

# Integrated Care Value Case

Greenwich, England



November 2013

This Value Case has been commissioned by the Local Government Association with support from the national partners on the integrated care and support collaborative

# Guiding principles for the value case:

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The overall goal of this work is to develop value cases which are:

- Aimed at Health & Wellbeing Boards

And incorporate:

- Service user stories, capturing changes to the service user's journey
- Features of the model, including enablers (e.g. technology initiatives to support the model)
- Costs of the model
- Evidence of benefit, including activity, spend and outcomes.

We recognise that the information contained in the value case may prompt further questions, in which case we recommend you use the contact details at the end of the value case to follow up with a direct contact.

# About integrated care in Greenwich

- Greenwich Integrated Care was launched in April 2011.
- The service is delivered by a collaboration between Greenwich Community Health Services, Oxleas NHS Foundation Trust and Royal Borough of Greenwich Social Care.
- It is open to all adults living in Greenwich with the aim of maintaining independence in the community and preventing unnecessary A&E attendances, hospital and care home admissions and delayed discharges.
- Users and staff access the service via a single point of contact which incorporates the referral pathways and immediately addresses user needs.
- Integrated health and social care teams provide a whole system response to intermediate care, hospital discharge, urgent care, and community rehabilitation.
- All teams have shared access to a re-ablement service.



Joined up  
services  
maximising  
independence

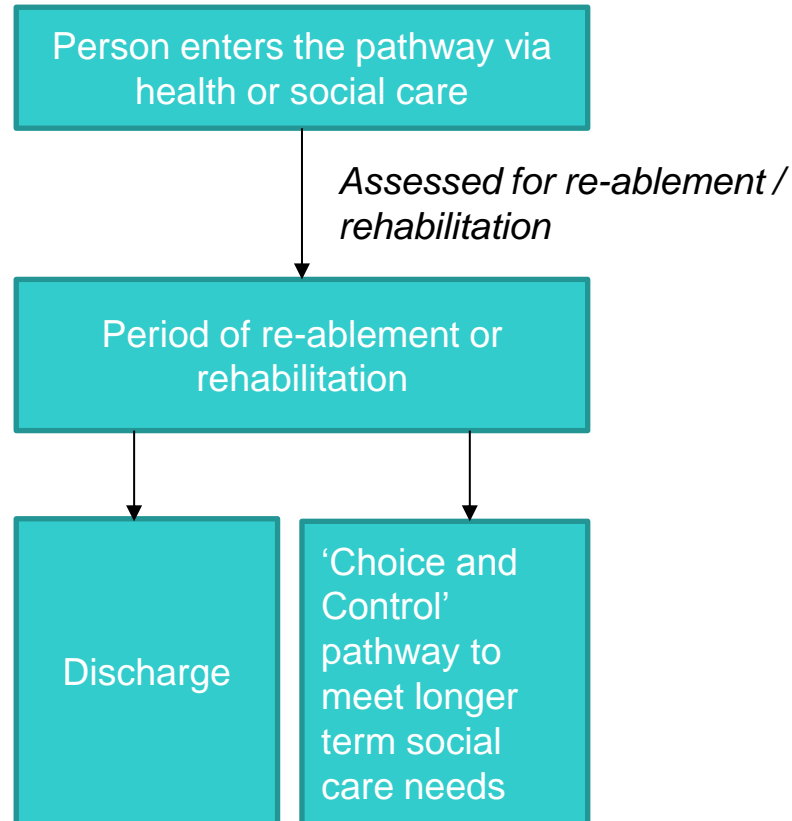


Separate  
services with  
limited access to  
re-ablement

# Greenwich visual model: Vision and teams

## Pathway

Driven by vision of prevention and early intervention



## Integrated teams

### Community Assessment & Rehabilitation Team (CAR)

Up to 6 week rehabilitation and social care linked to and working with home care re-ablement.

### Joint Emergency Team (JET)

Fast immediate responses to prevent hospital admission and urgent social care referrals.

### Hospital Integrated Discharge Team (HID)

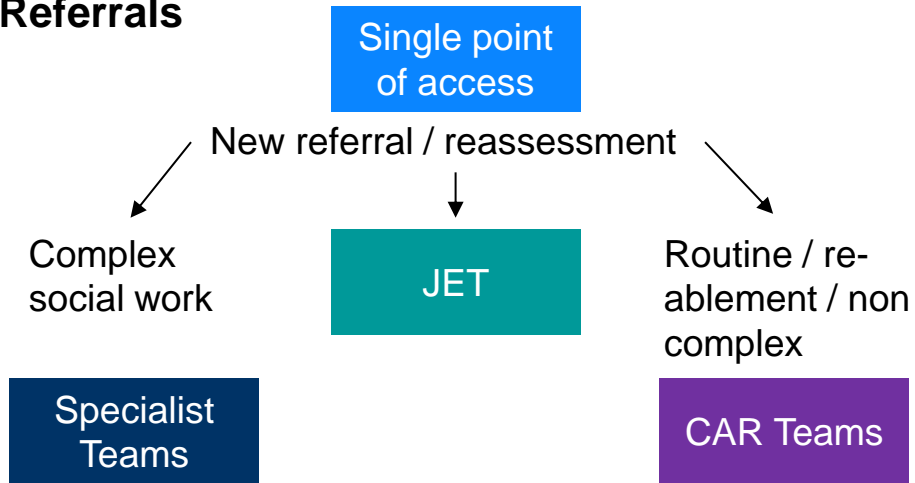
Speedy discharge to intermediate / social care.

## Specialist teams

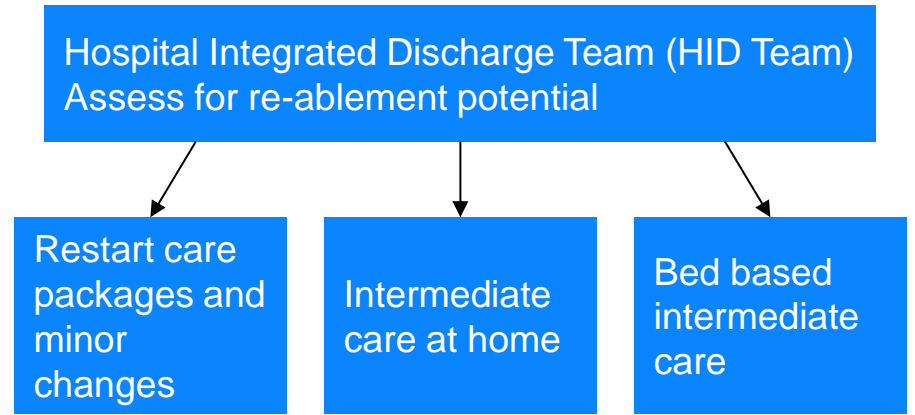
- Social Care OT
- Reviewing Team
- Falls Prevention Team
- Neuro-rehabilitation Team
- Wheelchair Service
- Specialist Social Work (OP/ PD)
- Community Learning Disability Team
- Older People's Mental Health

# Greenwich visual model: Referral and discharge pathways

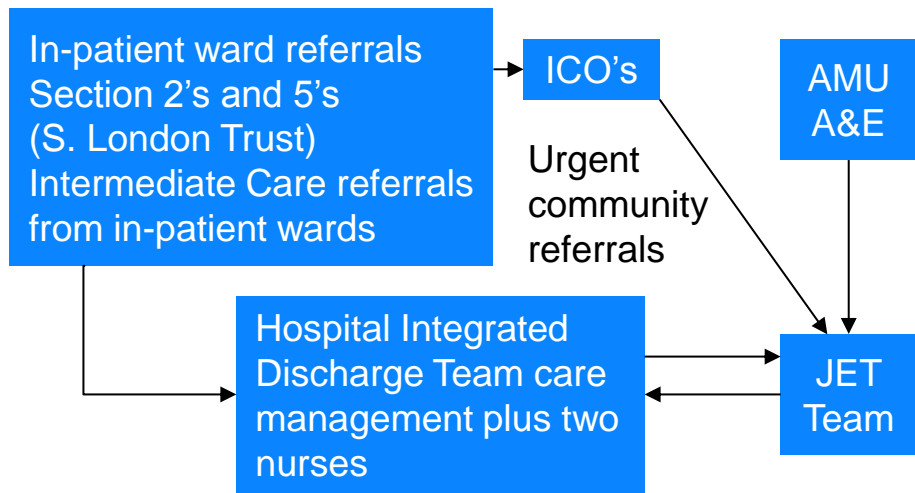
## Referrals



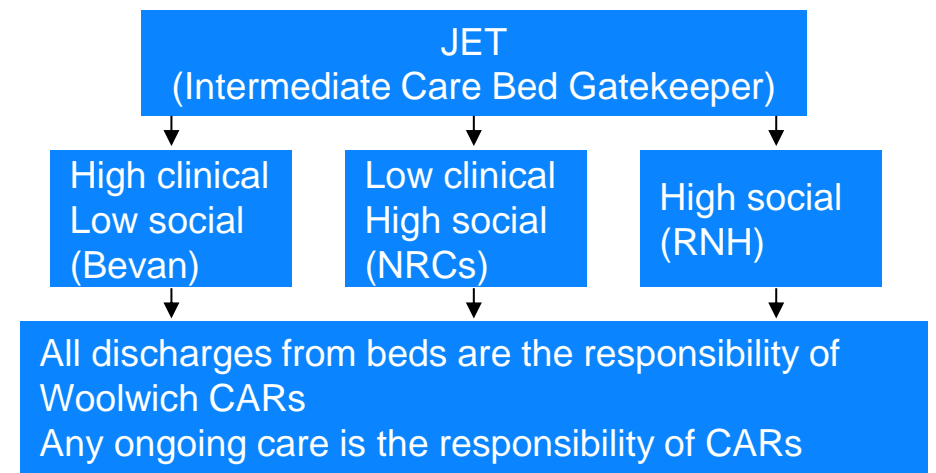
## Hospital Discharges



## Hospital Referrals



## Intermediate Care bed rehabilitation, discharge and follow up



# Outcomes evidenced by Greenwich Integrated Care: What difference does it make?

## User experience

- The elderly population maintain their independence longer.
- More people access universal services and on average, 50% fewer people enter full social care.

## Frontline staff experience

- A formal review demonstrated increased staff satisfaction.
- The changes have positively impacted staff motivation to maximise quality outcomes and efficiency.
- Workforce is more stable, compared to neighbouring authorities.

## Health & wellbeing outcomes

- On average, 64% of people entering the new pathway require no further services after completion of the pathway.
- There are good opportunities for people to regain their independence and become self caring.

## Impact on institutional care

- Reduction in A&E admissions - 147 prevented in Q1 2013 by working with GP's to refer to JET rather than hospital.
- Reduction in hospital admissions - 172 prevented in Q1 2013 by maintaining a presence in A&E and AMU, 8am-8pm, 7 days.
- 7% reduction in admission to care homes per annum.

## Impact on cost

- In the first 12 months, the redesign enabled an immediate 5.5% productivity saving on the health services alone.
- The social care budget was reduced by £900,000.
- Increasing the community interventions avoids the acute tariffs.

## Productivity

- There were no delayed discharges for patients >65, which was accomplished with fewer members of staff than before.
- Reduced LOS in intermediate care when compared to neighbouring authorities and before the pathway was in place.



*“Really quick and effective team that avoids people being admitted to hospital.”*

*“I was helped to regain my independence when I thought I would have to go into care.”*

# How we did it: key enablers

## Governance

- A joint governance board was established for the implementation and monitoring of the integrated care interventions.
- Joint performance management and collective KPIs.

## Workforce development

- From the start, staff at different levels were engaged in developing the final model.
- A change management programme was put in place prior to launch.
- Road shows, newsletters and workshops were organised for all staff.

## Programme design

- The integration was combined with the development of personal budgets.
- Users, carers and staff unions were engaged using a variety of methods including workshops and presentations.
- A neutral party (Institute of Public Care) was brought in to run the programme.

## Legal & contracting models

- An MOU was agreed and signed by all the relevant organisations, including community health and social care.
- There were no other formal arrangements.

## Financial enablers

- No new investment was required.
- Savings were made by:
  - Shared management arrangements thereby reducing the numbers of managers in health and social care.
  - Reduced A&E attendances and care packages etc.



*“To be with our social colleagues as a team has made access easier and we can share information in an informal and productive way.”*

*“Great improvement being co-located with rest of the team. This has improved communication between the teams.”*



# What we did: integrated care design

## Re-ablement service

- This service was remodelled from the in-house provision of domestic care.
- Extended competencies framework training was provided by nurses and therapists, who also work within the team.

## Joint Emergency Team

- This multi-disciplinary team works in A&E, AMU and in the community to prevent LAS call outs and reduce admissions 7 days a week.
- The team maximises use of intermediate care beds and re-ablement services to maintain people in the community.

## Joint Community Assessment and Rehabilitation

- These are joint health and social care teams, with a 'see and sort' approach.
- They provide rehabilitation, social care and manage intermediate care beds.
- GPs have a rapid admission process to JET – the 2 hour target response time has been achieved in 100% of cases.

## Single point of contact

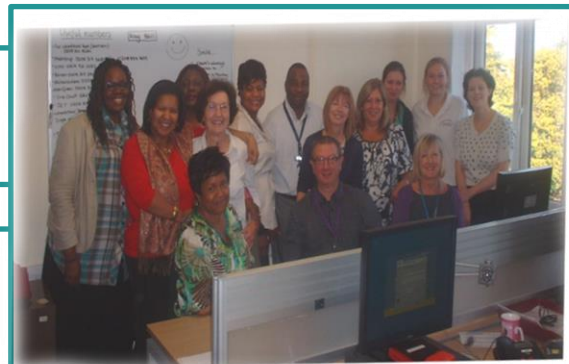
- Users & staff use the 'Council Contact Centre' as the single point of contact which incorporates the referral pathways and immediately addresses user needs via Greenwich's universal offer.

## Hospital Discharge Team

- This joint team facilitates discharge by maximising use of the re-ablement services and intermediate care beds.
- There are no delayed discharges despite it being a smaller team than it was previously.

## Management arrangements

- Where there is a health team manager, there is an assistant manager from social care and vice versa.
- There have been no changes made to the staff employers or contracts.



*“We invested time into developing the new pathway, so now we feel we own it.”*

*“I find it so useful having a social worker sat next to me. We can sort things out quickly and it improves the experience for the service user.”*



# Who we did it for and why

## Users and carers

- The aim was to provide a collaborative and proactive approach to managing people with urgent health and social care needs.
- We wanted to ensure that everyone had the opportunity to maximise their independence and avoid inappropriate admissions.

## Commissioners

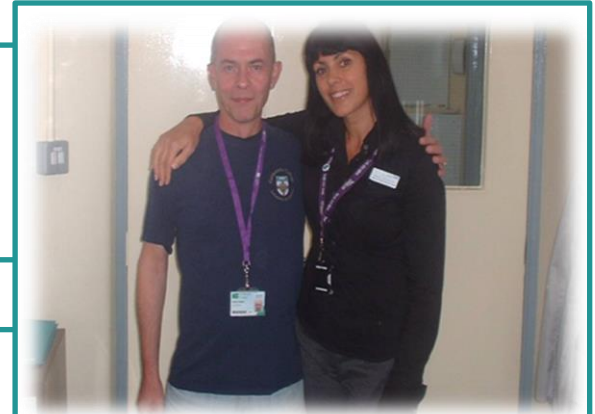
- Greenwich had a very congested health and social care system, with particular issues in the Acute Trust.
- There are significant pressures on all organisations and we wanted to capitalise on the positive outcomes that could be achieved by working together.

## Workforce

- We enabled the workforce to work together and learn from each other.
- By empowering our workforce we increased job satisfaction.

## Creating integrated organisations

- The integration was particularly prompted by the 'Transforming Social Care Agenda' which set councils the task of establishing a more preventative and re-ablement approach within adult social care.
- In bringing the two provider organisations closer together we wanted to maximise outcomes for service users by creating a culture of shared responsibility and understanding of roles. This led to a relationship that was built on trust.
- We wanted to show that improvements could be made by working together to prepare for further integration of services in the future.



*“Working with a lovely bunch of people who really care about the service and our clients and really are working well to make the integration work well. We have worked well together with no feelings of them and us.”*

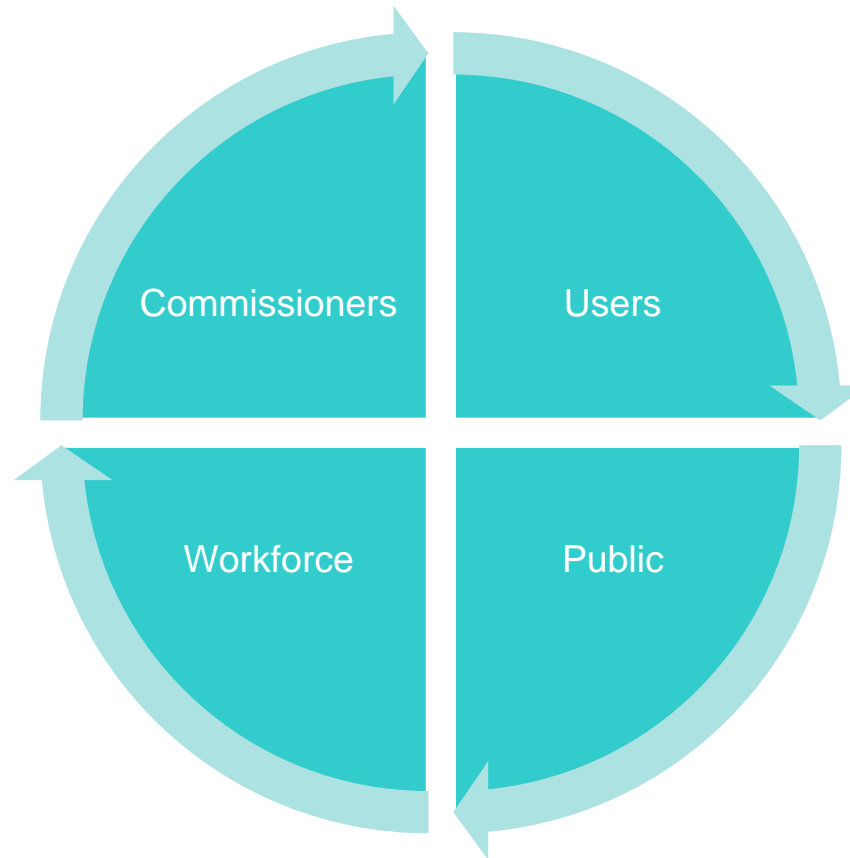
# Benefits

## Benefits

- 147 A&E attendances prevented in Q1 2013
- 172 hospital admissions prevented in Q1 2013
- Shorter LOS in hospital

## Benefits

- Staff development, cultural change, knowledge and skills transfer for all teams
- Increased job satisfaction
- Improving outcomes for people they work for



## Benefits

- Single point of access
- Joined up services
- Prevention and early intervention
- 35% reduction in people going into care since 2011
- Opportunity to maximise independence

## Benefits

- Understand the potential of preventative services
- Maintain people in the community
- Greater sense of community independence

# Lessons learned

## Users and carers

- Many people respond well to a period of re-ablement, enabling them to lead more independent lives.
- The initial point of contact to services is critical to the success of the whole pathway - interactions with people and their families set the tone for any future service and for others it should provide high quality advice, information and signposting.

## Council support

- The Council were fully signed up to the proposals.
- Shared KPIs led to a stronger relationship between organisations.
- A very positive relationship developed between the Council and the health commissioners.

## Capacity and workload

- The numbers being referred for re-ablement are much greater than was originally modelled for the 'go live', almost twice as many. This has resulted in changes being made to increase their capacity by using the services of external agencies and additional staffing.

## Finance

- There are no pooled budgets.
- Staff are trained to access resources from both organisations responsibly.

## Workforce and protocols

- We did not create new roles (except in management) or change people's employers and this led to a smoother process of change.
- We spent time allowing people to understand each others roles.
- When the new pathway did present challenges, the integration board was able to act as a change agent to resolve this.



*“Very useful team, quick response, effective.”*

*“The joint working has been brilliant, lots of preventative work, enabling independent living to continue for many, reducing hospital admissions. It is now much easier and quicker to access health professionals.”*

# Contact details

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