How is the government’s integrated care project faring?

NHS Pioneers has been described by one minister as the ‘starting gun’ for combining local health and care services. Alistair Kleeauer reports

Bringing health and social care services together is a long-held government ambition, which the coalition believes would improve patient care and be more cost effective.

In November 2013, moves to integrate care were given a boost when care and support minister Norman Lamb announced the NHS Pioneers programme, which is made up of 14 projects in England.

Launching the five-year programme, Mr Lamb described it as the ‘starting gun’ for local health and care services to work together in the interests of the communities they serve.

Since then the 14 pioneers, made up of local authorities and health organisations, have been devising ways to work jointly.

Teams of social workers and health staff, including nurses, have been looking at easing the pressure on A&E departments and reducing hospital admissions by caring for patients in the community.

The Department of Health is keen to minimise the strain on England’s
Since it was set up last year, the NHS Pioneers team at Queen Elizabeth Hospital in south London has prevented more than 750 admissions to the hospital’s A&E department

emergency wards, particularly in light of the projected rise in the number of people with more than one long-term condition such as diabetes, asthma or dementia – from 1.9 million in 2008 to 2.9 million in 2018.

In the Royal Borough of Greenwich in south London, one of the pioneer areas, a joint emergency team of nurses, social care workers and physiotherapists is based in Queen Elizabeth Hospital.

Funded by Oxleas NHS Foundation Trust and the local authority, the team of around 25 staff including band 6 and 7 nurses, physiotherapists, occupational therapists and social care workers is led by nurse Theresa Conroy.

It handles referrals involving patients in crisis, such as older patients with chest or urinary tract infections. Team members provide care in their homes or arrange a transfer to a rehabilitation unit, which avoids the need for admission to an acute ward. Since November last year, the team has prevented more than 750 admissions to the Queen Elizabeth A&E department.

Multidisciplinary care

The team has a three-pronged approach to easing the strain on the A&E department.

First, they deal with referrals from health professionals including GPs, nurses and social workers about people aged 65 and over who may be in crisis. Typically, they will have had a health setback such as a chest infection.

This will prompt a home visit to the patient by at least two members of the multidisciplinary team, such as a nurse and a social worker, who carry out an initial assessment.

The team can then admit the patient to an intermediate care unit – one of three rehabilitation units in Greenwich – or arrange for the patient to be cared for at home.

Medical cover at the centre is provided by two geriatricians and 15 nurses, each of whom cares for ten patients during a shift and are employed at the centre. Nurses carry out observations, assist with washing and dressing, and help patients to manage their continence.

Help and advice

They also spend a lot of time helping patients who have problems with medication, teaching them how to take it and putting plans in place so they can self-medicate when they return home.

There are daily reports on each patient involving every member of staff and a care manager, who is updated on the centre’s caseload and links the centre with social care services so they are ready when patients are discharged.

Senior nurse at the centre Sarah Crabtree says: ‘The care manager ensures patient discharge goes smoothly, instead of us ringing around trying to get hold of people and things getting delayed.’

The centre’s staff take an active approach to investigating why patients had to be admitted in the first place. Then they find solutions to prevent them from being readmitted, for example as a result of falling.

‘Our occupational therapists will look at all the environmental issues that have brought them to the centre,’ Ms Crabtree says.

Over the past year, the pioneers have been supported and advised by managers at NHS England and four other national partners – the Local Government Association, Monitor, Public Health England and the NHS Trust Development Authority – who help address barriers to integration.

Regional events, webinars and workshops allow the pioneers to demonstrate best practice in integration with each other and other NHS organisations.

An independent national evaluation of the pioneers programme has been commissioned by the Department of Health, with an initial report expected by next summer.

Second, team members can be ‘bleeped’ by doctors and nurses to go to the hospital reception, or they will make visits there themselves, to see if there are patients who can be treated without admission.

Again, the patient could be admitted to a rehabilitation unit or they may return home with changes made to their care package. In one month, 79 A&E admissions were avoided as a result, says Ms Conroy.

‘The A&E staff see our worth,’ she adds. ‘When patients cannot go home but do not need an acute bed, we step in and do something about it.’

Finally, the team visits the acute medical unit in the hospital with the aim of speeding up patient discharges. To build on the team’s success, Ms Conroy is encouraging staff to visit GPs to increase the number of referrals they make. Nurses are also being offered career development opportunities by undertaking advanced clinical skills courses and becoming nurse prescribers, which will widen the care the team can offer, adds Ms Conroy.

In Leeds, 12 health and social care teams co-ordinate care for older people and those with long-term conditions.

At the 40-bed South Leeds Independence Centre, which is a community rehabilitation unit, nurses, physiotherapists, occupational therapists and carers are working together to care for patients aged 65 and over.

Health professionals in Leeds can refer patients to an urgent referral centre, where staff can, in turn, find the patients community beds, including those at the South Leeds Independence Centre.

Patients who have been seen by their GP following a fall at home, as a result of a urinary tract infection for example, can be transferred to the centre for care rather than taken to hospital.

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