Case Study: Integrated re-ablement services in Taunton

Overview:

GPs in Taunton, Somerset, have played a central role in delivering a multi-disciplinary approach to helping people who have recently received treatment in hospital to retain the best possible quality of life in their own homes. The initiative is driven by close partnership working between GP practices, NHS Somerset and the Somerset County Council and has delivered positive outcomes for patients including reducing unnecessary hospital admissions. It has also helped to facilitate closer working between health and social care.

Aims:

The initiative aimed to:

- Support people to regain life skills, enabling them to avoid dependence and remain within their own homes
- Achieve significant gains in terms of service quality, patient outcomes and productivity

Intended outcomes were:

- Reductions in unplanned admissions to hospital
- Prevention of unnecessary admissions to hospital
- Reduced demand on social care packages
- Reductions in admissions to long term care
- Enhanced patient and carer experience and quality of life

Context:

The impact of an ageing population was placing both NHS Somerset and Somerset County Council under significant financial pressure. Reablement was identified as a key priority to help address this problem for both organisations within the Quality Innovation, Productivity and Prevention (QIPP) programme.

The new service was informed and designed around feedback from focus groups that centred on service users' and carers' experiences of existing services, summarised in the following quote from one patient: “I want to maintain my independence and for the service to help me to find the solutions to do the things that matter to me”.

Other issues identified as important by patients and carers included:

- The need for staff to listen to patients' wishes and understand their needs
• For patients not to have to repeat themselves to different professionals involved in their care
• For services to respond to their needs in a timely manner
• For patients to be in control of their care
• For patients not to be passed from pillar to post
• For professionals to treat patients and their careers with respect

Key features:

Somerset Clinical Commissioning Group (SCCG) led the design of the initiative alongside colleagues from the Adult Social Care department of Somerset County Council. 15 GP practices in Taunton are involved in the service with six separate multi-disciplinary re-ablement teams each working with 2-3 practices. Teams typically included occupational therapists, physiotherapists social workers, care workers and Rehabilitation and Adult Social Care Assistants.

The teams use a simple telephone referral system and simple paperwork, and have been constructed so capacity meets demand, resulting in no waiting lists and a responsive approach to patient need. Referrals are taken from two areas of demand that were identified as the points which would most impact on service outcomes:

• GP referrals for people who are struggling to cope
• Discharge from hospital – ensuring the right support is put in at the right time to prevent unnecessary readmissions and dependency on carers

The Taunton Deane GP Federation were involved in the project from the outset. Key issues were discussed regularly at Federation meetings which had a positive impact in terms of GP buy-in to the service. This enabled feedback about the service to be collected easily and fed into the design. A local approach has helped to ensure care is delivered by teams who understand their patients and local neighbourhoods.

Outcomes and results

A qualitative cohort evaluation of the pilot identified positive results from service users, staff and clinicians. Early evidence was found to support a statistically significant improvement in terms of a reduction of readmissions to hospital within 30 days and a reduction in cost of social care packages.

A study of the first 120 people to be supported by the service showed 116 out of the 120 referrals (97%) resulted in reduced support needs after the new teams’ intervention.

The re-ablement group also had significantly better outcomes for 30 day readmissions and social care costs when comparing the change between those at one year prior to intervention and three months post intervention.

The success of the service has led to its roll out to an adjacent GP Federation area in South Somerset. The South Somerset Federation was engaged before the roll out and a GP lead from the federation was selected to improve communication streams.

Feedback from both the re-ablement teams and GPs has been positive. Members of the re-ablement team commented:

• “Identified goals are not passed onto another service but kept within one team - it’s all about the patient”
• “There is now much better flow of communication between all the professionals involved. It has resulted in everything happening more quickly and efficiently”
A local GP commented:

“This approach is more than a breath of fresh air; it is potentially a storm to blow away established unhelpful working practices… The best way to make the new NHS work is to continue to build organic cross-disciplinary teams who are given autonomy to share professional skills to find the quickest answer to each patient’s problems. This is a new way of thinking that could really make a difference.”

Key findings

The model adopted in Taunton demonstrates the potential for investment in multi-disciplinary working across health and social care – anchored around GP practices – to deliver improved patient outcomes. The model also demonstrates how that grouping practices into federations can act as a vehicle for the facilitation of more integrated services based around patient goals and an informed understanding of local needs.

The model adopted represented a significant shift in culture from a reactive "one size fits all" service perceived to previously be in place. Teams are afforded flexibility to find creative solutions to patient centred goals at an earlier point of the patient pathway. This rebalancing of care involved pulling expertise from outside the Integrated Service as and when required, including utilising the skills of Specialist Nurses and Community Psychiatric Nurses.

The project has required up front investment at a time of competing and challenging demands to reduce costs across health and social care. Effective joint working between the NHS and the local authority – with buy-in and engagement from members of the re-ablement team, GPs, the voluntary sector and patients – has helped overcome these challenges and delivered an improved, more cost effective service.