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Title – Introducing Community Integrated Nursing Teams – How One Clinical Commissioning Group Applied an Evidence Based Approach

Introduction

The NHS is undergoing the most ambitious reforms in its history, during a period of immense funding pressures and increasing demographic burden. As a result, the effective delivery of integrated care is vital, connecting primary, community and social care services. A principle aim of the UK government is to provide integrated healthcare services near to where people live (Coulter et al, 2013).

The Health and Social Care Act established Clinical Commissioning Groups (CCGs) whose responsibility it is for influencing the delivery and assurance of clinically and cost effective healthcare services. This includes the shaping of integrated models of delivery with improved clinical outcomes, the Holy Grail of integrated care. Shaw et al (2011: 4) defines integrated care as, ‘an organising principle for care delivery to improve patient care and experience through improved co-ordination’.

The Five Year Forward View (DH, 2014) highlights the challenges faced by both health and social care organisations and effectively recommends a more integrated approach to the delivery of healthcare. Subsequently, across England 44 STPs (Sustainability and Transformation Plans) have been devised and a number of these are driving a move towards Accountable Care Organisations where providers and in some cases commissioners of health and social care are merging into one body. Community based clinical services, often nurse led are key to supporting the delivery of healthcare at or closer to patient’s homes and although they already work in partnership with acute services, primary care and social care, a more collaborative and integrated

model of working is advocated for these teams (Primary Care Workforce Commission, 2015).

NHS St Helen's CCG is a membership organisation of 35 GP practices and serves a registered population of 197,000. There are many health and social care challenges in the Borough related to socio-economic variations and inequalities and if current health and social care services continue to operate locally as they do now there will not be the resources over the next three years to fund the demand. Consequently, in 2015 the CCG embarked on a large piece of work to review existing community services with the aim of influencing sustainable health and social care for St Helens. The aim of this paper is to describe how St. Helens CCG used an evidence based approach to review and re-design local clinical services in order to initiate the longer term plan of integrated health and social care services.

The Case for Change

The CCG undertook an extensive review of existing clinical services in partnership with their current providers from community nursing services, therapy and acute care and held engagement sessions with frontline clinical staff, patients and carers. The review identified how clinical services could be more unified, moving towards a more integrated model for community nursing and alignment with social care. The CCG also recognised that successful outcomes would depend on the CCG implementation an evidence-based approach and acquiring knowledge from both national and international experiences.

Enablers for success – Learning from the Evidence

There are lessons to be learned from an international perspective in relation to integrated healthcare models as they are not a new phenomenon (West, 2013). This has been particularly evident in relation to the management of long term conditions and care of the elderly (European Observatory, 2012) with Kaiser Permanente and Geisinger in the United States providing insight and ideas for models of care.

There appears to be a lack of consensus to the best method for accomplishing effective, integrated healthcare services although it has been concluded that they need to develop within the perspectives of the local population where there is high deprivation and complex social needs (Zakaria, 2015). However, a report for the Nuffield Trust by Shaw, Rosen and Rumbold (2011) suggests that integrated health care requires a multi-layered approach to identify integration in terms of policy, values, culture, governance, relationships and patient centred approaches.

The following section considers the evidence when establishing effective healthcare integration and it discusses how St Helens CCG applied the evidence.

Location

There is little evidence about what works in terms of community based alternatives to hospital admission (Purdy & others, 2010c). However, a systematic review of the literature on the integration of health and social care by Mackie and Darvill (2016) identified that co-location of staff during the development of integrated teams was essential for fostering effective relationships. Similarly, Ling (2012) recognised that when members of a team work face to face communication is more effective as well as leading to a greater understanding of job roles and responsibilities. Co-location of staff, and enhanced communication appears from the literature to be significantly linked to successful, integrated working (Mackie and Darvill 2016). In St Helens only

a small number of community nursing teams have been co-located with primary care teams (GP Practices) but where they were joined up, working and effective communication appeared more evident. Feedback from GPs suggested that they wanted a closer working relationship with community nurses and as a consequence, in the newly designed community nursing service teams will be 'wrapped around' local GP practices across 3 localities in St Helens with the aim of facilitating more face to face communication.

Leadership and Management

In a study by Coupe (2013) leadership and management support was identified as crucial for the efficacious implementation of integrated care. The study acknowledged that although the change to integrated care was organisationally driven, for the teams involved to be effective they needed to concur with the expectations and endorse the new way of working. This is further supported by Zakaria (2015) who described a number of British Heart Foundation pilot sites which vertically integrated care across primary, community and acute services. The evaluation of these pilots suggested that a major factor in their success was the determination, energy and clinical leadership of those bringing different practitioners and specialist services together with a shared vision of improving patient outcomes. St Helen's CCG, using engagement events with clinicians including community nurses identified the need for more senior clinical nurses in community nursing teams and they are now establishing this early in the integration process to strengthen sustainability.

A systematic review by Greenhalgh et al (2004) identified the significance of certain features like understanding the values of individuals involved in health service redesign. This aligns with assumptions from the theoretical knowledge base within the

social movement which proposes that for service redesign to be sustainable over the long term, those involved need to understand and acknowledge why such change is taking place (Bibby et al, 2009).

There are numerous examples of integrated care models currently being piloted in the UK including managed clinical networks, care trusts and Whole Systems Integrated Care (WSIC) programmes. Initial evaluation of these have suggested that their success has been attributed to sound, effective management, leadership and governance structures. However, it has been noted that within these programmes, when there was a change of leadership or an alteration in the management arrangements the integration process was somewhat weakened and the credibility of the process reduced with those clinical staff involved (Erens et al, 2015).

Coupe (2013) also suggested that as it takes between 3-5 years for integrated team working to reach its full potential, sustained leadership and management support is essential. In other words, a long term pledge from senior managers that infrastructures will be sustained beyond the embedding period. Literature has highlighted that large scale change or health service redesign initiatives often begin with positivity and energy but as the project progresses, delays and obstructions hinder implementation resulting in resistance from those staff experiencing the change (Bardsley et al, 2013). Managing this hostility insists Timmins (2015) requires a specific type of leadership from those managing the process as they have to be comfortable in accepting times of chaos and turmoil.

The work undertaken in St Helens has been led by their Chief Nurse as part of a long term, strategic plan in the Borough to move to health and social care integrated working and facilitate collaborative innovative working with other key agencies such

as housing, police, fire and the 3rd sector. A key objective for the Chief Nurse will be to oversee implementation of the new community nursing services to ensure strong clinical leadership is sustained.

Outcomes and Measuring Success

Evaluation of 16 community based pilot sites all implementing integrated models of healthcare (Ling et al, 2010) found evidence that integrated care interventions did result in improved processes including changes in the roles of clinical staff but there was no indication of a reduction in emergency hospital admissions. However, the evaluations did demonstrate some fall in the number of planned admissions and in patient's attendance at outpatient appointments attributed to the effective use of multidisciplinary healthcare teams.

Similarly, evaluations of virtual wards, a model of co-ordinating community based, healthcare teams for the management of long term conditions has provided no evidence of a decrease in emergency hospital admissions (Lewis et al, 2011) although they resulted in a reduction in planned and elective admissions. There didn't appear to be any specific reason for this although it was attributed to insufficient numbers in patients included in the evaluation in order to determine the significant effects of virtual wards as an effective intervention. According to Goodwin and Smith (2011) evaluating the implementation of integrated services may not need evaluations that begin at day one as the early stages may not reflect the long term outcomes. Rather, they suggest some 'light' observation with formative monitoring in order to provide ongoing feedback which can inspire staff, influence progress and shape objectives.

To try and ensure the new model of community nursing services impact on key outcomes such as a reduction in acute hospital admissions and re-admissions St

Helen's CCG have tied this into the contractual arrangements so there is a financial incentive to impact on outcomes and this will be closely monitored as the new service is implemented.

A Patient Centred Approach

In addition to service level changes, in considering emergency admissions as an outcome measure requires that health professionals are able to assess patient need in a holistic manner in order to prevent admission. This is important to deal with what Tee & Bockle (2012: 824) refer to as 'real world complexity'. Long term conditions provide substantial challenges for patients and their carers and are often associated with poverty and a deteriorating mental health status (McVeigh, 2016). This can be exacerbated by services that are disease orientated rather than patient centred (Procter et al 2013) and in addition do not cater for people with several long term conditions. To address this, assessment ought to incorporate the influence of the psychological, emotional and social burden that long term conditions can have upon patients. In a systematic review exploring the link between depression and access to urgent care it was found that patients with depression were more likely to access urgent care (Dickens et al 2012). Also, Hill et al (2014) found in a study on patient perception of continuity of care in the community that the frequency and duration of healthcare contact was also affected by emotional factors. Despite this link, health care professionals are not always able to assess and support people with such challenges (Tee & Bockle 2012) and patients report that they need to be in a state of crisis before access to mental health services is granted (Ross et al 2014). St Helen's CCG have acknowledged the need to address the challenges associated with managing complex, long term conditions and a key goal of the new integrated,

community nursing teams will be to ensure a collaborative approach to meeting an individual's needs efficiently.

Patient and Service User Involvement

Significantly, the inclusion of patients, their carers and service users within WSIC programmes has been a prominent feature associated with their success (Erens et al, 2015). This initiative as part of the integration of services involved lay partners both challenging and raising concerns with those leading the redesign but in turn it appeared that they also act as advocates for the change, championing it within their communities. Clinicians have often thought to have had concerns about failing to meet patient expectations when resources are limited and expectations from patients are considered to be unachievable (Swansberg and Swansberg, 2002). St Helen's CCG through a number of forums have engaged with clinicians, patients and carers who have influenced the design of the new services.

Legislation has had an important role in influencing public engagement, supported by complaints systems that measure the patient's experience. In response to this, policy has increasingly utilised patient participation to improve trust in public services (Naidoo and Wills, 2015). Experience based design, is being used more widely it seems throughout the NHS in order to guide service redesign and improve patient care (Meroni and Sangiorgi, 2011). Ways of doing this include patients, carers and clinicians working together as equal partners and stakeholders in determining how clinical services should be delivered.

There is limited literature available that concentrates on patient or user involvement in service design, however, what is clear within the available evidence is that patient and service user involvement rarely moves beyond the consultation phase (Tzanidaki,

2012). Despite this in a study exploring service user engagement in the development of stroke services at the consultation phase, engagement and partnering with patients was found to create a more patient centred service and one that leads to improved sustainability (Jones et al 2008). Moreover, when budgets are under increased pressure partnering or consulting with service users can inform clinical services what the main priorities for patients are (Obarski et al 2015).

There is a strong case for involving patients in the design level to promote patient centred care however, the challenge remains that what patients report as subjective experience cannot always be interpreted objectively (Lord and Gale 2014). Evidence suggests that prior attempts to improve patient and family engagement through processes such as the application of Lean methodologies (Wickramasinghe, 2014) and Patient and Family Centred Care Methodology and Practice have had success in putting patients at the centre of service delivery (DiGioia et al 2015). St Helen's CCG have recognised the long term commitment required for partnership working with the setting up of working groups and regular engagement, and in doing so have established cycles of learning rather than one off results.

Evaluation

Over recent years evidence has suggested that integrated healthcare provided in the community is more cost effective and reduces the need to admit people into hospital (Ham and Curry, 2011). Wolfe and McKee (2013) have challenged this suggesting that although the potential is there to make significant impact on the delivery of healthcare services, studies and evaluations on such interventions are concluded too soon without the long term benefits being clearly defined. No clear evidence of reduced emergency hospital admissions exists (D'Souza and Guptha, 2013) although

it would appear that there is a positive impact on patient experience and the management of care (Coupe, 2013).

There is evidence that sufficient time needs to be allowed to demonstrate the impact of large scale change (Best, 2012; McNulty and Ferlie, 2002) especially in relation to cost savings as there is often pressure with initiatives to demonstrate positive outcomes in relation to cost quickly. The realisation that integrated teams take years to become effective is also clear (Wolfe and McKee, 2012) with redesign initiatives requiring a 'bedding in' period before any large scale evaluation happens. This is consonant with what Best et al (2012) considered essential for initiating large scale change in healthcare. Key to any evaluation has to be the length of time needed to demonstrate significant and sustainable impact (Duncan, 2014).

In relation to empirical evidence there is a clear need for robust, longitudinal studies, (Bowling, 2014) in order to implement evidence based models at scale across healthcare environments and so making a substantial contribution to improved patient outcomes. Similarly, it is clear that there exists a need to being explicit in terms of evidence of what is not working and why it is ineffective.

Evidence of success may be not merely the reduction in hospital admissions but more clinically focused measures such as symptom control and patient reported measures, like patient experiences, and the judgement of staff and clinicians. An important message from the literature appears to be that contextual factors are important to acknowledge in the implementation of integrated healthcare (Duncan, 2014). These include things like changes in the providers of local health services, demographic changes and the amendments to national health policy.

It is important to consider how many participants are needed in any evaluation to demonstrate positive results and decide on the metrics used as well as contemplating a mixed method research approach that monitors the process of implementation as well as measuring the outcomes (Bardsley et al, 2013; Goodwin, 2011).

NHS St Helens CCG are very aware of the need to evaluate the impact of these new services but also of the findings from previous work that this needs to be a systematic and longitudinal evaluation and it is planning for a systematic evaluation with the support of Liverpool John Moore's University.

Conclusions

There is a significant impetus across both the health and social care system presently to move towards models of formal integration because of the demands on services and the need to find an affordable and sustainable solution for health and social care. It is clear from the evidence that there are many potential patient and staff benefits to integrated working but there are key factors to success outlined in this paper that must be recognised and used to ensure success. The work undertaken in St Helens has used evidence to underpin both the design of and the creation of new service specifications and the review itself has been a collaborative piece of work between the CCG and Local Authority. It is anticipated that this will be a further critical factor in the successful implementation and long term impact of the new out of hospital nursing services for the population of St Helens.

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