

Greenwich Pioneer Programme – Profile

1.1 What is your area like?

Royal Greenwich is a borough of contrasts, with an ethnically and culturally diverse population of 260,000. Pockets of relative affluence, largely associated with the borough's royal and maritime heritage, co-exist with areas of entrenched deprivation, the legacy of industrial decline in the decades following the Second World War. There have been recent improvements but life expectancy is 78.5 years for men against an England average of 79.2 and 82.2 years for women, against an England average of 83.0.

While Greenwich is the 19th most deprived borough in England, over the past 10 to 15 years new investment in physical regeneration, including housing and transport infrastructure, has significantly improved the prospects for economic growth in the borough and considerable inroads have been made in helping people access employment; however there is still significant inequality and poverty in the borough.

The demographic composition of the borough makes equal and easy access to health and social care services an absolute priority and services must be delivered in acceptable ways for Greenwich's multi-ethnic community

The Greenwich Health and Well-Being Strategy identifies three key imperatives; a focus on prevention as the most cost effective approach to health and wellbeing; the need for new approaches to tackling health inequalities and greater integration in the commissioning and delivery of local services.

The partners involved in this programme are:

- The Royal Borough of Greenwich
- NHS Greenwich Clinical Commissioning Group
- Oxleas NHS Foundation Trust (community health, mental health and learning disability services)
- Greenwich Action for Voluntary Services
- Local Healthwatch
- Lewisham and Greenwich NHS Trust
- Greenwich NHS General Practices

Together these organisations constitute Greenwich Co-ordinated Care (GCC). Our programme of integration is overseen by a project board with representation from all the partners.

1.2 What are you aiming to achieve?

GCC aims to build on three years of prior work to integrate health and social care services. Our established integrated teams (see below) were delivering excellent support to people with acute problems or rehabilitation needs in the community. But they were not addressing the needs of a relatively small group of people with on-going complex health, care and other needs

Greenwich Co-ordinated Care takes the need of individuals as its starting point and embeds a truly person-centre approach in the development and delivery of care plans. We have used local consultation and the work of National Voices to identify what matters most to local people to help shape our vision. They have told us that they want:

- Information about help and support to be more widely available and GPs and other health and social care staff to be better informed about community services
- People who are vulnerable and isolated to be looked after with a strengthened 'human touch' and more psychological support
- Services to be moved from hospitals into the community with agencies working closely together to join up services

We will know that our integrated care system is working effectively when:

- The core team sees itself as responsible for the ongoing treatment, care and support of their population, focusing on intervening early to prevent an escalation in health or social care needs
- The concept of 'discharge back to primary care' is replaced with the expectation of the lifetime management of people's health and social care needs
- People are helped to manage their condition through self-management programmes
- Cluster teams know their patch well and use their local community and voluntary sector resources
- Cluster teams take pride in supporting their population to remain fully engaged, happy citizens

1.3 What have been the highlights of your first year?

We had already developed a vision and begun to implement a plan for co-ordinated care in the year before the Integrated Care Pioneers Programme began. The Royal Borough of Greenwich and Oxleas NHS Foundation Trust had reorganised their rapid response and intermediate care services into integrated health and social care teams. A clear service user pathway was agreed with an emphasis on enabling people, wherever possible, to maximise their independence. The redesigned pathway included the shared use of 52 NHS intermediate care beds and an in-house social care reablement service. We had introduced a single point of access, a joint emergency team to reduce the need for hospital admission, a hospital intervention discharge team and three community assessment and rehabilitation teams. We knew that this model reduced hospital admissions and length of stays, the numbers of long-term care placements and the need for social care packages.

During the first year of the pioneers programme, we built on this model by:

- Extending our integration of rapid response and intermediate care services into integrated health and social care teams to selected residents with complex health and social care needs in two areas of the borough, with plans to extend this model to the whole borough

- Introducing a care navigator role to co-ordinate multi-disciplinary care planning and joint care plans
- Ensuring that mental health services are involved as a central aspect of our approach
- Ensuring that the voluntary and community sector and other key services such as housing are an integral part of the model
- Preparing to retender local authority home care services on a geographical basis that will align with GCC. See case study: [Building the team around the person](#)

1.4 Details of the year

In this second phase of integration which forms the first year of our pioneer work, we have utilised recent research which shows that many people with long-term conditions also have mental health problems, leading to significantly poorer health outcomes and reduced quality of life. We also know that people with serious mental illness have significantly reduced life expectancy and poor physical health. We have redesigned local mental health care pathways so that they can be delivered within the new integrated structure. The full involvement of our mental health services is now a key feature of our work. Individualised care planning has been at the heart of our mental health services for over a decade. We know how to deliver person-centred care.

We have built on our existing health and social care integrated teams developed in phase one prior to the pioneer programme, to ensure that people with complex needs are now also able to benefit from better coordinated care. This includes older people with multiple long-term conditions alongside younger people with physical and mental health problems, drug and alcohol problems and sometimes also housing and financial problems. See case study: [Co-ordinated care – a patient's story](#).

Local services aligned around clusters of GP practices are viewed as 'communities of practice', grouping patients and service users according to their level of risk of deteriorating health and increasing need for services (risk stratification). Those at most risk are intensively supported for a time limited period by a care navigator.

Greenwich Council is preparing to retender its home care service so that providers align with the span of the clusters and core teams. This will enable co-ordinated care teams to work closely with their local home care providers to develop person-centred approaches to care.

Staff have developed their understanding of how they can support people with the most complex needs and have learned more about each organisation's services, including the services offered by multiple voluntary and community organisations. Staff have also learned a new way of talking as part of the Greenwich approach – not "I'll make a referral" but "I'll talk with my colleagues".

1.5 What has been the most exciting aspect?

We enable care planning for each individual that is absolutely centred around the individual's needs and priorities which they themselves have identified, using

personal 'I statements'. The fact that many different services and specialists are involved in our co-ordinated care approach means that people can expect to have attention paid to the things that make them feel better, not just what someone else thinks they need. For example, one individual said that having a downstairs shower so that they could feel clean would make them feel less depressed and more able to cope, whereas in contrast their GP perceived that treatment for their diabetes was their greatest need. The co-ordinated care approach can provide both the shower and the treatment and that is incredibly satisfying.

1.6 What has been the most challenging aspect?

It has not been easy to bring together all the different professional groups to engage with each other and change their professional behaviours to work in a more integrated way, but we had fantastic commonality of purpose and commitment from senior executive in local government, the community trust and commissioners. This meant we had support to work on creating a common vision and purpose.

1.7 What are you planning to do next year?

- Continue to extend our model of integrated care across the borough and adapt the 'test and learn' project into a 2-year project that will enable us to continue with a flexible delivery model. This is expected this to be in place by summer 2015
- An evaluation of the Eltham test and learn project will be completed later in the spring and will report on the impact on use of acute and community services before and after involvement with GCC

We have developed a set of criteria against which to evaluate our success. We are working with local Healthwatch to evaluate people's experience of how GCC has affected the support they receive and their experience. We are also working the public health colleagues to calculate the impact of the new model in terms of the cost of providing care, the processes we have developed and their subsequent outcomes.

1.8 What is your advice for areas starting on their own integration journey?

Develop a common language and understanding across the health and social care community. How we communicate and translate our vision to all the different stakeholders has been an important part of our communication and engagement strategy. Key to this has been developing a common language across all the different disciplines. For example, where appropriate we refer to patients and services users as 'people we care for and support'.

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.

We developed shared critical success factors and we believe that these have led to a stronger relationship between organisations.

We have learned the importance of integrating mental health services with physical health services and social care and of involving other services such as housing and the voluntary sector where these will meet the priorities identified by individuals in their care plans.

Investing time and effort in creating a sense of common endeavour among frontline staff has really paid off. We held workshops from the beginning, engaging staff from across health and social care. Once people had undergone the catharsis of expressing their views on each other's service, they began to discuss how to improve them collaboratively. We took an action learning approach with professional support. We did not create new roles (except in management) or change people's employers and this led to a smoother process of change. We spend time allowing people to understand each other's roles.

We have had strong leadership and commitment from our project board. When the new pathway did present challenges, the integration board was able to act as a change agent to resolve this.

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