Gloucestershire: creating a specialist multi-disciplinary community team

Summary

A multi-disciplinary community team led by community matrons including physios, dieticians, occupational therapists and wellbeing coordinators support people to stay as independent as possible. For people with multiple conditions there are medication reviews and access to activities that can benefit health and wellbeing, funded through personal budgets if eligible.

Main points

- Multi-agency project group set up to look at what could be done to improve care of people with multiple conditions as part of the push for integrated care
- Funding provided by the Better Care Fund
- Complex Care @ Home team established in April 2018 in two areas
- Use of a risk stratification tool developed with GPs so they can identify people on their registers who may benefit from the service
- Service rolled out to third area in April 2019

Context

Gloucestershire is in the south west of England and is home to around 630,000 people. There are more than 30 towns and one city, although large parts of the county are rural.

The county overall has an older population when compared with the national average and lower than average percentage of Black, Asian and Minority Ethnic communities.

It has pockets of deprivation, but overall the population is pretty affluent with the county ranked as the 124th most deprived out of 152 upper tier local authority areas.

Rates of ill-health are highest in Gloucester and Cheltenham and the district of Forest of Dean.

"THE KEY AIM OF THE MODEL IS TO PROACTIVELY IDENTIFY PEOPLE AT RISK OF DETERIORATION AND PROVIDE A WRAP-AROUND SERVICE TO ENABLE THEM TO BETTER MANAGE THEIR HEALTH AND WELLBEING TO REMAIN LIVING AT HOME FOR AS LONG AS THEY ARE ABLE"

– CHRISTINE CAM, SENIOR COMMISSIONING MANAGER

What was done?

With funding available through the Better Care Fund, the authorities in Gloucestershire decided they wanted to create a new model of care to help people with complex health conditions better manage their own health and wellbeing.

A multi-agency project group was set up including representation from primary care, adult social care, the mental health trust, community provider, commissioners and the commissioned carer organisation.

A combination of desktop research, data analysis and a stakeholder event for health and care professionals informed thinking and in April 2018 a new Complex Care @ Home service was launched in Gloucester and Cheltenham.

The service – run by Gloucestershire Health and Community Services, the provider of community NHS services – incorporates eight community matrons, two dementia matrons, two wellbeing coordinators, two occupational therapists, two physiotherapists, a dietician and two adult social care navigators.

People are proactively identified from primary care and the team also receive referrals from other health and social care sources, including the acute hospital. The team work with people with long-term conditions, frailty and dementia. Most of these people are losing their resilience due to a number of health and social factors.

The community matrons carry out a person-led assessment with the individual, known as "What Matters to You", which establishes the goals the person aims to achieve. The matrons address any medical needs including medication reviews. They are often accompanied on visits by an adult social care navigator who helps to find solutions for low level social care needs.

The wellbeing coordinators then work alongside the person enabling them to achieve the goals set out in their plans. This can involve a wide range of activities and includes getting involved in local groups, improving physical activity or helping people plan ahead in order to re-engage with society where people have become socially isolated.

The wellbeing coodinators work closely with the voluntary and community sector and the Community Wellbeing Service so they are well placed to link people to support networks in their local communities.

What has been achieved?

The service has now worked with over 800 people and is currently being evaluated. Early findings suggest a range of benefits for individuals receiving the service including improvements in mobility, the management of health conditions and access to local resources such as community cafes to reduce social isolation and improve wellbeing. Analysis of data to date illustrates a positive impact on the demand for primary care services. Further work is underway to establish the impact on other areas of the health system.

The case of Mrs B is a perfect example of what can be achieved. She has type two diabetes, hypertension, chronic pain and anxiety. She was on 10 medications and never left the house.
Her medicines were reviewed and reduced and she was given access to a personal budget to fund a personal trainer to start physical activity and motivate her. She soon joined a gym and also started going to a local coffee morning and "Knit and Natter" group. In the space of a few months she lost 10kg and started gardening.

Another person who has been helped is Dave. He has heart problems and ended up in hospital earlier this year after an accident at home.

He said their support helped him retain his independence and stay at home. "They are always there in the background to help. For people like me that is so important."

Gloucestershire senior commissioning manager for integrated commissioning Christine Cam says: "Our focus is on people who are at risk and beginning to lose their resilience and independence.

"The real benefit of the team is that they can take a holistic approach with clinical and social care input focusing both on health and wellbeing. The wellbeing coordinators play a vital role in enabling people to fulfil their goals and access low level community support to sustain the benefits achieved.

"One of the aspects which is really important is the support we provide to get involved with activities that can benefit health and wellbeing. For example, the wellbeing coordinators can book them in and sometimes even attend the first few sessions of a Slimming World group or exercise class. The ultimate aim is to keep people at home and active by maintaining their independence and, where possible, reversing decline."

"THEY ARE ALWAYS THERE IN THE BACKGROUND TO HELP. FOR PEOPLE LIKE ME THAT IS SO IMPORTANT"

– DAVE, PERSON WITH LONG-TERM CONDITIONS

"IT IS REALLY FULFILLING WHEN YOUR PATIENTS TELL YOU YOU HAVE CHANGED THEIR LIFE AND THEY ARE IN A DIFFERENT PLACE"

– LISA TALEB, COMMUNITY MATRON

What lessons have been learned?

In the early days of the service some of the referrals were for people whose needs were greater than intended by the model. The opportunities to prevent deterioration and increase self-management of conditions were therefore not always as possible as envisaged.

To help tackle this, a tool was developed that GPs could use with their own IT systems to identify the people who would most benefit from the support. The risk stratification tool uses set criteria to choose people from the GP register that are most likely to benefit. It includes the requirement that people are over 18, have three or more long-term conditions and are on five or more medications. Having an unplanned hospital admission, a fall or being housebound are also triggers.

The use of the tool and further engagement with primary care and other partners resolved those early problems and the cohort of people receiving the service is now as was intended in the original service modelling.

What is happening now?

Following on from the success of the work in Gloucester and Cheltenham, a Complex Care @ Home service has been launched in the Forest of Dean. This means all three areas of the county with the highest levels of ill-health now have the service. Community matron Lisa Taleb said that is making a huge difference. "The idea is that people will take control of their lives, become more independent and manage their long-term conditions more effectively.

"It is really fulfilling when your patients tell you you have changed their life and they are in a different place. It is great to know we have improved their quality of life."

The service has now been operating for over a year and is currently being evaluated further to establish the outcomes that have been achieved with people and the impact of the service across the wider system. There are plans to further develop the model in response to the findings of the evaluation.

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