

Case study

Pennine Care

April 2016

**The journey to integration:
learning from seven leading localities**

Summary and lessons learnt

- **Impact:** Pennine Care has designed a range of interventions as part of its integrated care strategy. A psychiatric liaison team within acute care, focused on A&E, alcohol and older persons care produced whole system net savings of £1.5 million in 2014/15. An intermediate care facility in Oldham reduced bed days by 5,268 and saved the system £900,000 in 2014/15. Together the interventions designed by Pennine Care have been shown to offer significant cost savings, reduce the length of stay in hospitals and cut A&E attendances, hospital admissions and unplanned re-attendances.
- **Place:** Pennine Care NHS Foundation Trust (FT) provides care to people across six main clinical commissioning groups (CCGs) – Bury, Oldham, Heywood, Middleton and Rochdale, Stockport, Trafford, and Tameside and Glossop. The population has a large burden of chronic disease and poor mental health outcomes.
- **Focus:** the focus is primarily on acute avoidance by delivering safe alternatives within the community for both physical health and mental health needs.
- **Care model:** Pennine's care model stresses the parity of mental and physical health. Key to success has been to design integration and the care model in terms of what's best for the patient so patient-centred integrated care services are delivered. The integrated care programme consists of four distinct elements:
 - A Rapid Assessment Interface and Discharge (RAID) model is a psychiatric liaison service aimed at providing adult patients presenting at A&E with mental health support. This service has three key elements: A&E liaison, alcohol liaison and older people's liaison. The Saffron Ward in Stockport is an extension to the RAID model, which provides a 20-bed step-down unit for people over the age of 65 who experience delirium.
 - Butler Green: an intermediate care facility in Oldham with 28 beds, designed to avoid hospital admission or reduce acute length of stay.
 - My Health My Community programme is designed to promote independence and give communities the health education skills, knowledge and tools they need to be able to live healthily with confidence.
 - The Trafford Community Enhanced Care Service which provides 24/7 urgent care and intensive support to prevent avoidable hospital admissions and to reduce readmission for patients with long term conditions (LTCs).
- **Information management:** Pennine Care has used information and online tools particularly for the My Health My Community intervention. My Health My Community provides service users with a web platform and apps which allow patient access to self-help tools, and information to support self-management. The creation of this web platform and app has proved vital in helping patients learn how to self-care alongside providing support for carers. RAID is in the implementation phase of information sharing, with psychiatric liaison workers able to access the acute hospital patient information system and shared access to data across different agencies.
- **Commissioning and payment model:** Pennine Care recommends carefully considering this as a key part of the planning process. It created specific business cases to fund each of the individual aspects of the integrated care programme. For the RAID and Saffron Ward pilot, the trust agreed to fund the pilot using Commissioning for Quality and Innovation (CQUIN) money (ie the trust

managed all the risk associated with the pilot). No large-scale changes to the commissioning and payment model have yet been made.

- **Workforce:** integrating mental health and community professionals into acute settings has brought challenges, requiring strong leadership and additional training to overcome. There, however, have not been large changes to the structure of the workforce or major recruitment drives. Communication is critical when integrating mental health service staff into acute care providers, such as through the RAID programme, particularly in understanding and working within different organisational cultures and behaviours.
- **Governance:** Pennine Care has not made any significant changes to the governance arrangements for integrated care provision, however this is likely to change through the Greater Manchester Devolution programme and emergence of local care organisations. Separate operational and decision-making processes remain between organisations and projects. Pennine Care is in the early stages of implementing some shared governance arrangements.
- **Leadership:** strong leadership and partnership working has played an important role and is required for the creation of an overarching integrated care vision and the development of implementation plans. Leadership and collaboration is pivotal when bringing together multiple care providers and putting people and staff in new environments. Pennine indicates that trying to integrate services too quickly can be met with resistance.

1 Impact

Psychiatry liaison (RAID)

- 11,219 patients were seen by the service in 2014/15. An evaluation by the university of Chester¹ identified that 99 per cent of patients and carers rated their experience with the RAID team as excellent or good
- 1,649 bed days have been saved from reducing acute ward lengths of stay
- approximately 1,900 deflections from A&E and ward admissions were achieved in 2014/15
- whole system net savings of £1.5 million in 2014/15 have been estimated²
- all patients presenting with self-harm are offered a follow-up appointment and development of a management plan.

The Saffron Ward, Stockport

In 2014/15 this ward in the RAID model:

- deflected 5,700 bed days from acute care
- cost per patient approximately £1,000 less per week relative to hospital care

¹ Working together living well, Pennine Care NHS FT (2015).

² Frontier Economics, Evaluation of the RAID intervention for Pennine Care NHS Foundation Trust (2015). In Pennine Care NHS Foundation Trust, Living well working together (2015).

- ran at a cost of £1 million per year, producing health system net savings of £300,000 per year³
- reported a 92 per cent occupancy rate
- gained a 98 per cent friends and family test score.

Butler Green, Oldham

A study by Frontier Economics estimated the impact of Butler Green in 2014/15 to be:

- 977 acute deflections from acute ward admissions via A&E
- reduced bed days by 5,268
- a low readmission rate following discharge
- a referral-to-admission time of 24 hours, which is 54 hours less than the national average of 78 hours
- reduced average length of stay
- potential annual acute cost savings of £2.8 million, which is equivalent to saving approximately £100,000 per bed per year
- with Butler Green costing around £1.9 million per year, health system net savings of £900,000 per year.⁴

My Health My Community

My Health My Community has improved condition management and reduced avoidable admissions; for example, diabetes-related hospital admissions due to poor metabolic control have been reduced by 20 per cent⁵. Carer and patient wellbeing as measured by the General Anxiety Disorder scale and Patient Health Questionnaire Depression scale have improved. Social isolation, disease awareness and understanding of self-management have also been reported to decrease.

Trafford Community Enhanced Care Service

This service has made an estimated gross saving of £1.3 million for the Trafford health economy. Over a nine-month period, 2,996 referrals have been supported, 760 hospital admissions have been avoided and 1,543 A&E attendances have been prevented. Pressure on the local acute trust has been reduced and patient feedback is positive, as they receive care in their own homes.⁶

2 Place and context

Pennine Care NHS FT provides care to people across six main CCGs – Bury, Oldham, Heywood, Middleton and Rochdale, Trafford, and Tameside and Glossop. As shown in Exhibit 1, these CCGs have high levels of deprivation and disease prevalence. The Pennine Care FT provides care to a population of 1.3 million.

³ Frontier Economics, Evaluation of the Saffron Ward intervention for Pennine Care NHS Foundation Trust (2015). In Pennine Care NHS Foundation Trust, Living well working together (2015)

⁴ Frontier Economics, Evaluation of the Oldham Butler Ward intervention for Pennine Care NHS Foundation Trust (2015). In Pennine Care NHS Foundation Trust, Living well working together (2015)

²¹ Pennine Care NHS Foundation Trust (2015)

⁶ Frontier Economics, Evaluation of the Community Enhanced Care Service intervention for Pennine Care NHS Foundation Trust (2015). In Pennine Care NHS Foundation Trust, Living well working together (2015)

Subsequently, the trust covers a population with significant health inequalities and is working on its approach to managing LTCs, in respect to both physical and mental health.

Exhibit 1: CCG indicators table^{7,8,9}

	Bury CCG	Oldham CCG	H, M & R CCG	T & G CCG	Stockport CCG	Trafford CCG	National median	Top quartile	
% pop 65+	16.8	15.1	15.1	14.9	19.4	16.8	16.9	12.1	<ul style="list-style-type: none"> Top quartile 2nd quartile 3rd quartile Bottom quartile
IMD score	22.8	22.8	35.0	n/a	19.0	17.3	21.5	13.7	
Emergency admissions per 1,000	23.6	31.8	30.2	29.8	29.8	22.6	25.5	21.6	
DToC per 1,000	4.6	3.7	3.5	4.6	5.1	11.4	8.4	5.0	
Stroke %	1.87	1.75	1.87	1.98	2.00	1.80	1.79	1.48	
COPD %	2.06	2.24	2.30	2.63	2.19	1.82	1.80	1.42	
Cancer %	1.94	1.89	1.86	2.02	2.29	2.14	2.17	1.87	
Diabetes %	6.51	7.05	7.21	7.09	5.85	5.96	6.26	5.71	
Dementia %	0.68	0.64	0.54	0.65	0.79	0.63	0.63	0.54	
Mental Health %	1.02	0.88	1.06	0.77	0.79	0.84	0.81	0.73	
Obesity %	10.72	10.54	12.44	10.70	8.85	8.33	9.66	8.12	

3 Focus

Pennine Care has developed different integrated care initiatives which are mainly targeted at people with mental health needs or comorbid LTCs. Although they target similar populations, each of the interventions described here have a slightly different geographic focus. RAID operates in all of the acute sites covered by Pennine Care. The Saffron Ward, which is part of the RAID model, operates only in Stockport. Butler Green provides intermediate care for persons in Oldham, while My Health My Community operates across five CCGs covered by Pennine Care. Each of these initiatives do not only focus on the patients themselves, but also support care givers.

4 Care model

Pennine Care has adopted a whole-person care approach to drive service transformation at pace and scale. The parity of esteem for mental and physical health is integral to the model for whole-person

⁷Better Care Atlas, NHS England (2014/15)

⁸ National General Practice Profiles, Public Health England (2012)

⁹ Quality and Outcomes Framework Data (2013/14)

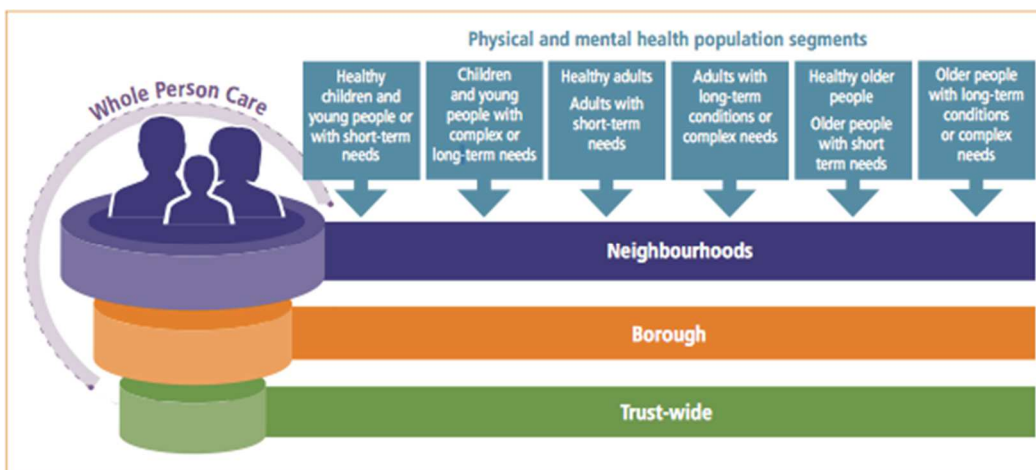
care, shown in Exhibit 2 below. The focus of this model is on delivering care close to the patient's home, with the neighbourhood highlighted as the first point of care delivery.

Seven design principles underpin the model:

1. Whole-person care approach: services should enable people to be assessed and treated holistically and recognise the importance of carers and families
2. Self-management ethos: co-production of treatment is a core approach, with patients enabled to manage their own health and wellbeing
3. Population segmented by need: services should be designed to meet population needs
4. Technology first: technological solutions should always be considered first, so that staff focus on delivering services which cannot be delivered using technology
5. Embracing partnerships: the ability of other organisations to deliver health and care interventions, working alongside Pennine Care, should be considered in the design process to produce effective and efficient services
6. High-quality outcomes for people: services should improve patient experience, safety and effectiveness at the same time as reducing costs per capita of care and improving population health
7. Neighbourhood by default: integrated neighbourhood teams should be the starting point for care delivering, with borough and trust-wide services only used when local services cannot meet the complex needs of the individual.¹⁰

These core design principles underpin the four main interventions described here: Psychiatry Liaison (RAID), My Health My Community, Butler Green Enhanced Intermediate Care and the Trafford Community Enhanced Care Service.

Exhibit 2: Pennine Care's New Model for Whole Person Care



Source: Pennine Care Annual Report 2014/15

¹⁰ Driving service transformation through a whole person care approach, Pennine Care NHS FT (2015).

Rapid Assessment Interface and Discharge (RAID) model

The RAID model implemented by Pennine Care is an innovative psychiatry liaison service. It is based on Birmingham's RAID model. The service is composed of three teams: older people's liaison, A&E liaison and alcohol liaison. Consultant psychiatrists, psychiatric nurses, social workers and occupational therapists form a psychiatric liaison team which supports the diagnosis, assessment and management of people with mental health conditions in the acute setting. The service provides patients with care and discharge planning advice, support with eating and drinking as well as support to the families and carers of those with mental health conditions. The RAID model enables people to be assessed and discharged with psychiatric input and support. It is available 24 hours a day to all adults aged over 16.

There is also an educational element to RAID as the psychiatric liaison team educate and train general acute staff on how to identify and treat mental health conditions to improve the capability of acute hospital staff to treat patients suffering from these conditions.

The Saffron Ward, Stockport

Saffron Ward in Stockport is an enhancement to the RAID model, which is a 20 bed unit that provides mental health support for people over 65 experiencing delirium. The ward accepts people as a step down from acute care, who have been identified by the trust's liaison psychiatry team.

Some two-thirds of over 65s are in hospitals because of delirium, dementia, or a depression-associated condition. Treatment for those with delirium in the acute setting is challenging, and often results in extended lengths of stay or misdiagnosis. To target this problem, Pennine Care worked with commissioners to open the Saffron Ward to provide the appropriate care to these people when they are too unwell to return home, but no longer need acute care.

The Saffron Ward is staffed by an expert multi-disciplinary team including mental health nurses, GPs, physiotherapists, social workers and occupational therapists. All staff have mental health training and experience. Discharge and packages of care are organised by a social worker with relevant mental health expertise. Input is also received from consultant psychiatrists who work with the GPs. As a result of these interventions, people recover more quickly in Saffron Ward, with people generally returning home or being admitted into residential care, as opposed to nursing homes.

My Health My Community

This programme was designed to promote independence and give communities the health education skills, knowledge and tools they need to be able to live healthily with confidence. It targets improving health literacy for people with long term conditions to support better self-care, improve health and community resilience as well as providing easy access to appropriate and meaningful educational support for LTC patients and carers.

The programme offers courses for both patients and carers to promote self-management, with tailored courses developed for diabetes, chronic obstructive pulmonary disease (COPD), cardiac, stroke, dementia and end of life patients and carers.

Butler Green Enhanced Intermediate Care, Oldham

Butler Green is an intermediate care facility in Oldham. This service was designed to avoid hospital admission or reduce length of stay in the acute setting. It offers enhanced recovery and rehabilitation, which can be provided to patients referred from primary or secondary care settings. It has 28 beds: 20 nursing beds, and eight clinically enhanced beds.

Additionally, Butler Green provides a blend of nursing and therapeutic interventions. An ambulatory IV therapy clinic, urgent response to patients at home, A&E therapy in-reach and GP helpline services are also all provided from Butler Green.

These services are delivered by a multi-disciplinary team of health and care professionals who are additionally trained in mental health interventions. This team includes nurses, GPs, occupational therapists and social care workers.

Butler Green is a flagship model for delivering effective intermediate care in the community. The current focus is Oldham, but Pennine Care aspire to work with partners to roll the model out further to provide a viable alternative to hospital.

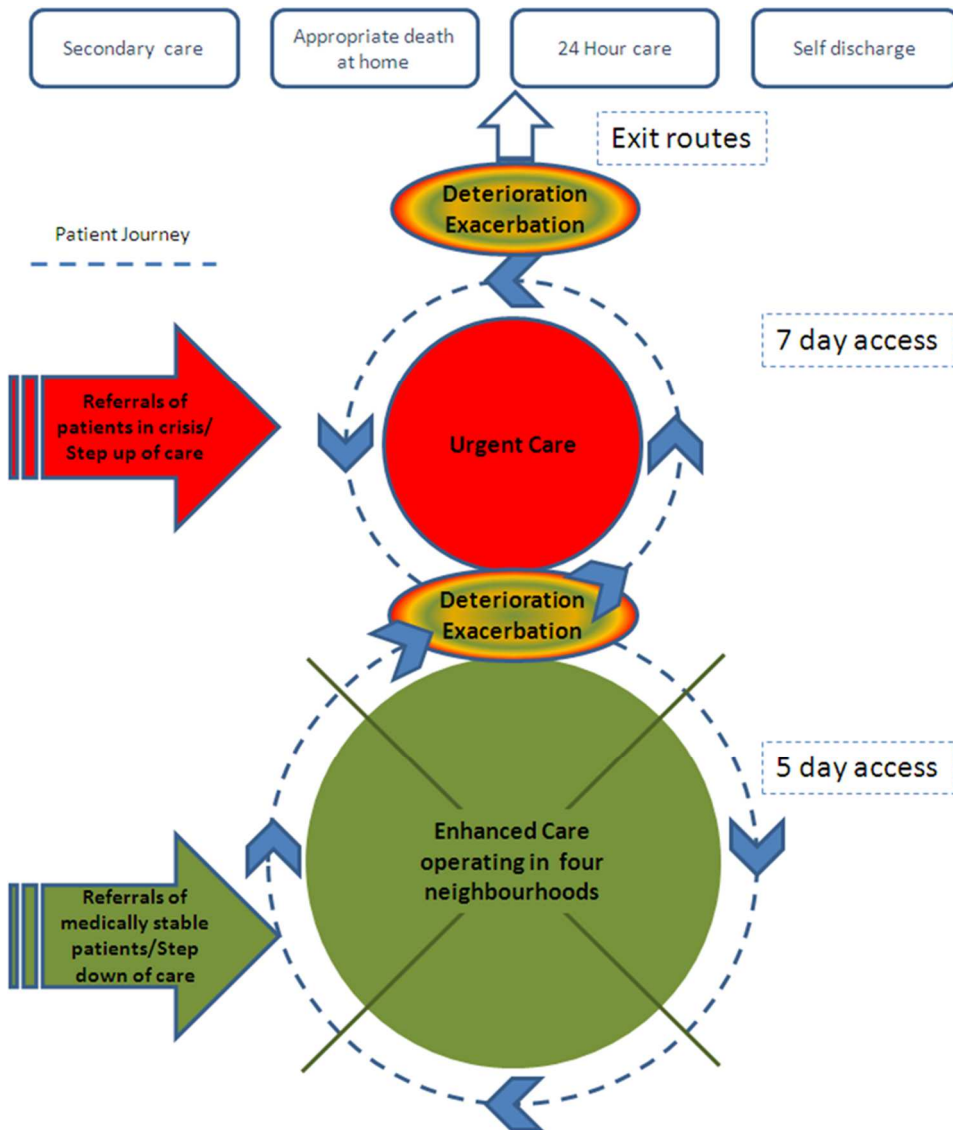
Community Enhanced Care Service, Trafford

Trafford's Community Enhanced Care Service was designed to work seamlessly with other community services to prevent avoidable hospital admissions and to reduce readmission for patients with LTCs, to support the downgrading of the local acute hospital to an Urgent Care Centre.

The community-based service provides an urgent care team, 24/7 access and intensive support with an enhanced care component that manages caseloads of medically stable patients working in conjunction with specialist nurses, district nurses and therapy services. Rapid access to an enhanced support package with access to social services for up to 72 hours is provided. There is a seamless pathway to community matrons and district nurses for ongoing care. A matrix model of district nursing, enhanced care, specialist care and urgent response enables flexibility and responsiveness to multiple needs. The service also provides physiotherapy, IV therapy, dementia care, social care, heart failure care and geriatrician input.

This service allows patients to be cared for in the community, usually within their own homes, rather than in an acute setting. A&E admissions are avoided, as patients can access the enhanced care service when an issue arises rather than attend hospital. Patients are empowered to manage their own condition at home, but are supported by specialist care when required. The service works closely with GPs and social care to provide continued, long-term support for patients with LTCs or complex needs. There is a single point of access for patients. Here patients are referred either as medically stable for a step-down in care or in crisis for a step-up of care. Stages within the model escalate or de-escalate as required, and patients stay within one system. The model is displayed in Exhibit 3 below. The model is staffed by community matrons, IV therapists, dementia specialist nurses, heart failure specialist nurses, occupational therapists, physiotherapists, medicines management and social care workers.

Exhibit 3: Pennine Care NHS FT Community Enhanced Care Model



Source: Pennine Care

5 Information management

The use of information and online tools is a key enabler in the My Health My Community work. An online virtual resource centre for patients and carers was developed. This provides educational courses, interactive forums, appropriate and relevant local information and signposting to other resources. In addition, a Type 1 diabetes online platform and application was developed to support children with the condition and their families. This was co-designed with young people with the condition. The creation of this web platform and app proved vital in helping patients learn how to self-care alongside providing support for carers.

RAID is in the implementation phase of information sharing, with psychiatric liaison workers able to access the acute hospital patient information system and shared access to data across different agencies.

The community-based stroke service located at Butler Green is the first service offered by Pennine Care that uses Skype video conferencing for routine patient appointments. This has cut appointment time by half by eliminating the need for travel, either by staff to a patient's home or the patient to a clinic appointment. It also reduced the need for additional face-to-face appointments which usually follow a telephone consultation.¹¹

6 Commissioning and payment model

Commissioning and payment models need to be discussed and agreed in the planning phase of the programme. Pennine Care created specific business cases to fund individual aspects of the integrated care programme. The RAID model is built on a robust evidence base of similar work undertaken in Birmingham. This evidence base was used and an agreement reached where the trust funded the RAID and Safford Ward pilot using CQUIN money (ie the trust managed all the risk associated with the pilot). Following successful delivery of the pilot the commissioners agreed to fund the service on an ongoing basis. No large-scale changes to the commissioning and payment model have been made.

7 Workforce

Overall, Pennine Care has a workforce of around 6,000 consultants, nurses, therapists and specialist practitioners. There has been significant development for psychiatric nurses through the RAID programme to help them work in a different system. The reorientation and training of the workforce has therefore been a critical enabler to this programme, as different cultures and behaviours between workforce groups and organisations were in some instances acting as a barrier initially. These barriers were overcome through training, and coaching in understanding, and valuing different perspectives. Common, shared ways of working were agreed to recognise, manage and address these differences. Further, within each of the different integrated care initiatives, staff have been offered additional training. For example, the My Health My Community programme offered relevant staff care package training and education in behavioural change. All staff working at Butler Green have been trained in Mental Health Matters.

8 Governance

As yet, no major changes to governance have been made. The care trust oversees each of the projects, but separate operational and decision-making processes remain between organisations and projects. Pennine Care has been able to deliver the different integrated care programmes within these governance arrangements to date. This is likely, however, to change through the Greater Manchester Devolution programme and the emergence of local care organisations.

¹¹ Pennine Care Progress Report (2015), Pennine Care NHS FT

The board of the trust recently accepted responsibility for the monitoring and improvement of the quality of service provision from the borough's Quality Governance and Assurance Committees demonstrating the early progression to some shared governance arrangements. Each scheme run under CQUIN has its own reporting mechanisms through the trust's assurance team¹ to ensure clear accountability for delivery of the programme.

9 Leadership and journey

Strong leadership, partnership working and vision have been required to push through the changes required for integrated care. Challenges arose when merging the mental health workforce with other clinicians and this required significant negotiation between teams and individuals. Strong leadership facilitated this process, and was key to the implementation of each of the facets of integrated care.

At present, Pennine Care is fairly early in its journey towards fully integrated care. Some key milestones of integration include:

- April 2011 – community services from Bury, Oldham, Heywood, Middleton and Rochdale join mental health services across the trust through the Transforming Community Services Programme
- 2011/12 – commence refreshed Service Development Strategy with new models of integrated care
- 2012 – development of Psychiatry Liaison (RAID) offer
- August 2012 – Butler Green enhanced intermediate care opens
- November 2013 – Trafford Community Enhanced Care Service launched
- June 2014 – publication of Pennine Care's new Working Together, Living Well strategy vision and strategy for whole-person care
- January 2014 – Saffron intermediate care ward launched
- February 2015 – Greater Manchester Devolution programme announced
- May 2015 – My Health My Community programme launched
- December 2015 – Strategic Care for Greater Manchester Devolution published.

Alongside the main interventions of RAID, My Health My Community, Butler Green, and the Community Enhanced Care Service, several other locally focused interventions have emerged during the journey to integrated care, each of which has reduced avoidable admissions and improved outcomes.

10 Bibliography

1. NHS England (2014/15). Better Care Atlas. Online: NHS England.
2. Public Health England (2012). National General Practice Profiles. Online: Public Health England
3. Health and Social Care Information Centre (2014). Quality and Outcomes Framework Data. Online: HSCIC
4. Pennine Care NHS FT (2015). Working together living well. Online: Pennine Care NHS FT

5. Pennine Care NHS FT (2015). Rapid Assessment Interface and Discharge Model. Online: Pennine Care NHS FT
6. Pennine Care NHS FT (2015). Intermediate care examples for My Health My Community. Online: Pennine Care NHS FT
7. Pennine Care NHS FT (2014). My Health My Community Transformation Group Update. Online: Pennine Care NHS FT
8. Pennine Care NHS FT (2015). Driving service transformation through a whole person care approach. Online: Pennine Care NHS FT
9. Pennine Care NHS FT (2015). Pennine Care Annual Report 2014/15. Online: Pennine Care NHS FT
10. Pennine Care NHS FT (2015). Pennine Care Progress February 2015. Online: Pennine Care NHS FT



Local Government Association

Local Government House
Smith Square
London SW1P 3HZ

Telephone 020 7664 3000
Fax 020 7664 3030
Email info@local.gov.uk
www.local.gov.uk

© Local Government Association

For a copy in Braille, larger print or audio,
please contact us on 020 7664 3000.
We consider requests on an individual basis.