions. There was poor skill mix - too many highly skilled staff with underutilised skills and too few lower grade staff to undertake more basic care - an inefficient and expensive model of care.

NHSCT began by creating two new roles that would replace the existing 34 Grade G District Nursing Sisters.

Depending on individual experience, skill and preference, District Nurses were given the option of taking up one of two roles:

Continuing Care Nurse (based on the Wagner chronic care model of effective management of long term conditions) or

Primary Care Nurse Team Leader, managing a district nursing team with appropriate skill mix roles.

Alongside redesigning the roles of existing staff, NHSCT recruited nursing auxiliaries to undertake some of the work previously done by District Nurses and achieved a skill mix of 70% registered nurse: 30% unregistered nurse workforce.

Out-of-Hours-changing the focus to prevention

The Rapid Response Nursing Team, which provided out-of-hours care, required a change in focus to work more proactively with patients with long term conditions. An example of the change in practice that occurred was that, rapid response nurses wouldn't previously have weighed heart failure patients at the weekend as part of their acute care remit as they felt that this was not *"an acute patient need"*. By educating them about the role of preventative care, the Trust has brought about a shift in understanding and behaviour that contributes to avoiding unnecessary admissions to hospital.



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Nursing and pharmacists partnership
Independent nurse prescribers, began working with local community pharmacists who were skilled at medicines management. This allowed a rapid transfer of skill and increased confidence for the nurses, an important component in preventing unnecessary hospital admissions.

An unexpected outcome of this partnership was that nurses discovered that pharmacists were not aware of Health & Safety issues related to nebulizers that they hired out to COPD patients. As a result, some patients were contracting infections and being hospitalized. Rigorous Infection control measures were quickly introduced by the pharmacists and this issue was resolved.

Nursing home partnership

It was recognised that a high proportion of hospital admissions for patients with long term conditions were coming from nursing homes. A closer partnership has been developed between the Trusts nursing services and nursing homes, including providing training on management of patients with long term conditions for nursing home staff by Trust staff, and improved communications and support.



Telling Patients' Stories – continuous improvement

Every fortnight, nurses meet to share case histories. This helps to promote critical thinking, identify the causes of unnecessary hospitalisation and promotes continuous learning and improvement of services.

For example:

A Heart failure patient was repeatedly hospitalised at the weekend. It transpired that she went shopping with her daughter every Friday and stopped taking her diuretic on a Thursday so she wouldn't have to keep going to the toilet, resulting in an exacerbation of her condition.

Discussion with the patient enabled her to better manage the situation, and she has not been admitted to hospital since.



Step Two: Integrating Health and Social Care Teams

The process of developing an integrated nursing and social care model began in 2006 by mapping the patient journey.

Groups of staff were brought together and asked to map out a patient journey, revealing many misconceptions about services amongst staff.

Most patients were not receive any interventions outside secondary care, there were no key professionals involved in managing their care, secondary and primary care seldom communicated; altogether care was definitely not joined-up.



Changes were introduced gradually, with staff and patients

involved at every step. PDSA (Plan, do, study, act) cycles were used to good effect, allowing small scale change to rapidly move to widespread adoption.

Staff became very motivated to improve things for patients and the role of the Key worker was developed.

Integrated care pathways were devised for each of the most common conditions (COPD, heart failure, diabetes etc). The many patients with co-morbidities are given personalised care plans, which encompassed the relevant parts of each generic pathway.

The Trust's aim is to prevent one in four re-hospitalisations by predicting the patients' risk of rehospitalisation and managing them appropriately.

Step 3: Towards Full Integration

In 2010 the NHCST embarked on the developed of Integrated community teams of Social Workers, Nurses and Occupational Therapists (OT's), each led by an Integrated care manager from one of these professions. The Trust is currently aligning its social workers and OTs to GPs, aligning them with nursing team.

Ultimately, teams will be co-located and work closely together with the same practice population. It is a truly integrated way of working that is a world away from the original superficially joined-up model.

Success factors

"I never had anyone to help the way the new nurse does... I think I must have been invisible to people before then... the nurse asks how are you doing... is there anything I can do to help... imagine that!"
(Carer)



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 Before and throughout the changes, discussions with patients about service improvement have been pivotal to design and implementation.

 There has been widespread consultation with the staff and unions to facilitate the changes in roles.

Staff have helped to develop the vision and implement the changes.

 Training has been very important to the success of this programme. Development programmes have been designed with staff to ensure that they were competent to undertake their new roles.

Challenges

Trust Staff have been anxious, and at times, resistant to change, with 'professional territorialism' evident at every level. This is driven by fear of loss of professional skills, and identity.

Stakeholders, GP's in particular, have challenged the changes, particularly changes to the District Nursing services.


Marina describes how having an effective communications strategy is vital, involving key stakeholders in the change process, talking to people: communicating the vision and potential of the new services, and listening to individual concerns.

The change has required a change in culture and the attitudes and behaviours that underpin and drive attitudes and behaviour. That change is now becoming evident.



Evaluation


A prospective non-randomized controlled trial involving a control-intervention design was undertaken to investigate the effectiveness and cost-effectiveness of the chronic illness case management approach, for high risk older people with multiple co-morbidities, within a community healthcare setting.

 Nurses were asked to collect data on 590 patients over a 12 month period.

This trial reports findings indicate a reduction in both the number of hospitalisations and the length of bed-day utilisation for the intervention group which was not apparent within the control group.

This evaluation revealed a 59% reduction in total bed days, compared to what would normally be expected (33%). The reduction in lengths of stay was accompanied by a reduction in mean number of hospitalisations for the intervention group across all time-points in comparison to the mean number of hospitalisations for the control group which increases over time.

This amounts to a 26% reduction in total bed days

 Patient related outcomes measures of Health-related quality of life and functionality also demonstrated significant improvements across time for participants receiving the CICM service. In relation to patient related outcomes participants of the intervention group report a significant improvement in their perception of their health status, their overall health related quality of life and level of functionality over the period of the CICM intervention.



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In economic terms it was found that for the group of patients who received the CICM interventions, there was a £400,000 reduction in costs over nine months.

The majority of the savings originated in the reductions of hospital bed days, primary care services, A&E attendances, ambulance costs and medications.

The economic evaluation concluded that as the CICM service is associated with decreased costs and improved health outcomes it is considered cost-effective.

The findings provide supportive evidence for the use of a measure of subjective burden that is based on caregivers' own assessment of their needs. This service did not increase the burden of care experienced by the caregiver.

This research confirms the political rhetoric that if you provide care to the right patient, at the right time, using the right intervention, provided by the right professional you will achieve effective and cost-effective outcomes.

 *"Effectiveness can be of value if it reduces costs incurred by the organisation but it is only of significance if there is a real improvement from a patient perspective"* Marina explains.

By measuring factors like pain control, anxiety and the ability to self-care, the Trust could see that not only were these improvements having an impact on cost and efficiencies, but critically, there were making a real and

sustained difference to the quality of patients' lives and their ability to stay out of hospital and remain independent.

"When I first got sick the GP and the hospital doctor looked after me... now I have the nurse and she told me to call her when I get sick and that is what I do... I haven't been to hospital since..she will maybe call with me twice a day when I am sick and then phone me as well... she got me a couple of days at the daycentre and I met some nice people there... she also organised my tablets so I know when to take them and what my tablets are for" (Male patient age 69)





The future

The future aspiration is to continue to strengthen Joined-up work, by involving other professionals, Secondary care and Independent providers.

A reflection by the Mrs Hazel Baird (NHSCT Director of Nursing, Dental and Governance): *"This initiative involved a major transformation in how we delivered not only our nursing service but all the health and care services that were required by this group of patients"*

 Marina concludes, *"We now have a joined-up care relationship between professionals and patients. Previously we had a model of care where patients were being told what to do by professional staff. Now, it is the patients who tell us what to do. We have moved away from a paternalistic way of caring to a patient-driven model"*

Top tips for success:

- Leadership is critical to make this happen. Marina states, *"We had two brilliant champions, the previous CEO & the Director of Nursing, Dental & Governance, who provided inspiration, had belief in the process when we met challenges and the drive to make it a reality"* 
- Develop critical thinking skills in nurses. They need to be able to identify people with the potential to become sick, educate them to recognise the early signs of illness and work through periods of sickness with them. 
- Give control back to the patient - allow them to tell you what care they need and when. 
- We began by joining up nursing, then other professionals in the organisation and next we looked at independent providers (care homes, community pharmacists etc.). This step by step approach is the only way to get a truly integrated service - you can't make such big changes all at once. 



patient
centred



patient
involvement



staff
involvement



strong
leadership



creating the
vision



changing
the culture



measurement



clinical
engagement



making it
happen