

MENTAL HEALTH

INTEGRATING ALL PARTNERS

Wendy Wallace explains how health, care, mental health and the third sector can work together

Tile House, a collaboration between Camden and Islington Foundation Trust and One Housing Group (OHG), provides supported accommodation for people who have complex long term mental health issues. It is an alternative to being hospitalised or being put in a care home. We are proud to have been involved in such an innovative scheme – the first of its kind in the UK – which has helped save the NHS nearly £900,000, according to a report released at the beginning of the year.

The nature of need among those at Tile House is complex and of a level that would not usually enable other forms of supported housing to offer the nature of support needed. Many of those referred to Tile House have issues around treatment or medication, they may have a forensic component to their mental health history or a history of placement breakdown. They are often high risk, especially in terms of self-harm, and require clinical input to manage their mental health. Due to a combination of these factors and the complexities of their conditions they require a unique support system to aid their recovery and encourage independent living.

There are a number of clinical staff who manage the needs of the accommodation's service users. All residents have access to support staff who are on site 24 hours a day and everyone will be allocated a key worker who will develop an individualised support plan. On-site visits are carried out by a care

coordinator, while an occupation therapist facilitates life skill training and a psychologist provides individual assessments and therapeutic interventions. The multidisciplinary team works closely to avoid crises in people's care which very often results in hospital admissions.

Prior to moving to Tile House many of the service users had little engagement in social and community activities, but in this environment they are encouraged to maintain positive relationships and build these skills. This underpins part of the philosophy behind the project – service users are not just living with a mental health diagnosis, but living well.

Good mental health and resilience are fundamental to our physical health but each cannot be thought of as separate entities. All Tile House residents are registered with a local GP and encouraged to raise any health concerns they have. This has resulted in a few who have engaged in the stop smoking programme, a target which has been included in their support plan, and they all receive an annual health check. The staff also run cycling sessions, nutrition



workshops and cooking groups to encourage them to think about health and wellbeing.

Critical to the success of the model is a shared approach to risk management and governance. As well as daily discussions with their key worker and weekly joint team meetings, Tile House is overseen by a

CASE EXAMPLE: PREVENTED ADMISSIONS

Mark has a history of several suicide attempts, one of which had resulted in serious permanent physical harm. This stems from severe auditory hallucinations and paranoid beliefs during most of his life. Mark had found talking about this difficult in his previous placements, and had often isolated himself.

When Mark moved to Tile House, the One Housing Group clinical lead worked closely with him to develop a positive relationship and encouraged him to attend the in-house hearing voices group with which he began to engage well.

This helped him to feel able to speak to the

clinical lead and psychologist when his voices increased and he began to experience suicidal feelings, and reaffirm his crisis plan and coping strategies. The psychologist and care coordinator worked with all staff around containing a suicide crisis and how to approach the voice hearing experience in a non-challenging way.

Mark's suicidal feelings continued for approximately two weeks before they subsided. The crisis was contained in-house through therapeutic intervention by the onsite clinical team with no change of medication or hospital admission being required.

'This scheme – the first of its kind in the UK – has helped save the NHS nearly £900,000'

This feature is supported by Allied Healthcare, an HSJ & LGC Integration Summit partner, as part of our integration series



THE TILE HOUSE

Tile House opened in September 2012 and provides 15 high quality, self-contained supported housing units in King's Cross, London for customers with a range of complex mental health issues. Each customer has their own flat which is designed to the same specification as One Housing Group's private sale units.

The One Housing Group has collaborated with Camden and Islington Foundation Trust to provide a safe, positive and supportive environment to help customers with their recovery. All customers at Tile House are referred by Camden Council.

strategic implementation board made up of senior managers from the One Housing Group and the FT. The senior oversight ensures the momentum for the partnership is maintained and patient outcomes remain a clear focus.

Following their time at Tile House service users who would have been in very high cost placements funded by social care or hospital, move onto more independent and often cheaper accommodation. We are proud to have pioneered an approach that so effectively delivers our values of a positive and dignified recovery journey for our patients.

The success of Tile House means we are committed to making the most of further opportunities and deliver the very best outcomes for our patients across London. ● Wendy Wallace is chief executive of Camden and Islington FT.

MORE ON INTEGRATION SUMMIT 2016

For information about next year's Integration Summit, contact Jenny.Vyas@Emap.com

CASE STUDY: FROM ANATHEMA TO THE ANSWER TECHNOLOGY'S EMERGING ROLE IN HOME CARE

The objectives are simple. First, the need to maximise operational efficiencies to meet current and projected fiscal challenges and demographic changes. Second, to then deliver outcomes based care solutions that meet the expectations of funders and the increasingly complex personal needs and priorities of individuals.

Of course, on paper the objectives are straightforward. However, the practicalities of delivering effective, reliable, consistent, affordable and sustainable care in the home are quite another matter. And the disparate and evolving needs of individuals adds further complexity.

Knowing what's gone before is not sustainable, Allied Healthcare are determined to provide their customers with the reliable and personalised care they rightly expect. So they're gone back to the drawing board to determine how they can deliver person-centred care as efficiently and effectively as possible – and to do so within known funding parameters. The aim is to develop a comprehensive, truly integrated, scalable approach for the delivery of care services that will provide the required operational capacity in tandem with an unprecedented level of service personalisation.

Grasping the nettle

Although the health sector has benefited from technological advances over many years, when it comes to care in the home, service delivery is often still dependent on spreadsheets, handwritten instructions and manual interventions. Here, new technology has been pretty much an anathema.

Keen to test long held assumptions, the team set out to identify how, where and what technologies could make a real difference in delivering both operational and financial benefits in the delivery of person centred care solutions in the home. To do that in a planned and controlled way, a new method of working needed to be created that was more conducive to innovation and progression.

Technology experts were commissioned and they consulted extensively with the organisation's care teams and commissioning bodies. This helped to develop a roadmap for implementing a new generation of care solutions based on new ways of working where both emerging as well as proven technologies could be harnessed fully. And, significantly, the new model will move towards care to be measured in terms of effectiveness and wellbeing of customers rather than arbitrary records of visit, punctuality and duration.



Comprehensive and personalised care plans can now be captured on secure smartphones

Plans into practice

The first major step was the development of a new operational structure where care teams are created to focus entirely on local service delivery. The new approach provides the right processes and management structure to ensure the right people with the right skills are in the right place at the right time. This provides the foundations for progressive service developments that fit the best processes and meet the real needs of those receiving care, as well as their families, regulators and, not least, the carers themselves.

The people and processes have been piloted and embedded in a number of community based branches. The team is now building on this by working closely with specialist IT software solutions companies developing new technology for service transformation, covering three areas:

- automated scheduling of visits, including route optimisation and all variables regarding the availability, experience and skillset of carers;
- digitised care plans for every recipient of care services; and
- mobile enablement for every member of a care team.

Critically, all of these initiatives have to be integrated fully to deliver real time information, service consistency and accountability if the risks of errors and delays arising from the manual routing and scheduling of visits are to be eliminated.

Technology is enabling us to achieve just that. And carers have all the information and updated instructions at their fingertips and in real time.

Digitisation is the cornerstone

Digitised care plans and the mobile enablement of care teams are at the heart of the new service delivery model. Significantly, comprehensive and personalised care plans can now be captured on the secure smartphones, providing carers with all relevant instructions and constantly updated support information.

The new mobile enablement also provides automatic verification of visits using a near field communication devices and the ability to capture any early warning signs so that, for example, a care delivery manager can take prompt steps to arrange for the intervention of specialist support as required.

Ongoing analysis of the new digital data will help to constantly align the care being delivered with the outcomes that matter most to individuals and to the funders of care. This truly integrated and expansive approach will help to extend service capabilities and responsiveness. It will also create new opportunities for dedicated portals for clients, customers and families, as well new gateways to client systems.

It is not change for the sake of change. The considered adoption of new technologies can help provide an even greater level of personalisation and responsiveness at a lower cost. And this is being achieved at the same time as delivering new care paths, the transparency and greater accountability expected by regulators and the agility that is required in an ever changing care environment. All of this has only been possible by truly grasping the opportunities presented by new technologies.

COMMUNITY SERVICES

Work together to cut alcohol related hospital admissions

To stop people who experience drug and alcohol problems falling through the cracks, a charity is providing integrated services to complement NHS hospital care teams, writes Lynn Lason

In the UK in 2012-13, there were 1,008,850 hospital admissions related to alcohol consumption where an alcohol related disease, injury or condition was the primary reason for hospital admission or a secondary diagnosis.

Provision of alcohol services in emergency departments has been shown to be effective but there are substantial numbers of patients with serious alcohol problems who are repeat attendees of hospital medical services, usually presenting via medical assessment units. Many have potentially life threatening illnesses and consume substantial amounts of NHS resource.

Project 6 is a charity in Keighley that provides a range of integrated services for more than 3,000 people a year who are experiencing drug and alcohol problems. In 2007 the organisation became aware that problem drinkers who dropped out of service were being hospitalised, “detoxed” and discharged back into the drinking context where issues such as isolation, poor accommodation and poor relationships were leading to relapse.

As a voluntary organisation, Project 6 was able to swiftly respond by allocating resources to exploring the issue, establishing a foothold in Airedale General Hospital and engaging key people in addressing the need. In 2012 Project 6 received statutory authority funds to develop a secondary care team consisting of an accident and emergency worker and an alcohol crisis intervention team (ACIST) to work alongside NHS alcohol nurses as part of a hospital alcohol care team.

The services were established to provide a seamless, interlinking pathway of care for alcohol users across Airedale, Wharfedale and Craven, following a patient from screening, identification and engagement in a hospital setting out into their homes and the community.

Identification and engagement

Hospital staff on wards where alcohol problems are most likely to be identified – for example, A&E, medical assessment and gastro-intestinal wards – screen patients using AUDIT C, an alcohol screening tool. Patients who present conditions likely to be associated with hazardous, harmful or dependent drinking are those selected for screening for alcohol use.

Positive promotion by the team ensures that hospital staff are aware that the service can help patients make long term positive lifestyle changes upon discharge and 18,000 screenings were carried out in the hospital in 2014-15.

Patients identified as having problems are met on the ward by the ACIST workers who start to form a therapeutic alliance and elicit change talk, grasping the “teachable moment”, readying individuals for engagement in psychosocial interventions and helping to ensure retention in service.

The ACIST team carries out the essential post-discharge support to those patients who have experienced problematic alcohol use. In general, the majority of alcohol services rely upon the individual attending an appointment at a unit in a town centre. When this model is followed the most vulnerable in our society become lost.

Patients are visited in their homes as soon as possible on discharge and offered an intensive programme of therapeutic and practical support through a care plan which links them to a range of other relevant

services. These can include mental health and social care services.

In addition to helping with their alcohol dependence, practical support such as help with telephone calls, counselling for underlying issues, housing, establishing routine, and introducing new experiences is offered. These interventions have a direct positive impact upon the health of the service user; when life is more stable you care more about your health. As a community based organisation Project 6 has an in-depth knowledge of community services that can be involved in building a holistic care plan.

Secondary care services are now established in the new A&E department at Airedale. Alongside the main work of screening and psychosocial interventions, the service is responsible for alcohol harm reduction materials in the A&E waiting room. This includes a state of the art instantly accessible harm reduction video.

Figures provided by the hospital show that the work carried out by ACIST is reducing the number of hospital attendances by our target group. A snapshot provided by the hospital for 19 individuals shows a reduction of 97 A&E attendances or hospital admissions at a cost saving of approximately £70,000.

A further result of this initiative has been the development of the recurrent attendees meetings at Airedale. It is hoped this work can be used with targeted individuals to measure the savings to the hospital care trust that this work makes.

Going forward, the aim is to increase the effectiveness of this work still further by engaging with multidisciplinary teams in GP surgeries and at Airedale to ensure that the services are aimed at individuals who are intensive users of medical services. ●

Lynn Lason is director of development and communications for Project 6.

OUTCOMES AND SAVINGS

In 2014-15 the A&E worker provided 856 brief interventions within the hospital while ACIST carried out 572 home visits, supporting 240 individuals who were unable to access town centre services.

Integration is a question of balance

The health service needs a holistic view of integration, where all organisations involved come together around the real needs of patients, writes Matt Jackson

Much has been said about how service integration can be undermined by legacy attitudes and the preconceptions of the parties involved in the commissioning, funding and delivery of health and social care services. But attitudes and perceptions are changing. More and more people now accept that improved service standards and cost savings are not necessarily diametrical opposites.

By exploring the potential opportunities for service enhancement in times of austerity, Allied Healthcare's workshop at the *HSJ/Local Government Chronicle* Integration Summit highlighted the substantial benefits that can be derived from focusing on what matters most when grasping the nettle of integration.

To look first at "service provision", inevitable differences arise when the subject is viewed from the different perspectives of the various parties involved. This is not a constructive scenario for opening dialogue or fostering a broader understanding and appreciation of the diverse issues and responsibilities involved. As a result, it is easy for the existing "system" to restrict the ability to deliver what is in the best interests of a patient or service user.

Attitudes become even more entrenched when the subject is viewed from disparate financial parameters. Indeed, competing agendas and rivalries simply compound the difficulties. We should remember, however, the financial realities of austerity have been remarkably similar for all organisations involved every facet of health and social care. NHS foundations and non-foundation trusts, for example, collectively ended the 2014-15 financial year with a loss of £822m. Local authorities face a £1.1bn shortfall this year, having experienced a 31 per cent overall budget reduction since 2010. And 70 per cent of social care providers have not had a rate increase in three years.

We need a far more holistic viewpoint where all organisations involved in the care of individuals come together around the real needs of each patient and service user. To achieve that, we need to go back to what is really important: the wellbeing of those individuals who are in need of care and

'We need to look at how we can change the way we do things to champion service improvement'



support, not just today but also in the future. In short, we need to look at how we can change the way we do things in order to champion service improvement.

The starting point has to be a very basic question – what do we mean by service improvement? Most people in the health and social care sector would agree that the ability to provide a coordinated service which meets the specific and evolving needs of individuals represents the ideal outcome. Certainly, patients and service users would always aspire to such personalised care. So an increasingly customer centred service model has to be our target.

Here, the priorities are quite clear – individuals want to receive a reliable, tailored, consistent, adaptable, high quality and affordable service where everyone is treated with the respect and dignity they

rightly expect. There is no panacea and it is now clear that no single party in the field of health and social care has the entire answer. A broader perspective, greater teamwork and better understanding of the capabilities, limitations, and priorities of other organisations are required.

Workshop participants were encouraged to view the needs of an individual from different perspectives. Many references were made to the enormous costs associated with the admission of elderly people into hospital in the absence of practical and more appropriate alternatives. The case of patients with dementia was highlighted as an example where the disorientation of new surroundings and unfamiliar people in a hospital are likely to worsen rather than improve their condition. With specialist dementia care support readily available, they would be far better off in their own homes – and that would not only improve the outcome for the individual, but also save costs, reduce ambulance call outs and release hospital beds.

Similarly, the loneliness felt by many elderly people is often a far greater worry than physical health issues. This can lead to frequent and avoidable direct demands being made on the health service. Here, the right care package and support from appropriate organisations would minimise "emergency" callouts and provide a far more effective solution for the individual, at any time of the day.

In addition to misplaced preconceptions, the workshop discussions also highlighted a fear factor in this process – a fear of relinquishing control and of introducing greater transparency with other third parties and external organisations. But it is only by sharing information and understanding just how effective other organisations can be in fulfilling the needs of an individual at different times in the care cycle that we really see the true value of integration.

And, as the workshop demonstrated, that goes for clinical commissioning groups, health trusts and councils as well as third sector organisations and service providers. ● *Matt Jackson is regional managing director of Allied Healthcare.*