



Leading local partnerships

How CCGs are driving integration for their patients and local populations

NHS Clinical
Commissioners

The independent collective voice
of clinical commissioning groups

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Foreword

As co-chairs of NHS Clinical Commissioners, it is our pleasure to introduce a report highlighting how our colleagues are driving integrated care for their patients.

We use the word 'colleagues' in a broad sense. It refers to our fellow GPs who work every day to help meet the needs of their patients. Like us, they are seeing increasing numbers of patients with complex needs, perhaps due to long-term conditions or to advancing age and increasing frailty. And, like us, they know that these people need the support of multiple healthcare professionals and organisations.

We also use the word to describe our fellow clinical commissioners, who are taking the experience they have every day in the surgery and using it to improve local services.

As GPs, we know that we and our patients are sometimes hindered by a fragmented system. We know that while we can treat the chronic obstructive pulmonary disease that has affected an individual for years, there has traditionally been little we could easily do about the damp patch at home that was exacerbating the problem.

As clinical commissioners, we know that we are leading changes to reduce that fragmentation and ensure patients get all the support they need. This report is proof. It showcases 20 examples of CCGs joining with partners not just from social care, but from the voluntary and private sectors, to improve the health of their populations.

None of us want to see barriers between organisations or sectors when it comes to healthcare. We all want to be confident that, should we fall unwell, all our needs will be taken care of in a coordinated, efficient, professional way.

We are delighted to introduce a report that celebrates the CCGs and colleagues already making this important vision a reality. We look forward to seeing even more innovative and integrated new models of care develop, and working with our wider partners such as local authorities, Public Health England and secondary care to continue to improve outcomes for our patients and the public.



Dr Amanda Doyle OBE

GP and Chief Clinical Officer, NHS Blackpool Clinical Commissioning Group
Co-chair of NHS Clinical Commissioners



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Introduction from NHS Clinical Commissioners

We are now 18 months on from the formal establishment of clinical commissioning groups (CCGs). The change was a significant one. For the first time, it placed the leadership of planning and purchasing care in the hands of clinicians rather than managers. The concept was of organisations centred on the needs of people, patients and the communities in which they live.

This report reveals the extent to which that concept has now become reality.

Through a series of case studies – drawing on the work of CCGs across the country – a picture emerges of organisations committed to developing a more coordinated system. It is a system focused on wellbeing as well as illness, and one that places a premium on the needs and preferences of patients and carers. And while it may not be the sole solution to the NHS's cost savings challenge, it is an important contributor.

There was no end to the stories we could have told about the work CCGs are doing, but we have chosen integration as our focus. The most obvious reason for that choice is that it is commonly acknowledged that healthcare must become more integrated – both within itself and with other sectors.

But there was another reason for the choice of topic: it is one that clearly demonstrates the value of having clinicians leading the commissioning of our healthcare services.

In Cornwall, for instance, a highly successful project to bring together the health and voluntary sectors was the brainchild of a community matron. She was visiting an older person with limited mobility, and realised she was about to confine that individual to a one-room existence – commode, bed and sofa all in the same room. There must, she said, be a better way. She and her colleagues found it: working with the voluntary sector to ask what people really want, and finding a way to provide it. People across the area are now living happier, healthier lives as a result.

Many of those who spoke to us for the report – and we thank them all for their contributions – explained how clinical leadership is leading to faster change. On the Isle of Wight, the need to integrate had been talked about for years. But it was only once CCGs were established that the discussions became reality. Now there is an ever-increasing number of integrated projects across the island.

More will follow. The same will be true for the other CCGs covered in this report – and for the many more that exist but which we weren't able to cover. There is more work to do. This is a developing system, and change takes time in healthcare.

But there is great potential, not least as CCGs take an increasing role in primary care commissioning. And it is clear that progress is being made. Clinical commissioning is quickly maturing, and it is benefiting patients and people each and every day.

Summary

In January we published a report entitled *Taking the lead*. It demonstrated the successes CCGs were already having in improving the health and wellbeing of their local populations.

This publication follows on from that one, and shows how the system of clinical commissioning has further matured and developed. It shows that, a year and a half after their establishment, CCGs are starting to drive complex change. They are leading a coming together of healthcare professionals of all disciplines including social care, and of voluntary organisations. The outcome is that the needs and desires of patients are being placed at the very centre of the system.

The ten case studies that follow showcase organisations that are driving integration and, through it, higher quality care. They show how CCGs:

Are caring for people closer to home

- In Barking and Dagenham, Havering, and Redbridge, community teams are supporting people at home when they fall ill. It means that fewer people have to be admitted to hospital
- In Greenwich, care navigators are supporting those with complex conditions. The navigators can help direct people to services that will keep them well without the need for a visit to the doctor or to hospital

Are ensuring people get the right support at the right time

- In Hammersmith and Fulham, mental health support is being made more readily available in acute healthcare settings
- In Warrington, staff from the local home improvement agency are visiting people at home, accompanied by a pharmacist. Through this, potential problems with an individual's living environment can be identified early – and resolved before they affect health
- In Bexley, an integrated discharge team makes sure people have the support they need when they come home from hospital

Are caring more effectively for frail older people

- In Cornwall, the CCG is working with Age UK to help vulnerable people meet their goals: whether it's walking their dog on the beach, going shopping, or setting up a coffee morning
- On the Isle of Wight, an Alzheimer's Café run with the voluntary and private sectors is providing an informal setting in which carers and those with dementia can get together and support one another

Are making care more efficient

- In Bristol, North Somerset and South Gloucestershire, the Connecting Care programme means that professionals across health and social care will all have access to the same information about a patient. It means that patients don't have to tell their story several times over to several different people

Are helping people to protect and take control of their own health

- In Gloucestershire, a weight management referral programme enables those who are struggling to control their weight to attend a private sector slimming club free of charge
- In Fylde and Wyre, breast and colorectal cancer patients can take part in an exercise programme at the local YMCA.

NHSCC believes that if national policy continues to support CCGs and the concept of clinically-led commissioning, these successes will continue – and increase in number.

Care closer to home

Barking and Dagenham, Havering, and Redbridge CCGs

When Rose McMurray experienced severe difficulties with her breathing, the options for receiving care seemed limited. The 80-year-old was familiar with trips to the local accident and emergency department or polyclinic and, as the Romford resident says: “You’re taking a long while to get there, aren’t you?”

Earlier this year, however, a new integrated service meant she was able to quickly receive care within her home. “My husband rang the number for the community treatment team, and the nurses came down within half an hour,” Mrs McMurray explains.

The team quickly diagnosed congestion in Mrs McMurray’s left lung. A doctor was contacted, an antibiotic prescribed, and within a few days she was feeling better – without the need for a visit to either hospital or a clinic.

The community treatment team is a fully integrated one – it includes social care as well as healthcare professionals – and acts as a single point of contact for patients within Barking and Dagenham, Havering or Redbridge.

It forms part of a new approach to intermediate care that has been trialled across three CCGs in east London. The local integrated care coalition – which brings together senior leaders from the acute trust, community provider North East London NHS Foundation Trust (NELFT), the three CCGs, three local authorities, and other key players – decided last year that intermediate care needed to be a priority area for change.

“Our review of services identified that we had too many people being admitted to hospital for entirely preventable causes,” explains Dr Gurdev Saini, chair of the intermediate care steering group for Barking and Dagenham, Havering, and Redbridge CCGs. “And because we had convoluted and fragmented pathways of care, there was an over-reliance on bed-based services. We had more rehabilitation beds than other similar parts of the country, and high occupancy and long lengths of stay as well.”

This analysis was backed up by the views of patients and carers. “We did a lot of engagement work, and it became clear we needed to look at how we could further develop our community-based infrastructure to focus on supporting people at home. People were telling us they wanted to be cared for at home if possible.”

Last November, the community treatment team was launched, along with the intensive rehabilitation service. Both care for individuals who do not need the level of support provided by an admission to a bed, but who do need support to enable them to stay at home.

The results of the new services, which are provided by NELFT, are highly encouraging. Some 90 per cent of patients seen by the community treatment team do not go on to be admitted, and the same percentage of those under the care of the intensive rehabilitation service are able to recover at home rather than through a hospital stay. More people are now being cared for – 7,000 since the start of the trial versus 1,300 under the old model – and recovery times have improved substantially.

The success is testament in part to the strength of an integrated approach, suggests Dr Saini. “The new services are CCG commissioned, but this hasn’t just been the CCGs operating in isolation. There has been a really strong co-development approach with the trust, local authorities and so on as we have trialled the services.”

Dr Saini also suggests that clinical engagement has been central to the positive outcomes. “The GP engagement with these projects has been absolutely critical,” he says. “The fact that we now have clinical commissioning means clinicians have been involved in this work right from the very beginning.”

Better end-of-life care

South Norfolk CCG

When staff at South Norfolk CCG realised that there was no formal strategy for end-of-life care in their area, they decided to take an integrated approach to developing one. Staff from primary and secondary care, community services, social services, the voluntary sector, Healthwatch and many other organisations came along to an event to discuss the new strategy, and were joined by patients of all ages. The idea is to ensure end-of-care services are based on what local people and healthcare professionals say is wanted and needed.



“The rationale for this work is entirely clinical. As a GP and for my patients, I think that’s very, very important.”

Dr Gurdev Saini, chair of the intermediate care steering group for Barking and Dagenham, Havering, and Redbridge CCGs

A united approach

Bexley CCG

Integration has been a priority for Bexley CCG right from the organisation's inception. While preparing for formal establishment in April 2013, the CCG joined with the local council to form an integrated commissioning unit. The aim? To promote a joint approach to caring for the health of the local population. An integrated care collaborative, meanwhile, has brought together senior figures from the borough, the CCG, local provider trusts and the voluntary sector.

The result is that, just 18 months since it was established, the CCG is providing a range of well-integrated services that benefit its local population. GPs are leading new multi-disciplinary teams (MDTs) – which include social workers – to identify and plan for patients with complex needs. There are rapid response teams that help keep patients out of hospital by caring for them at home during a health crisis. An integrated discharge team supports timely discharge from hospital, and ensures people have the support they need when they come home. And a community geriatrician is ensuring that expertise normally only found in hospitals is more widely available and more strongly integrated. The geriatrician is able to advise intermediate care services, GPs, community teams and nursing homes among others – and takes part in the GP-led MDT meetings.

Ask Dr Nikita Kanani to explain the reasons for such progress and she points to the concept of clinical commissioning. “Fundamentally, I think the reason that integrated care has been so successful for us is because we're clinically led,” says the clinical vice-chair for the CCG, who leads on integration. “And I think that means you have complete insight of what the patient journey currently is. As clinical leaders, we bring a complete understanding of what the patient really needs.

“Our ethos here in Bexley is making sure that the patient is at the centre of everything we do, but also making sure that clinicians have as much input as possible,” she continues. “So I have been leading on integrated care, and I think we would have gone on a completely different route if we hadn't had that clinician involvement – the clinical vision has driven what we've been doing over the last year, and continues to do so.”

Dr Kanani suggests it's notable that all of the integrated care meetings have been attended by at least two people from every GP practice, as well as representation from social and healthcare. She says this is indicative of the power of clinical leadership.

“The momentum hasn't drifted for integrated care. We're not completely there yet – we've only been working in this way since last year – but it's definitely going in the right direction.”

Information at the click of a mouse

Dudley CCG

Dudley CCG has launched an enhanced online community information directory, which helps local people find out about health and social care services – as well as those offered by voluntary, community and social enterprises (VCSE). Better information is also going to be made available to GPs. The work is part of the Building Health Partnerships programme. The funding covers 12 CCGs and will be exploring ways to improve collaboration between CCGs and VCSE.



“I think clinicians can bring people and organisations together in a way that is different from that we’ve seen in the past. In Bexley, there’s a real willingness for everyone to work together on integrated care.”

Dr Nikita Kanani, clinical vice-chair of Bexley CCG and lead for integrated care

No need to say that again

Bristol, North Somerset and South Gloucestershire CCGs

Ensuring easy access to all those who can support health and wellbeing is clearly beneficial. The growing prevalence of long-term conditions coupled with an ageing society means that more and more of us are likely to have complex needs that cannot be met by just one professional.

Yet one of the most frequent complaints of those using such services is the need to tell their story time and again. Explain to your GP what is troubling you, only to have to repeat the explanation to the hospital doctor who is treating you – who does not seem to be aware of the details of your conversation with your GP. For those in frequent contact with a number of professionals at a number of organisations, it is a situation that replicates itself repeatedly. The knock-on effect is that patients' time is wasted, and that healthcare professionals find themselves unable to work as efficiently as they might like.

In the Bristol, North Somerset and South Gloucestershire area – home to three CCGs, three councils, five provider trusts and a range of other health organisations – there is a clear understanding of the issue.

"In our local area, we have multiple organisations employing multiple professionals, all seeking to provide the best care they can and all recording information about the patient in multiple systems and multiple formats," says Andy Kinnear, director of informatics and business intelligence at South West Commissioning Support Unit.

"It is a complex situation but for the person seeking care, that complexity is irrelevant. It is simply a source of frustration when the professional they encounter does not have access to the information needed to provide the best possible care."

It is that final point that a local project called Connecting Care is addressing. The aim is to integrate all of a patient's health and social care information into one record, which any authorised health and social care professional can then read. The simple idea is that, whichever member of staff you see, he or she knows your story and the care that you have already received. Some 17 organisations are involved in the project, including all three CCGs.

"Connecting Care pulls together information that was not previously linked in any way," explains Jocelyn Palmer, the programme manager. "It means that professionals in hospitals, community settings, GP practices, out-of-hours service and social care team have a single electronic view of information about the person they are caring for.

"What staff are telling us is that the system is allowing them to deliver better, safer care – not least because it allows them to make better, more informed decisions about the best way to care for an individual.

"Connecting Care is centred on the person using our services," continues Ms Palmer. "Integration is not just an issue of bringing professionals together so that sectors work more closely. It's making sure that everyone has the same information and knowledge at the same time, and that's where we're going with Connecting Care."

Right patient, right place

North Cumbria CCG

The biggest challenge in delivering integrated care can often be making sure that a patient moves smoothly and efficiently from one service to another. Traditionally, referrals have been made by one healthcare professional sending a hard copy letter to another. But that can be slow and inefficient, and it's difficult to know whether the service to which a patient is being referred has the capacity to see them. North Cumbria CCG has worked with a private sector supplier to introduce an integrated 'air traffic control system' for the local health economy. It means that referrals can be made electronically rather than on paper and, in due course, will make it possible for staff to see exactly where there is free space. Dr William Lumb, the chief clinical information officer for the CCG, explains that the system "ensures that the right patient goes to the right resource at the right time".



“There is a real focus on the patient being at the centre of the care and having a system-wide plan.”

Dr Martin Jones, GP and chair of Bristol CCG

From illness to staying well

Fylde and Wyre CCG

The treatment of a cancer patient involves an array of healthcare professionals and, often, support from other sectors too. But when treatment concludes – when the focus needs to move from illness to wellbeing – that support often falls away.

“Anecdotally, we had feedback from patients that they’d had so much clinical intervention during treatment that when it finished it could almost feel like they were falling off a cliff, because everyone disappears for a while,” explains Jennie Collins, commissioning manager for cancer and end of life at Fylde and Wyre CCG.

It was a situation that Ms Collins and her colleagues were keen to address. How could patients be guaranteed regular, continuing, individualised support that was more to do with wellbeing than illness? The answer was an exercise referral programme, organised by the CCG with funding from Macmillan Cancer Support and involvement from a number of organisations.

“There’s a lot of evidence out there that shows that if a patient partakes in physical activity, either during or post treatment for cancer, it can improve their health and wellbeing but also reduce the risk of cancer reoccurrence,” says Ms Collins. “With colorectal cancers, for instance, exercise has been shown to reduce the risk of reoccurrence by up to 50 per cent.”

Since late August, GPs have been able to refer breast and colorectal cancer patients from across the Fylde Coast district of Lancashire to the Moving Forward programme. The scheme’s development is the product of eight months’ work with Macmillan Cancer Support, Blackpool CCG, Blackpool Teaching Hospitals and Fylde Coast YMCA, which provides the exercise programme.

“Everybody has really come together and been part of the implementation of the programme,” explains Ms Collins. “Which then makes sure that the care is coordinated and that everyone’s working in partnership for the same goal.”

Patients referred to the programme will first have a motivational interview with their exercise instructor – who is someone from the YMCA who has received additional training in cancer rehabilitation – to discuss the sort of physical activity in which they want to take part. “Not everybody wants to be a gym bunny,” says Ms Collins, “but they might want to do a walking class, or gardening a couple of times a week. It’ll be very much tailored to the individual.”

And it will be a programme with regular contact. “The exercise facilitator will first contact the patient at week four to see how they’re getting on, again at week seven, and then at six months and at month 12. So it’s not just the case that it’s a 14-week programme and then it’s over. It’s making sure that we are there for the patient, and seeing how their health and wellbeing progresses over that 12-month period.”

It is a programme that is seen as particularly important for a local population where the prevalence of cancer is on the increase. “We’ve got one of the biggest spends in cancer across Lancashire,” explains Ms Collins, “so we need to do something about it.”

She believes that the ease of taking such action has been increased by the introduction of clinically-led commissioning.

“I do think having that clinical input makes a difference. I have a GP clinical lead who I work with and by having his buy in, and by running things past him, it’s much easier to engage with primary care more widely. Now that GPs have an involvement and input, it’s much easier to embed changes.”

Starting early

Leeds CCG

In Leeds, health visiting services and children’s centres are now all integrated into a new Early Start Service. It runs across 25 local teams in the cities, and means youngsters and their families now have one service to support their health, social care and early educational needs. The result? 94 per cent of families have face-to-face antenatal contact with professionals – compared to 46 per cent before the service was launched. It is a success that has seen the CCG named an NHS England integration pioneer.



“As a clinician at the heart of commissioning local care for our population, I am in an advantageous position: my GP role helps me understand the needs of our patients, and in turn informs my work as a commissioner. In the PCT days, a project would be initiated centrally and GPs would have very little say about its structure and outcomes. In the new age of clinically-led commissioning, frontline staff like me are able to tailor projects and services to suit our patients’ needs. Our CCG has clinicians working closely with commissioning staff. We have formed excellent partnerships that have resulted in more clinically relevant services being commissioned.”

Dr Adam Janjua, vice-chair and GP clinical lead for cancer,
Fylde and Wyre CCG

Help to get healthy

Gloucestershire CCG

When Gaye Dalby's GP referred her to a slimming club, she was distinctly reluctant. "Initially, I really didn't want to join," admits the resident of Tewkesbury in Gloucestershire. It is fair to say that she has since had a major change of opinion.

"I'm absolutely delighted with the results. At 11 weeks, I had lost 1 stone 10lbs and started feeling so much better. I now have excellent control over my diabetes and have managed to stop having insulin injections during the day. I've also reduced the amount I need at night."

Gaye is one of more than 3,500 people who have already benefited from a new weight management referral scheme in Gloucestershire. Jointly commissioned by the CCG and council, the scheme means that local healthcare professionals can refer people to a free 12-week course at private sector partner Slimming World.

Anyone with a BMI of 30 or more – or 28 in the case of significant co-morbidities such as diabetes, high blood pressure or depression – is eligible for referral to the course, which can be made by pharmacists, nurses and others as well as by GPs.

The project's integrated approach is one that Dr Andy Seymour says characterises the work of the CCG. "The CCG has always worked closely with the council and public health locally," explains its deputy clinical chair.

"With this particular project it was recognised from the outset that success depended on a wide range of knowledge and skills that could only be brought together through collaborative working between the organisations."

Obesity is an increasingly significant health issue in the UK. Recently published data revealed that 67 per cent of men and 57 per cent of women are either overweight or obese. In the Gloucestershire area, weight management has been identified as a key local priority.

"Obesity can have a major impact on the individual and the NHS as a whole," says Dr Seymour. "People who are obese and overweight are at increased risk of a range of serious health conditions, including diabetes, cancer, heart disease and osteoarthritis.

"In Gloucestershire, there was a shared desire to build a comprehensive network of support within local communities to help meet this major challenge."

The weight management referral scheme has been in place since September 2013, and an evaluation of the results has led to an extension of the contract with Slimming World, through to March 2016. The CCG and council are not the only ones to extend their association with the slimming club, however. Gaye Dalby has too.

"I've decided that I will carry on attending Slimming World to lose even more weight," she reports. "The health benefits are amazing."

Pain killer

Trafford CCG

Back, neck or joint pain is a common complaint and one that can have a real impact on a sufferer's quality of life. Staff at Trafford CCG were keen to help local people who had been experiencing such pain for some time, and so asked this group what they would find most helpful. The answer was pain management education, and so the CCG joined with a local healthcare business to develop this. Patients now receive face-to-face education as well as having access to an application that runs on a tablet computer and supports them to self-manage their pain. The results are impressive: 73 per cent of patients have reported an overall improvement in their condition. The project has won national awards and attention.



“The support of our member GP practices, other referrers and the strong partnership with the county council has been instrumental in getting the project off the ground.”

Dr Andy Seymour, deputy clinical chair, Gloucestershire CCG

Better care for those with complex needs

Greenwich CCG

In 2012, Greenwich was designated London's third royal borough. But in recent months, it has also started a stronger association with a very different type of VIP: very important patient. The designation is being used for the 8 per cent of local residents who are deemed to have very complex health needs, and a new integrated approach is designed to serve them better than ever before.

"We feel we've dealt well with other patients within our existing integration, so we're now tackling the final 8 per cent who have really complex issues," explains Jay Stickland, senior assistant director (care management), Royal Borough of Greenwich, who works closely with his CCG colleagues on the Greenwich Coordinated Care programme. "They're still bouncing around the system, using huge amounts of resources, and actually are very inappropriately served by which bits they hit."

It is these patients who have been dubbed Greenwich's VIPs. It is they who the local partners hope will be helped by a model being piloted in Eltham, in the south of the borough.

"We've started to try to manage this complex group in a very different and very tight way," explains Mr Stickland. "Basically we have a lead integrated practitioner who links in with care navigators.

"They talk through who they think could be involved [in the patient's care], and then the care navigator talks to the patient and asks what is making him or her unhappy. And what's surprised us is that very often it's simple things that have absolutely nothing to do with their medical condition. So we're using some very creative solutions – we've used the third sector very heavily, [and] social care."

This has not been the only surprise. "When we first started doing this, we imagined that lots of the people [we would be targeting] were going to have multiple long-term conditions, and so were really going to require lots of services. What's really surprised us is that although there is a proportion of those people in the group, there are equally people who have no long-term conditions and their situation is still completely out of control. Some are just people with very poor and chaotic lifestyles."

Some 130 people in Eltham have now received care in this new way. In many instances, they are now managing their own wellbeing far more efficiently than ever before. "We have people who were attending GP practices five days a week, maybe even going into A&E at weekends, who have now completely changed the way they manage their own care," reports Mr Stickland.

Following the successes in Eltham, the model will now be used in Woolwich as well, before being extended to the rest of the borough.

Mr Stickland is full of praise for what his CCG colleagues bring to the continuing process of integration. "With this project, we've really had GPs on board – because there is nothing more powerful than a GP [within the CCG] talking to a fellow GP."

Blazing a trail

South Devon and Torbay CCG

South Devon and Torbay has long provided integrated health and social care services, such that the area has been a model for many other areas of the country. But it is now working to provide integrated services across all services, including mental health and GP provision.



“I think the CCGs have a real appreciation of what we’re all trying to do locally with integrated care.”

Jay Stickland, senior assistant director (care management), Royal Borough of Greenwich

Bringing together the body and mind

Hammersmith and Fulham CCG

When talking about greater integration in healthcare, much of the focus is on ensuring the sector works more effectively with social care and voluntary organisations.

This is undoubtedly crucial to patients having a smooth and efficient experience. But it risks overshadowing another important aspect of the challenge: better integration within healthcare itself, and particularly between mental and physical health.

In North West London, a liaison psychiatry service helps ensure that care of the body and mind are united. Staff on the team are employed by the local mental health trust but work within the local general hospitals, providing support to patients who have mental health as well as physical health needs.

In Hammersmith and Fulham, the service had traditionally operated on a pilot basis. But in the past 12 months it has become a contracted service, and commissioned across all eight local CCGs (Brent, Central London, Ealing, Hammersmith and Fulham, Harrow, Hounslow, West London, and Hillingdon).

“We worked with our acute and mental health trust colleagues to design this service,” explains Clare Lyons-Collins, the mental health commissioner for Hammersmith and Fulham CCG. “So the psychiatric liaison team are employed by the mental health trust, they sit within the acute trust, and then obviously they are commissioned by us.”

One big focus for the service is A&E. Many of those who attend an emergency department have mental health needs. By having the liaison psychiatry team based on site, such needs can be met more quickly and efficiently than ever before.

In the longer run, the aim will be to support patients before they even get to A&E. Last winter, Hammersmith and Fulham CCG funded a pilot focused specifically on people who were attending A&E frequently and had mental health needs.

“People with long-term conditions such as diabetes or COPD can sometimes experience mental health problems, and they may be frequent users of A&E,” says Ms Lyons-Collins. “They may have developed some maladaptive coping skills. Liaison psychiatry can help these individuals develop other coping strategies, which in turn helps keep them out of hospital.”

In each of the nine local emergency departments, 15 patients were identified who often came to the department. In each instance, mental health was a significant factor, if not necessarily the main factor.

All the patients were referred to the liaison psychiatry team, which worked to give support in the community rather than in hospital. The result is that there were 1,075 fewer hospital attendances among the group over the course of a year.

A steering group is now in place to decide how to continue and expand the work of the team. But Ms Lyons-Collins emphasises that the decisions made – and, indeed, the successes so far – are the result of true collaboration between all partners.

“I think we’ve really raised the profile of psychiatric liaison locally,” she continues. “It’s now off a pilot basis and onto a contractual basis. And we have started the dialogue of where this fits in terms of preventing people coming into hospital, as well as seeing people in hospital and supporting people going out of hospital. So it’s the whole patient pathway, and it’s fully integrated.”

Prevention is better than cure

Eastern Cheshire, South Cheshire and Vale Royal CCGs

The focus of healthcare has traditionally been on treating an illness when it occurs. But, as the saying goes, prevention is better than cure. That’s the idea behind the introduction of wellbeing coordinators in Cheshire, the product of a partnership between Age UK, the local CCGs and the local acute trust. The coordinators work within the local integrated teams, and can direct people towards services that might increase their wellbeing. So whether a local person wants to find ways to feel less lonely, to lose weight or to help out in their local community, the wellbeing coordinator can quickly point him or her in the right direction.



“As commissioners, we have developed a really good relationship with the psychiatric liaison team.”

Clare Lyons-Collins, mental health commissioner, Hammersmith and Fulham CCG

Developing a dementia-friendly community

Isle of Wight CCG

When the My Life A Full Life integration programme launched last year, it was the culmination of a discussion that had been going on for some time. "I think the idea [of greater integration] on the Isle of Wight was first mooted around 2006," says programme director Suzanne Wixey.

"It wasn't until the changing landscape with the creation of the CCG, the acute trust's decision to apply for foundation status, and change around political leadership in the council that the whole programme came into being. The shifting landscape was the catalyst to do something differently."

That 'something' was a commitment by the CCG, trust and council to work together to deliver more coordinated health and social care services on the island. A programme board was created with representatives from all three organisations as well as from the voluntary and private sectors, and a variety of individual initiatives launched.

Ms Wixey explains that the demographics of the Isle of Wight make the need for such an approach particularly pressing. "We're a third above the national average in terms of older people," she says. "So we're ahead of the national curve there. We're having to respond now to demands that some areas haven't yet experienced but are expected to experience in the next five to ten years."

One of those demands is for increased support for those living with dementia, of which the island had the highest reported prevalence rate in the UK in 2011/12. A partnership with Age UK and the private sector has led the creation of an Alzheimer's Café, a regular informal meeting for those with the condition and their families and carers. "It's an opportunity to get information and advice, to hear from national and local experts, and to get support," says Ms Wixey.

Meanwhile work has been underway to make the island's largest town a dementia-friendly community. Again, this has involved a true partnership approach. The police and many local businesses in Ryde have received dementia-awareness training. So too have bus drivers. A card has been developed that dementia sufferers can show to a driver to explain their condition, and to allow drivers to know when support is needed. And there is an established 'safe place' for those with dementia and their carers to go (a GP practice where practice nurses are dressed in 'dementia-friendly' colours to help with signposting).

All of this forms part of the overall My Life A Full Life programme, which is chaired by the practising GP who also chairs the CCG – Dr John Rivers. Ms Wixey feels that the introduction of clear clinical leadership of commissioning has been important to the success of the programme.

"Having a GP leading the programme has made a significant impact on it overall, and on our work with primary care as well. We've moved forward building those relationships."

Everything in one place

North West Surrey CCG

Older people often have complex health needs that require the support of a number of healthcare professionals from a number of disciplines. That in turn can mean inconvenient visits to several different surgeries, clinics and centres. In North West Surrey, all 42 GP practices are joining with community services, acute trusts, the local mental health trust and community services to establish 'locality hubs'. These will bring together all services for older people in a single place. It won't just be medical care that is offered – there will also be services to help people keep well. The development of the model is being led by local GP practices, and the hubs will be led by primary care physicians. CCG leaders say this has been made possible by the introduction of GP-led commissioning.



“Having a GP leading the programme has made a significant impact. The issue in the past is that we haven’t had that clinical leadership.”

Suzanne Wixey, programme director, My Life A Full Life

Just what the patient ordered

Kernow CCG

Dr Matthew Boulter has a simple way of describing the integrated care project he's leading in Cornwall. "It's the best thing I've ever done," says the GP. "It's completely changed the way I practise."

The Penwith Pioneer scheme launched earlier this year, an extension of a smaller but immensely successful project in Newquay. The initial idea was to bring together the voluntary and healthcare sectors to help vulnerable people live the lives they want to lead.

So Kernow CCG partnered with Age UK, and staff from the charity began working in two local GP practices. They also went out to visit people at home to find out what they really wanted to do – whether it was to get out and start doing their own shopping again, walk their dog on the beach, or just feel more connected to their community.

"We're very good as a state at doing *to* people," argues Dr Boulter. "So we say, right, you're struggling with your mobility now so we'll bring your bed and a commode into your lounge and you can live in one room because that suits us. But nowhere in any of that does anyone ask the person: what do you want? And when you do, it just spins things completely on their head."

The result of integrating the voluntary sector with the healthcare sector has been what Dr Boulter terms "a quiet revolution". It is one that has brought about measurable benefits for all. Among the 100 people in the Newquay group, unplanned hospital admissions dropped by between 30 and 50 per cent, healthcare spend fell, social care budget flatlined and wellbeing scores improved. One patient in the initial group sums up the project as "marvellous". "You're treated like a human being rather than a poor, old, worn out thing in a chair," she says.

Staff satisfaction increased too, with many reporting that they felt more able to offer the care they had come into the service to deliver – Dr Boulter among them.

"The amount of visits I go on where you're offered a cup of tea and asked if you want to sit down and stay," he says. "And you're probably the first person they've seen in ten or 12 days, and they're lonely, and they want to chat.

"And I haven't got time, sadly, as much as I'd like to. So I do my bit, and make my excuses and bustle away. But now I can ask the question: how are you, really? Before we had the voluntary sector involved, you'd say, yes, you're lonely, but actually I can't do much about that. But now I can. With confidence.

"It is great to have that in your armoury, because that's quality of life stuff that medicine doesn't do. So to have that on offer is brilliant."

The success in Newquay gained national attention – it was mentioned at all three political party conferences – and is such that the scheme is now being extended to 1,000 people in Penrith. Dr Boulter is chairing the project board there, and says the CCG's aim is to drive an even greater degree of integration.

"In Newquay, it was integrating the voluntary sector and health, but what you really need to do is also integrate the social care sector and the communities as well," he suggests.

"So the vision for Penrith is to have one team with all the local social care assets, all the healthcare assets and all the voluntary sector. Rather than having six people go up the same old lady's path one day, you'll have one organisation do it. That then frees up the other five people to do other stuff elsewhere, and to spend more time with the people they're seeing."

Dr Boulter says he believes that a clinically-led commissioning system is crucial to driving innovations such as Penwith Pioneer. It is notable that the initial idea for the Newquay project came from Lucy Clement, a community matron in the area.

"It's clinical commissioning, clinically led and management asking how they can support us," he explains. "Whereas traditional PCT thinking was all the other way around."

Helping with hoarding

Liverpool CCG

Liverpool CCG has backed a local housing association project to support those who have problems with hoarding. Staff at Liverpool Housing Trust developed the 'Outside the box' toolkit to support people to sort through their possessions in a carefully managed and sensitive way. The CCG then funded eight session workshops, designed by two cognitive behavioural therapists. After encouraging early results, staff at the CCG and Liverpool Housing Trust are working together to further refine the programme.



“It’s clinicians setting the pace now.”

Dr Matthew Boulter, GP partner at Alverton Practice in Penzance and chair of the Penwith Pioneer board

Home sweet home

Warrington CCG

The importance of health services caring for older people in their own homes is frequently emphasised. It's generally more efficient, more cost effective and what patients want. But what happens when the individual's home itself is in danger of being part of the problem? What if, for instance, the central heating is broken and the person is unable to arrange or afford its repair?

Home improvement agencies can be a key support in such situations. They offer advice to older or other vulnerable individuals who want to improve or adapt their homes, including on issues of funding. The challenge, however, is making sure people know such services are available.

"So often people get to us by accident," explains Geraldine Kiddle, manager of Warrington Home Information and Improvement Agency (WHiA). "That might be because they've had a stroke and so can't manage to do the things they used to do around the house, or because they're caring for someone [whose needs have changed]."

In other words: staff at the agency often find themselves getting involved once a problem has already occurred, or once it's already causing significant difficulties. Staff at Warrington CCG recognised that there was clear potential for intervention at an earlier stage, and so last year funded a pilot to capitalise on that opportunity.

A group of older patients with complex needs was identified to receive home visits from staff at WHiA and a pharmacist. "It was a two-pronged approach," explains Ms Kiddle. "The pharmacist did a medicines use review, and then we did a holistic assessment that covered everything from home safety, to falls, to social isolation, to whether someone was getting out enough."

"The CCG was interested in taking a proactive approach, and I think that's the key to this," she continues. "It's going into somebody's home, which is a very powerful thing to do in the first place because you're far more likely to have an engaging conversation with them. It's a different sort of relationship, you can build trust and you've got the experience of actually having seen the home."

The result, she believes, is that people "take the opportunity to tell you about little, annoying things that they wouldn't normally bother anybody with but that can have a big impact on them."

The data from the pilot bears that out. Through the CCG project, WHiA arranged for 20 separate repairs and similar numbers of aids and adaptations. But wider issues were also touched on: the need for help with gardening or cleaning, the desire for more social activities, or a need for advice on adopting a healthier lifestyle. For these issues, staff from the agency were able to make referrals on to colleagues in the health or third sector.

Following the pilot, the CCG has invested in an extended project that will begin later this year. Working with GP practices, patients will be identified that could benefit from a visit from the agency and pharmacist.

Ms Kiddle firmly believes in the power of the integration of home improvement agencies into healthcare – not least to deliver greater efficiencies.

"I think so often the wrong people are doing the wrong things. You don't want the district nurse having to make 50 phonecalls to try to get someone's central heating fixed. Instead, they can just ring us and we can sort it out. We need to be integrated and embedded into this process."

The right care in an emergency

Barnsley CCG

A new centre has been set up in Barnsley to help ensure local people quickly get the right help in an emergency. When staff at the centre are alerted about an urgent case, they assess whether it is an individual issue, a family issue or a community issue. This makes it much easier to quickly provide the right sort of help – whether from healthcare, social care or the third sector. The centre is part of Barnsley's work as an NHS England integration pioneer.



“GPs understand that what we can do helps them by helping their patients. So I think our work with the CCG is a very good example of integration.”

Geraldine Kiddle, manager of Warrington Home Information and Improvement Agency

Further information and acknowledgements

If you would like to speak to NHS Clinical Commissioners about this report or any of the case studies, please contact Emily Teller, head of communications at press@nhsc.org

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