Final report

April 2018

Innovating for Improvement

- Specialist Lower Limb Wound Clinics
- OT Integration
- Health Coaching / Patient Activation
- Implementing the Buurtzorg Principles

Southern Health Foundation Trust

The Health Foundation

About the project

Project title:

Project to facilitate new models of care within Integrated Community Services

Lead organisation:

Southern Health Foundation Trust

Partner organisation(s):

Hampshire County Council
BSN Medical Ltd
Totton Health Centre
One Community Voluntary Services
South Central Ambulance Service (SCAS)

Project lead(s):

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Part 1: Abstract

Our focus has centred around four innovative projects within our Integrated Community Teams; These include Specialist Wound Clinics, OT Integration, Health Coaching and implementing the principles of the Buurtzorg Model.

The introduction of the Specialist Lower limb Wound Clinics aimed to provide a quality and efficient service to patients who currently receive their wound care through home visits. The project design is based on The Gloucester Model which has demonstrated improvements in healing rates and a reduction in number of contacts, through assessment, management plans and continuity of delivery in a clinic setting, by a specialist skills team.

It is widely recognised that Health and Social Care Occupational Therapy staff frequently receive referrals for the same patient. Our response has been to start a joint project to improve links with our social care colleagues, identify referral criteria for each service and to reduce the number of duplicate referrals into both services.

The development of a Health Coaching programme aimed to provide skills, knowledge and tools for staff to have empowering conversations with patients and facilitate self-management. The training would shift culture initially in clinicians', then patients' behaviour that would lead to a more independently managing caseload.

Implementation of the principles of the Buurtzorg model aims to allow teams to be responsible for the entire range of home-care services: assessing individuals' needs across the personal and health care spectrum, developing and implementing care plans, facilitating services from formal or informal networks to support individuals in a health system.

Part 2: Progress and outcomes

Specialist Wound Clinics

The need and solution was identified by an evidence based Lower Limb Specialist Clinic which was piloted within Gloucester NHS Trust. Our current community service provision for lower leg wound care has been delivery in patients homes where multiple clinicians are involved in assessment and management of wounds and patients were not fully reaching the healing potential that a specialist clinic environment could provide.

Beneficiaries of the service are current and future wound care patients within the Eastleigh Southern Parishes, Eastleigh North and Test Valley South and Totton & Waterside areas covering a population of approximately 140,000-180,000 patients. Lower limb wound care has been an integral part of our integrated care team for a number of years providing basic wound care provision for our patient population. The innovative idea of implementing Specialist Wound Clinics provides us with the opportunity to substantially improve the quality of treatment and care provision with potential healing rates to lie within a 12 week timeframe.

New Care Model	Diagram 1	Appendix 1
Leg Ulcer Management Pathway	Diagram 2	Appendix 1
Huw James BSN Medical Wound Care	Data Diagram 3	Appendix 1
Patient Experiences	Diagram 4	Appendix 1

Integration of Health and Social Care Occupational Therapy

It is widely recognised that Health and Social Care occupational therapists (OT) frequently receive referrals for the same patients owing to a scattergun approach to referrals and a lack of understanding of the referral criteria for each service. With small numbers of therapy staff working in the community and a recent significant reduction to Social Work workforce, current ways of working are no longer sustainable.
Our local response to this is:

* To improve links with Social Care colleagues
* To reduce duplication in referrals and service provision
* To improve the timeliness of service provision for patients
* To ensure patients are seen by most appropriate service and continuity of care is prioritised.

A working group from Hampshire County Council (HCC) and Southern Health Foundation Trust (SHFT) was formed with the aim of finding a way forward to achieve the above aims. Initial work was done at a high level to identify referral criteria for each service which highlighted the number of crossovers between services. Following this, we piloted an intervention in which a member of the HCC OT team co-located with SHFT Totton and Waterside over a 4 week period to joint triage all referrals. During this time 14 duplicate referrals were identified. Having proven the need for the intervention, identifying a

sustainable model reproducible at scale is required which could encompass all teams. The model would ideally be initial admin triage with clinical phone call to discuss duplicates, minimising clinical time. Whilst there are currently complexities around access to each other's electronic record systems, alongside admin resourcing and pressure on clinical time, a number of workaround pathway solutions have so far proved difficult to implement. The next stage will be raised to senior management to facilitate discussion with HCC to unblock some of the issues identified.

Health Coaching

The team proposed an intervention that aimed to shift culture in clinicians' and then patients' behaviour that will lead to significant reduction of patient demand on services in the future, enabling patients to manage their long term conditions more confidently.

Health Coaching is an approach that guides and prompts people to be active participants in behavioural change though a transformation in their relationship with their clinicians. The intervention is aimed at helping people gain the knowledge, skills, tools and confidence to become active participants in their care so that they can reach their self-identified health goals.

By providing clinicians with new skills that help people identify what's most important to them, and tapping into their own internal motivation, evidence shows health coaching can also address health inequalities, improve health behaviors including medication compliance and reduce avoidable admissions. The aim of the project is to develop a commissionable Health Coaching and Patient Activation Model (PAM) leading to better conversations with patients.

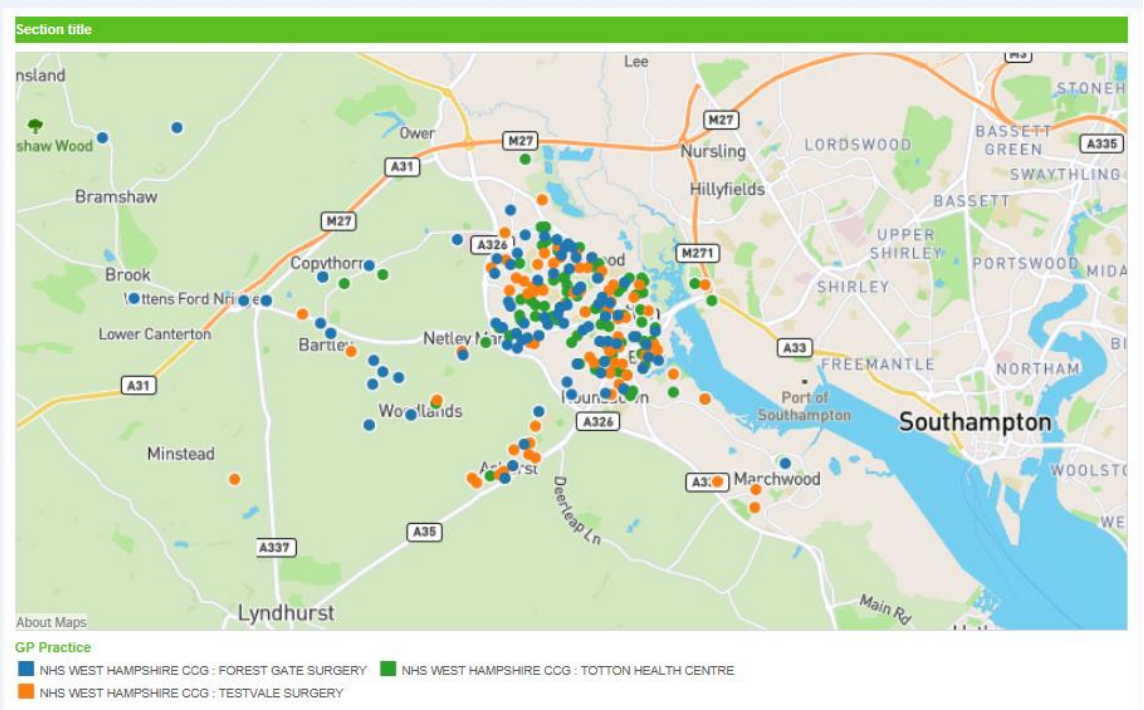
The Totton Health Centre team began with a small pilot of 3-4 patients led by Dr Andrew Powell to test out the potential in this model of service delivery.

The Implementation of the Buurtzorg Principles

The Buurtzorg Model of Care is essentially a nurse led model of holistic care which was introduced in the Netherlands 12 years ago which has revolutionised community care.

The model is essentially based around empowering nurses to deliver the appropriate care that patients need in a self-managed team of up to 12 nurses covering a community care base of up to 40-50 patients.

A substantive amount of planning and implementation work has been undertaken to date, with a view to adopting The Buurtzorg Principles into our integrated community services including patient caseload mapping around registered GP surgeries and changes to our internal patient record system (RIO) to allow for allocation of key workers and case managers.



The key principles we aspire to adopt in this project is the allocation of a client base for teams of nurses in the shape of key workers and case managers to provide a holistic nursing service for our community patients.

Process measures

- 100% of all pts on caseload will have a key worker
- 100% of all pts with a defined complex need will have a case manager
- 100% of all pts with a defined complex have my wellbeing plan completed
- Turnover in the pilot area will reduced to x %
- Vacancy factor in the pilot area will reduced to less than 3%

Health Outcome measures

- an increase in positive patient experience surveys
- Reduction in contacts for patients defined as a complex case (ICT)
- Reduced unplanned admissions
- qualitative interview to evidence increased staff satisfaction and health and well being

The implementation phase of the project is still to be recognised due to the current high community care demands and restrictions on our nursing staff availability to step away from the traditional model of community care and trial The Buurtzorg model in practice.

Part 3: Cost impact

Wound Clinics

The clinic is funded through the Integrated Care Team (ICT) services budget and accesses the current workforce that have extended skills in wound care; clinic space within the Community Hospital and the clinic administration is supported by the Business Unit 2 (BU2) Integrated Single Point of Access (ISPA) administration teams.
The caseload is reviewed at the point of referral by the local ICT Duty Clinicians and, where the service is stand-alone, forwarded to the clinic lead for further review and eligibility check. All new referrals are formally invited to clinic for an extensive holistic assessment and investigations to compile an appropriate management plan with the patient. Patients are either transported by patient transport services (SCAS) or arrive independently.

The current Wound Clinic is auditing evidence of effectiveness and in following months will provide evidence of its successes. Several themes are being monitored at present. These include healing rates; clinic cost efficiencies; care plan concordance as well as patient feedback information. Effectiveness reviews and Standard Operating processes have been considered across all clinics functioning within the Trust and every effort has been taken to learn from operational challenges and provide clarity regarding clinical benefits and associated costs including invest to save opportunities regarding equipment purchases.

Health Coaching

The Health Coaching work has been funded through the ICT services budget and accesses the current GP partners. Additional funding of £25,100 has been achieved from the Southern Health Vanguard Fund in order to provide training for health professionals in Health Coaching Methodologies. As the health care team conducted a ‘small’ patient cohort, it is not possible to predict the financial impact on NHS future primary care services in relation to the benefits of health coaching vs traditional consultancy methods.

OT Integration

The development of Health and Social OT Integration has been facilitated by the project manager but the time taken by clinical and admin staff has been funded through the Integrated Care Team (ICT) and Hampshire County Council (HCC) budgets, both services being commissioned by West Hampshire CCG.

Clear criteria for referral and reduced duplication will lead to savings for both services, as evidenced in the pilot, along with reduced waiting times for patients. However some upfront funding to pay for licences to access electronic systems and admin time will enable integrated function to succeed.

The Burrtzorg Model

The Burrtzorg Model was funded through the Integrated Care Team (ICT) services budget and accesses the current workforce and administration is supported by the Business Unit 2 (BU2) Integrated Single Point of Access (ISPA) administration teams.
Future implementation costs are expected to be met by the ICT services budget as part of transformation of service delivery.

Part 4: Learning from your project

Specialist Lower Limb Wound Clinics

We achieved our objectives evidenced by two successful Lower Limb Wound Clinics now fully operational within Romsey and Hythe Hospitals. The engagement of patients in the clinic setting vs home care is clearly an ongoing task, however, all new referrals will go directly to the clinic, and therefore, the client base is likely to grow stronger in the coming months. The enablement of the project was due to the dedication and hard work of nursing staff and senior management involved who fully committed to the project's success. To enable the clinics to be fully operational we were dependant on charitable funds in order to purchase essential equipment and were awarded the following:-

League of Friends Hythe Hospital	£6,557.04
League of Friends Romsey Hospital	£8,024.45
Brighter Way Charity, Southern Health FT	£20,860.00
Total	**£35,441.49**

The success of the Lower Limb Wound Clinics in Winchester and Andover were very much enablers in staff resistance to the clinics. Our teams visited the clinics to see how they were being managed and gain an insight to their healing success. Following the Leg Ulcer Management Pathway (Diagram 2, Appendix 1) through a thorough and individual treatment pathway utilising the advantages of a full doppler assessment and compression dressing in order to improve healing rates.

Outcome measures were essentially derived from the purpose of the project in reducing community nursing time, expenditure and improving healing rates in lower limb patients. It has not been possible to quantify these aspects in such a short period time the clinics have been operational, however, this is data that will be assessed through trust audit processes in the future. Patient experiences and testimonials have provided the team with evidence of the success of the clinic setting (Diagram 4, Appendix 1).

The main barriers experienced in the project were access to reliable patient transportation which we experienced in sporadic 'good' and 'bad' days. Some of the patients who received 'bad' transportation experiences have since refused to attend clinic; therefore, this aspect of the process is key in the clinics success. Ongoing discussion and improvement plans with SCAS are currently in progress in order to address this issue.

Health and Social OT Integration

The success of the project has been around the teams working together to find solutions and how this has enabled cross organisation barriers to be lifted. Staff have become familiar with each other, building professional relationships, creating open lines of communication and collaboration.

Future enablers might be in the shape of a joint triage process or access to each other's referral systems; however data protection and governance issues prevented this during the project. An alternative solution may be to co-locate services in order to enable a more joined up, efficient and effective OT and social care service provision for the future.

Health Coaching

The health coaching project was successful in that 3 out of the 4 patients showed a marked improvement in the management of their condition and an improvement in the quality of life as a result. The team at Totton Health Centre assisted with engagement with the programme and attended the appropriate health coaching training provided by Petrea Fagan. Although outcomes were positive, the healthcare professionals involved felt it was a challenge to change their consulting style during a standard 10 minute GP appointment and no information was documented on PAM (Patient Activation System) due to time pressures. The progress and appointment information was however, documented within the patient notes as in a normal consultation. It is without doubt that health coaching is a positive intervention in assisting patients in managing their long term conditions. In shaping this model in the future, it may be prudent to manage health coaching as a stand-alone service with longer appointment times and referrals identified in normal GP appointments, however, in order to warrant a separate service identification of patients with long term health conditions and demand would require thorough analysis.

The lead clinician, Dr Andy Powell provided an insight into the challenges he and his team faced during implementation of the Health Coaching Model at Totton Health Centre:-

Time, especially for GPs is always a barrier to any new working practice model. Patients attend appointments for a myriad of problems, often with a list, any/all/none of which may be relevant to their long term condition; therefore, the time to offer an intervention is often minutes at best. Some techniques such as "on a scale of 0-10 how important is 'X' to you right now", and why it is not a 0, are useful questions, however, there was not enough time within a standard GP appointment to complete the PAM.

For our small cohort of patients, health coaching was very useful. The skill of picking up the motivated patients with simple awareness questions and trying to work with them as best we can is certainly a change for us and is often valuable than providing everyone the standard doctor centred approach.

Buurtzorg Model

The need for the Integrated community team to change their model and approach to patient care has required significant change management tools to ensure that all staff are included, involved and value the changes made to benefit the patients.

The requirement for full establishment of staff has meant this element of the project has been a little slower in progression than anticipated due to significant turnover of staff.

The principles are supported by the team and once in a more positive staffing position the team have identified their preferred method of organising team members caseloads, whether they align with location or with practices. The latter has been chosen in order to work more closely with the GP and Practice nurses and to gain that professional communication to enable patient focused care through primary and community integrated working.

Part 5: Sustainability and spread

Specialist Lower Limb Wound Clinics

For future Specialist Lower Limb Wound Clinics we plan to introduce further clinics across all integrated care teams within the division, providing quality wound care to cover a wider area of our patient population. Evidence from research and our own implemented projects shows considerable benefits for patients, therefore, the future model will offer clinic settings as a primary place with rare intervention at home if clinical conditions warrant it. The benefits in reducing social isolation in bringing patients together has been noticeable, and patients have come to look forward to seeing other patients they have become familiar with through regular appointments.

We have trialled and propose to continue an 'information café' within the clinics in collaboration with 'one community'; a voluntary organisation who provides refreshments and support information for patients whilst waiting for their appointments or transport collection. Patients responded enthusiastically to the introduction of this intervention and found it educational and socially stimulating. The social aspect of the wound clinics may be expanded in the future to include access to care navigators to support patients in all areas of healthcare during their time at the Specialist Wound Clinics.

Health and Social OT Integration

There is both the desire and intention to progress this work to ensure the full aims of the project are achieved.

- Both Hampshire County Council (HCC) and Southern Health Foundation Trust (SHFT) Occupational Therapists (OTs) across the New Forest have engaged with the working group and will be continuing to meet regularly for joint training and supervision. This project has been the catalyst for this and has created an open

dialogue between organisations which can only be positive for future Occupational Therapy Services.

- Some initial high level work has been done to identify and confirm key referral criteria for each service. This works needs completing and communicating to referrers or a joint fully integrated referral process needs to be considered.
- The comparison of caseloads and referrals to avoid duplication requires further commitment from both services at a higher level and some upfront funding to create the opportunity for further efficiencies and potential cost savings.
- The project has highlighted some inconsistencies in service provision between these two services which are both commissioned by the same CCG with patients referred to SHFT waiting longer to be seen. This is wider than the initial project remit and will be pursued through other avenues.

Health Coaching

Following our own experiences with implementing Health Caching in general practice, it seems that the long term benefits are understood by the clinicians however the challenge to make available the time to implement this methodology in clinical approach is very difficult in the practice environment.

This approach continues to be of benefit however it is understood that this may well be best places within specialist services that work alongside the GP Practices and ICTs to focus their approach to self-management and care planning with the patient specifically around their long term condition.

GP's found that their current time allocation of 10 mins per appointment could not accommodate this style and would require a system change to accommodate this in the longer term.

Buurtzorg Model

The teams are now in the position to be moving current caseload patients into their individual case management/key worker model. As yet we have not been able to quantify the results although we already know from patient feedback that involvement in their care is key to successful management, along with continuity by professionals.

Aligning clinical staff and their clinical competencies with patients assigned to a surgery this enables the development of specific teams providing to a cohort of patients registered with one practice having a named clinical lead (case manager) and supported by Non-registered staff providing key working to other patients with less complex needs, building clarity for the patient as to whom is planning and organising their care with them, who co-ordinates on their behalf and who to go to with any questions.

This will continue to be implemented across the business unit and shared with other teams across the trust, along with the benefits that accompany the change in approach.