neighbourhood
integration
project

Community
NETWORK

Delivering neighbourhood-level integrated care in Luton

JULY 2020

Introduction

The COVID-19 pandemic has rapidly accelerated the integration of care in the community. The transformative potential of organisations working together at a neighbourhood level to meet local needs has never been clearer.

Before the crisis hit, the Community Network initiated a project to capture the successes and share the learning from areas where local service integration was already well underway. This case study forms part of a series published as part of this Neighbourhood Integration Project. With funding from NHS England and Improvement, the project focuses on how long-standing local partnerships have resolved the operational challenges that so often hold back the integration agenda.

These case studies were written before the pandemic, with all the change that has brought about, not least the move to digital ways of working. However, as the NHS faces unprecedented pressures not just to recover but reset how services are delivered, we hope they are still a timely way of sharing the practical strategies health and care organisations have already used to deliver more joined-up care.

This Community Network project is supported by NHS Providers, NHS Confederation, the National Association of Primary Care, the Association of Directors of Adult Social Services and the Association of Ambulance Chief Executives.

Key learning

- For successful transformation to take place, strong relationships, a sense of common purpose and transparency must be shared between the project partners.
- The concept of integration and its value must be articulated at all levels – tactical as well as strategic – and to all partners in order for it to succeed.
- Leaders need commitment, drive and resilience – and must model the courteous, cooperative and empathic behaviour they would wish to see in their staff teams.

How integrated services are being delivered

This case study focuses on the successful introduction of system-wide collaborative models of care in Luton. This began as a six-month pilot in October 2018 and is now moving towards business as usual.

Working together across the system was not new to Luton with innovation and integrated working encouraged to flourish by commissioners Luton Clinical Commissioning Group and Luton Borough Council. The enhanced collaborative models of care project built on the foundations laid by earlier work under the auspices of the Better Care Fund including care coordinators facilitating multidisciplinary meetings in each GP practice as part of an *At home first* initiative. With the move towards more collective financial responsibility across the system, commissioners and providers knew they had to keep a keen eye on their bottom line and were passionate to stay ahead of the policy curve.

The Luton Provider Alliance – a body which meets monthly and whose members include senior leaders from local providers – gave the strategic leadership for the new project. Luton clinical commissioning group (CCG) provided a dedicated pot of money to facilitate transformation, and although there were high level outcomes specified, there was flexibility in how it needed to be spent. This funded a dedicated programme resource along with the introduction of additional roles.

The initial project aimed to test how partners across the heath and care system could deliver enhanced care for a defined cohort of patients, building on Luton's *At home first* model. The patients were aged over 65, identified as either moderately or severely frail, with experience of two or more unplanned hospital admissions over the previous 12 months. Initially the cohort was around 800 patients. Local partners included the CCG, Cambridgeshire Community Services NHS Trust (CCS), Luton and Dunstable hospital, local GP primary care networks (PCNs), Luton Council's social care team, local mental health services provided by East London NHS Foundation Trust (ELFT), and the third sector.

The programme also commissioned Medeanalytics to create an integrated dataset that would enable the team to pick up daily information on patients in the cohort, as they were admitted to or discharged from Luton and Dunstable hospital. If patients were already known to the team, they could see when their care plan was last reviewed. If they weren't already known to the team, an *At home first* coordinator contacted them to ask five assessment questions, with the answers brought back to the daily multi-agency team huddle.

The enhanced collaborative models of care team initiative included:

- A daily huddle, attended by CCS community clinicians, social care, primary care and Luton and Dunstable clinicians. A community matron oversaw the huddle, prior to which community matrons attached to local GP networks worked with GPs and coordinators to establish which patients need to be targeted.
- A weekly consultant-led multidisciplinary team (MDT) meeting for the most complex cases, to which all partners including the third sector were invited.
- A monthly MDT meeting with GP practices with a marker added to the electronic records of patients identified as 'complex cases' enabling multiple providers (most of whom use SystmOne clinical records) to identify such patients.

- All staff ask patients five simple questions to assess their needs.
- A hotline available for community staff to call for advice from a consultant.
- A pathway enabling more IV antibiotics to be delivered in community clinics or at home, rather than in hospital – made possible by consultants from Luton and Dunstable hospital working with nursing teams to support their delivery of challenging and complex care in the community.
- Step up beds, providing a step between community and hospital for patients who need 24-hour care for an urgent condition that could be managed in the community.
- Medication reviews by pharmacists and technicians.
- Reinvigorating a previous initiative, where community patients wear a pink bracelet, so that other clinicians are able to identify them easily.

The five questions

The enhanced models of collaborative care team use these five questions to assess patient needs:

1. Who visits you, how often and what do they do for you?
2. Have you fallen recently? Are you worried about falling?
3. Do you feel confident to manage your own medication?
4. Do you tend to forget things and struggle to recognise people?
5. How do you manage with washing, dressing, shopping, cooking and cleaning? Activities of daily living?

Now that the pilot is complete, the project's reach has extended to include any person who meets the criteria for moderate or severe frailty in two of the five local primary care networks – Hatters Health (with a population of 45,000) and Medics (60,000). CCS is now trialling home visiting with Hatters Health, as has found that the complementary skills and knowledge that the community nursing team are able to contribute can help keep people at home when a lone GP might have had to admit them to hospital.

In addition, the model has now moved to encouraging proactive needs assessment and care planning for older people with frailty across the system. A population health spreadsheet based on frailty status using community and GP data enables the focused recall of specific cohorts of patients (see below). All Luton GPs are now incentivised to undertake proactive frailty clinics. A shared approach to holistic assessment and data recording and sharing using the *Geriatric 5Ms framework* (developed by Frank Molnar et al) has been adopted across the system. A winter pressures initiative has led to proactive respiratory assessments (see below).

Since October 2018:

- Over 3,000 people have been asked the five holistic questions to assess their initial needs. This has led to 174 falls referrals and 418 medication reviews.
- There have been 29% fewer readmissions within 30 days in the group who have been asked these five questions compared with a matched (by age and frailty level) group who have not been asked.
- Nearly 800 active patients have care plans/escalation plans in place compared with 194 when the project began.
- Over 90% of people over 80 with dementia and severe frailty who live on their own have been seen or reviewed. Of the 160 people who have had five or more unscheduled admissions in the last calendar year, 158 have been seen or reviewed.
- At the end of January 2020, 58% of the patients with frailty had contact with adult community services, compared to 37% in April 2019.
- Respiratory clinicians have used the risk tool to identify and reach out to 589 patients with frailty and a COPD diagnosis to prepare them for winter. They are then helping these patients get their flu vaccines, access and understand how to use rescue medications, develop escalation plans and, where appropriate, receive MDT reviews. Respiratory community services have now worked with 85% of this group.
- The five questions have also been completed for the 560 people living in care homes in Luton, some of whom were not previously known to services, and a clinical pharmacist has undertaken a medication review for each of these people leading to significant prescribing savings.

In the 12 months since April 2019 the scheme:

- Has supported over 3,200 people at daily huddles.
- Has reviewed over 2,000 of the cohort at primary care and consultant-led MDTs.
- Is forecast to have saved circa £750,000 of emergency admissions against plan.
- The programme team is currently developing a models of care approach for complex adults of working age.

Enabling factors

Involving and supporting staff

As the programme director puts it, "there's no point in designing a fantastic model you can't staff, so our priority was to maximise the impact of existing staff within the system to best effect." Luton's provider of community services recognised that engaging staff in designing the new approach would be critical to retaining their skills. Equally important was the leadership team's commitment to ensuring the trust's values of honesty, empathy, ambition and respect underpinned the change process. Positive results in the CCS 2019 staff survey show this approach has reaped rewards.

Forward-thinking approach

With the chief executive of CCS also leading on the national Ageing Well programme for NHS England and Improvement – as well as being a previous chair of the Community Network – Luton's leaders have been exposed to the national agenda and the language that describes it for some time. In addition, Luton had developed a healthy ageing programme and frailty framework in line with the NHS Rightcare frailty toolkit. This forward-thinking approach has encouraged an early willingness to share and test new approaches across the system, complemented by the funded resource of a dedicated programme director with both clinical and strategic leadership experience who was already known to the system. The development of GP practices in clusters, now formalised in PCNs, has enabled significant GP leadership in service design and has improved collaboration with community services.

Leadership

The importance of leaders leading by example, modelling positive relationships and seeking to understand the different pressures their colleagues face enabled colleagues to move beyond blame for clinical decisions which may have had a challenging impact elsewhere in the system.

The personnel in leadership positions across health and care in Luton has been relatively stable, with a joint CCG and LA vision for the new way of working. Leaders already had strong working relationships, but the enhanced collaborative models of care approach has nurtured those at staff level too, even without formal co-location. Having a coterminous local authority and CCG has also encouraged those working together to feel like one team at place level. Before Christmas, when the Luton and Dunstable hospital was particularly busy, community services were invited to bed meetings and helped to deliver care in the hospital itself, something that respiratory consultant Dr James Ramsay describes as "just massive as a message."

The Luton lung health check: working across boundaries to improve lung health

As a town with historic health inequalities, it makes sense for Luton to focus on prevention. For example, as lung cancer outcomes are poor, there are plans for a team to deliver a mobile lung health check service. The proposal is that rather than have a single team owning the staff on the bus that delivers the check, they will rotate so that for two weeks of the month the nurse might be delivering mobile lung health checks, then for a week they might be working in the community managing patients with COPD, and then for another week working in the acute sector supporting patients that are now on a cancer pathway as a consequence of the CT scan they had on the bus.

Overcoming barriers to delivering integrated services

Despite the high level of commitment to changing ways of working in Luton and its neighbourhoods, coupled with clear leadership from the front, partners have faced a range of challenges.

Some professionals feared that changing ways of working could unleash overwhelming demand. For some GPs, the attraction of delegating some of their workload was matched by concerns that the new model might ultimately generate more work for them. To understand and tackle that fear, it was crucial that the programme team communicated and worked effectively with each of the local PCNs as they evolved from four clusters to five networks.

Whereas previously no-one knew what was happening overall with the patient cohort, enabling data sharing and tasking via SystmOne meant that previously clunky referrals could be avoided. Information governance remains a challenge as the project team consider how to bring in partners from outside the statutory sector.

Existing financial models presented a challenge to new ways of working. For the CCS, the block contract model meant there was no financial incentive for their teams to go 'above and beyond' in their daily work, although clinicians regularly do so. Working with social care means bringing together a system that allocates according to need together with a system that allocates according to eligibility criteria. Aligning financial incentives across the system will involve commissioning based on outcomes, rather than activity.

As clinicians work in different settings as part of the new model, the programme also had to consider how its governance would protect them from clinical risk. Working in new ways might otherwise have left staff feeling vulnerable. Honorary contracts were developed so that consultants from the acute sector who were supporting community teams could effectively become CCS employees.

The Luton system remains financially challenged. Although the pilot has been able to demonstrate positive outcomes, the programme continues to grapple with the challenge of demonstrating long term improvement at a population health level or substantial cash savings based on a relatively short-term intervention working with a small group. Without ICS money, the programme might have struggled to be sustainable.

Benefits for local people and staff

Patient satisfaction in the targeted cohort has improved, as have satisfaction levels among relatives, suggesting that they find the new model of care easier to navigate and more holistic – with access to a dedicated advice line and the ability to self-refer if they have concerns.

One of the initial shocks as the programme began to carry out dedicated care home rounds was the high number of residents with multiple complex medical problems but no end of life or treatment decisions in place. Having multi-professional conversations with these people and bringing clinical decision-making into the community means that everybody involved including patients, relatives and teams of medical professionals is aware of the plan should medical needs suddenly escalate.

For staff, there is more support with decision-making, with the huddles and MDT sessions providing a safe space where they can take more complex patients and be supported in a team environment. Team responsibility means that rather than fearing going on annual leave, staff can be confident that patients will be cared for by colleagues swiftly should the need arise.

> ***Things that used to take days to sort out – now you have a solution in the afternoon.***
>
> Austin Chinakidzwa, community matron, CCS

In addition, the focus on anticipating needs as well as reacting to them means that staff may have more of an opportunity to make a real difference to patients and develop a strong relationship. New ways of working – such as the IV pathway – offer opportunities to upskill in new areas, and to operate at the top of professional competence.

> ***The success of this system-wide integrated approach has reaped huge rewards during the COVID-19 pandemic. It has enabled new and flexible approaches to integrated working to be speedily introduced, such as the pioneering work undertaken with partners to roll out digital technology to care homes across Luton. This has enabled community and primary care clinicians to introduce rapid access to virtual consultations, including weekly check-ins and multi-disciplinary team sessions to ensure this vulnerable community is able to access advice and support during this challenging time.***
>
> Nicky Poulain, director of primary care, Luton CCG

Advice for others

Learning from Luton shows how important it is to articulate the concept of integration and its value at all levels and across all the organisations who will be key to its success. As crucial as it is to gain buy-in from senior leaders, it is just as important that objectives are aligned at a more operational level. Commissioners can take a role in enabling that alignment, by commissioning on outcomes and fostering a longer-term approach that does not focus on efficiencies and savings alone – sometimes transformation is just the right thing to do.

Leaders will need commitment, drive and determination, as well as a good helping of resilience to see challenging plans through. They must model the trust and respect they want to see from their staff in embracing new ways of working by understanding, acknowledging and allaying the genuine fears that clinicians may have. This requires empathy, and what one interviewee called 'anchors in the ground' – key clinical staff who will champion the new model to their peers.

> ***One of the things I'd say to other systems who are about to embark on something like this – there is a real perception and fear of the floodgates opening: it never happens.***
>
> Dr James Ramsay, respiratory consultant, Luton and Dunstable Hospital

One interviewee described a triangle where all parts must be in place in order for effective transformation to take place – relationships, common purpose, and transparency – with the patient at the centre. Starting with a small, well-defined 'problem' and giving teams permission to get on and solve it is more likely to be effective than encouraging integration for integration's sake. Getting patient organisations such as Healthwatch on board can also strengthen the case for change and ensure that what emerges is fit for purpose.

> ***When leading a programme of this kind, you can be Prince 2, you can have an MBA, you can be all of those things... but fundamentally it's about hearts and minds, it's about people... at the centre.***
>
> Clare Steward, programme director, Luton Integrated Care System

Other useful information

- An overview of the enhanced collaborative models of care project
- Clinicians' views on the benefits
- A patient's view

Community
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The **Community Network** is the national voice of NHS community providers, hosted by the NHS Confederation and NHS Providers. We support trusts and not-for-profit organisations providing NHS community health services to deliver high-quality care by influencing national policy development, sharing good practice, and promoting a vision of integrated care in the community.

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For further information and to get in touch:

nhsproviders.org/training-events/member-networks/community-network/neighbourhood-integration-project

www.nhsconfed.org/neighbourhood-integration-project

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