Integrating Health and Social Care
In NHS Somerset & Somerset County Council

Background

Somerset, like the rest of the UK, is acutely aware of its increasing older population. And like the rest of the UK both health and council budgets are under severe pressure. They are also aware that the current systems aren’t perfect, no one’s are, but they decided to take action and explore ways of improving outcomes for people through integrating frontline health and social care in a whole systems approach.

Somerset NHS and Somerset County Council are responsible for over half a million residents, just over 5% of which are being cared for by Somerset County Council’s Adult Care Services. They put Taunton, one of their highest areas of health and social need, under the microscope to determine what could be done. They then engaged Vanguard consultants, who are running a number of similar projects across the country, to help them make their ambitions a reality.

Why change is needed

When people think of health and health care, it is often hospitals that spring to mind. However, the great majority of people do not need hospital care in any given year. Over 90% of all contact with the NHS takes place outside hospital in people’s homes and in other community settings.

Effective and efficient community rehabilitation services aim to support people to stay healthy and ensure people can live as independently as possible and for as long as possible within their own homes, and to have the best possible outcomes in terms of quality of life.

However, primary and community care must evolve to meet changing circumstances. Advances in treatment are allowing more care to be provided in local communities, people are living longer and we are facing greater public health challenges from obesity and other ‘lifestyle diseases’.

Historical approaches to reablement are scattered across the NHS and social care organisations where staff all work hard in their functional islands. They ‘assess’ patients, ‘treat’ them and if necessary refer them onto other appropriate services, often not knowing whether other interventions are successful.

Many of these people continue to present at GP surgeries, A&E, outpatients and social care services despite numerous interventions by health and social care staff. Each intervention has its associated costs in time and money.
The growing levels and pressures of these acute needs cases have obliged many overstretched services to focus primarily on them. The lower needs cases are pushed aside and we get caught in a never ending cycle of fire fighting problems instead of investing in preventing their occurrence or escalation.

So how do we break out of this cycle? It is believed that by returning to a focus on the individual as a whole person, rather than a collection of issues to be isolated, detached and dealt with separately, we can achieve smarter, simpler and above all more effective solutions. In order to make this work we need an integrated multidisciplinary approach. That’s not a simple matter to make a reality on the ground but so far we have found that if approached with care and support it is both achievable and worth it.

**The change process and its results**

Detailed analysis of patient journeys through the system proved particularly helpful in understanding what was happening to people over time, how the system was intervening in their lives and their experiences and outcomes.

To test the level of need 5 patients were followed in a detailed analysis over a two year period. Over this time, there were a total of 71 GP contacts, and 20 hospital admissions of which 70% were for non-medical reasons. These 5 patients used a total of 415 bed days over this period and despite the fact that all of them wanted to remain in their own homes, the outcomes were as follows:

- Three of these service users are currently in residential care.
- One service user has 24/7 care at home.
- One service user has died.

This evidence convinced those involved that there was a justified need for change and great potential for improvement. Vanguard was engaged to assist with a pilot to integrate frontline health and social services. Vanguard consultants Fiona Catcher and David Chesters devoted themselves to the project.

An integrated team was formed consisting of:

- One GP surgery, including the District Nurse, Pharmacist and Community Matron
- A single telephone number for referrals
- An Integrated Support Service team with five team members (Health Occupational Therapist, Health Physiotherapist, Adult Social Care Occupational Therapist, Social Worker, Care Worker Supervisor)

It operated on the principle of one key worker per patient, simple paperwork and minimum criteria (over 18 and GP registered).

It was named the ‘Integrated Support Service’ (ISS).
The aim of the ISS would be to provide a simpler, more effective and more cost efficient service. It focused on reablement: supporting people in their desire to remain independent in their own homes, helping them to avoid medicalised and care solutions that fostered dependence and to regain life skills and control.

The test ran for 5 months. Results were positive and a further 15 GP surgeries were rolled in over the following 6 months with the creation of 5 more ISS teams.

A study of the first 120 people to be supported by the ISS showed the following results. 38% were referrals to support hospital discharge and 62% were referrals from the community.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced length of stay in hospital</td>
<td>26</td>
</tr>
<tr>
<td>Prevented admission to hospital</td>
<td>12</td>
</tr>
<tr>
<td>Reduced package of care</td>
<td>18</td>
</tr>
<tr>
<td>Prevented package of care</td>
<td>27</td>
</tr>
<tr>
<td>Prevented admission to care home</td>
<td>7</td>
</tr>
<tr>
<td>Reduced carer strain / prevented breakdown</td>
<td>10</td>
</tr>
<tr>
<td>Prevented provision of equipment</td>
<td>16</td>
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</tbody>
</table>

In summary 116 outcomes out of the 120 referrals (97%) resulted in reduced support needs after ISS team intervention. In addition the reablement group also had significantly better outcomes for 30-day re-admissions and social care costs when comparing the change between those at one year prior to intervention and three months post intervention.

The qualitative evaluation of the pilot has shown very positive results from service users, staff and clinicians. The responsiveness of the service and the focus on individual need is very much welcomed and is considered to have resulted in an improved quality of service provided to individuals and overall, an increase in staff motivation and satisfaction.

The main challenges to existing thinking

Culture change

Health staff are focused on the physical body. Social workers and carers are focused on function skills and the service user’s environment, family and community. Such different cultures and foci take time to integrate and time had to be deliberately taken by staff to appreciate the values of different skills and strategies working together. There was also a natural dependency on known processes and ways of thinking and working. These needed to be overcome and replaced with a realisation that staff could use their experience and skills to make decisions for themselves and help people immediately and directly. For some this was outside their comfort zone and project managers worked to support everyone in embracing change.
Staff liked the new model. Some social care staff described it as ‘old fashioned social work’ and were enabled to do preventative work instead of only being able to focus on those already at the stage of critical need. The results of their work were visible and positive but they found the process of removing the barriers to integration slow and frustrating.

One example was communication and information sharing. For staff on the ISS teams, being able to have a simple conversation with colleagues about a service users needs rather than writing to them in a referral letter was not only faster, but also a much more effective form of communication. Recording information for organisational sharing was another matter. Having differing IT and governance systems across the health and social services was a barrier which both partner organisations had to work to overcome, with the systems not even having an identification number for individuals in common.

**New thinking about cost**

In service organisations, the majority of cost is in the time of professionals. The plausible logic is that if we can control that amount of time then we will save money.

This manifests itself in the system as a focus on productivity and the length of transactions. For example: eight minute GP appointments in the surgery, 12 minute average handling time targets over the phone at the call centre and kitchen assessments in the hospital kitchen rather than in service users’ homes.

The consequence for performance is that the service user has to repeat him or herself, feels passed around and will often re-present repeatedly in the system because their real problem still hasn’t been understood or solved.

*Alternative Principle – Design to Understand*

For those service users with non-straightforward issues, this might mean taking more time and going to their own environment. When this is done we learn that the presenting problem is quite often not the actual problem. Frontline workers can then build solutions to address the cause of the problem, rather than transact with the symptoms.

The consequence for performance is that the service user receives help for their actual problem, decline is avoided and the system saves on expensive support.

**The problem with functional design**

The logic here is that if everyone is given a smaller part of the process then they will become very good at doing that bit and the overall speed and quality will improve. However, what this actually leads to is functional islands of help with many hand-offs, over-specification, duplication and re-work.

The consequences are frustration for the service users, staff being denied seeing the end result of their labours and extra costs for the organisation.

[www.systemsthinkingmethod.com](http://www.systemsthinkingmethod.com)
Alternative Principle – Retain Ownership and Pull Support

In the new model a key-worker is selected and they then have responsibility for the service user and will pull for help if the problem is not one they can solve on their own, rather than referring on to another professional to begin the process of understanding afresh.

The service user establishes a relationship and trust, and the system can design a service user-shaped solution which can develop as they do. Staff get to know the people they are helping and can see their progress. Although the professional might spend more time with the service user, the system spends less time and money overall.

A personal story

A simple example of the difference between the old and new systems would be the case of Mrs D.

Under the old system Mrs D had been falling a lot and presenting to health services with resultant injuries. She had been referred to a falls clinic but the clinic was in a community hospital miles away from her house and she had no transport to get there. The falls clinic also only accepted new participants on an 8 week cycle, which she had just missed, so assuming she could get transport somehow it would be another 7 weeks before she was seen. Meanwhile she continued to fall.

The new ISS team simply went into her home and asked her why she was falling.

It turned out she was fond of fresh air but couldn’t reach the small vents at the top of her widows to open and close them so was standing on a wobbly pouffe to reach them morning and night and inevitably, given her age and slight infirmity, falling frequently.

The team gave her a long armed grabber she could use to open the window from ground level. She stopped falling.

Costs

Ina recent BBC 4 interview following the success of the project Anne Anderson, Deputy Director of Strategic Development at NHS Somerset was asked about the extra time frontline staff were taking with service users and wasn’t it costing more?

“These aren’t new teams over and above what’s there existing. This is about redesigning what we’ve currently got to make it work better. So it is costing us a little bit more money up front because we’re spending a little bit more time understanding what the real issues are, but what we’re seeing already is that if we get it right first time then it’s costing us less down the line. And also the outcomes for the service user are so much better. It’s reducing the admissions to hospital and reducing the admissions to long term care as well and people don’t want to go into long term care, they want to stay in their own homes.”
Conclusion

- Building relationships and understanding what ‘a good life’ is from the perspective of the individual, rather than ‘pushing’ standard services, products, processes and commodities, is key to helping them solve their real problems.

- The more we standardise and functionalise services the less we understand what matters to people and the less able we are to help them.

- Putting more resources and expertise at the beginning of the process delivers better outcomes and savings over time.

- People shaped solutions are often simpler, more effective and cost less than service shaped solutions.

The fiscal and societal benefits of providing a much stronger focus on frontline preventive care and of intervening at much earlier stages to prevent situations worsening have been clear for a while. But how to achieve this in the complicated world of multiple agencies, departments and budgets is another question. We believe this pilot shows a way.

Since May 2011 the pilot scheme has helped over 750 people. The decision has now been made to roll out the new service across the county from 2012 onwards. Early adopter GP practices are already reporting a reduction in emergency admissions for the over 65s.

Further Resources

An in depth study of this service transformation will be available in John Seddon’s forthcoming book ‘Delivering Public Services That Work: Volume 2’ which will be available from Triarchy Press within the next few months.

A recording of the BBC 4 radio coverage can be found here: http://goo.gl/ZoPIW

To contact Vanguard Scotland Ltd about service issues you might like to work with us on please call 0131 440 2600 or email office@vanguardscotland.co.uk