Report on Meeting on Integrated Care at Reading Town Hall on 29th Jan 2013

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1 Recommendations

1. Community Staff Boards. Just as in a ward there should be web pages with photos and names of local community nurses and therapists to give residents and patients a feel for the community nursing services. At present these services are almost unknown to those who do not come into direct contact with them.
2. There should be a public description of the community nursing services available.
3. Clarity about who provides what. Sometimes services from one supplier rather than another have come into use just because of the foresight or flair of some particular leader - there is not always a technical/administrative rationale. So it would be good to be clear about who provided what.

2 Context

I attended this meeting at the suggestion of Dr Elizabeth Johnston, of the South Reading CCG. The meeting appeared to be organised by Berkshire Healthcare FT (BHFT), which is the provider of most community nursing services in Berkshire as well as of the mental health services and others, or by NHS Berkshire. There seemed to be more than 100 attendees and they included the head of Adult Social Care for Reading Borough Council (RBC) oncillor Bet Tickner, the RBC lead for Health and Wellbeing. At my table there were a Community Matron (a species until then unknown to me), the head of the Heart Failure Community Nursing team for Berkshire West, the Manager of Intermediate Care for RBC, a therapist from the Prospect Park mental health hospital, someone involved in home palliative care and end of life care and several others.

3 Presentations

3.1 Dr. Rod Smith

Dr Rod Smith is the leader of the North and West CCG and of the Berkshire West Federation of CCGs. He reminded us that there were up to 100 admissions a day at the RBH this winter. We had practices, community nurses, social care and mental health services all hiding data from one another to make our problems worse. He then introduced other speakers.

3.2 Dr Elizabeth Johnston

Dr Elizabeth Johnston is leader of the South Reading CCG. She spoke about Long Term Conditions (LTC), for which she is the Federation lead. The LTC Programme Board brings together the Royal Berks Hospital FT (RBHFT), BHFT and the Clinical Commissioning Groups (CCGs). 1 in 3 children and adults suffer from a LTC. LTCs account for 55% of GP appointments, 64% of outpatient visits, 72% of inpatient bed days, 58% of A&E attendances, 59% of Practice Nurse visits and 40% of calls to the non-emergency 111 service.

Efforts were being made in Patient Education, Patient self-management and provision of Dementia care advice services. There was a local LTC website. Major conditions were Dementia, Diabetes, chronic obstructive pulmonary disease (COPD() and neurological conditions. There were many patients with multiple morbitiies.

CCGs were appointing their care coordinator - an administrator to supoprt review and management of LTC cases.

Admission avoidance would be a theme of future care of patients with LTC. This will necessarily involve medical interventions outside the hospital and appropriate social care.

3.3 Councillor Bet Tickner

Cllr Tickner spoke against the background of the "graph of doom" - a graph showing social care costs rising to consume all of local authority spending.

Integration would help drive up the quality of social care, and should provide a single personal contact to be in charge of that person's care.

3.4 Suzanne Westhead

The head of adult social care for Reading spoke of the need for "creative conversations" and the need to combat isolation and depression which could result from keeping the patient in their own home.

3.5 Mark Robson

The director of operations for Networked Care at RBH spoke with a great many bullet points, but I must say, I was at a loss to understand any clear message.

3.6 Julian Emms

The CEO of the BHFT started by defining integrated care as person-centred, coordinated care, which seemed to command universal agreement. He mentioned shared robust clinical records and the needs of carers. BHFT delivered some 2.5 million treatments per year.

3.7 Julie Curtis

The director of commissioning for NHS Berkshire discussed examples of integrated care: Northamptonshire's "Patient in the Centre", Devon's combined Health and Social Care (co-locating "community virtual ward", complex case teams, mobile/smart working, and the rapid assessment "Hospital at Home"), Southend's Information Driven Integration (costing whole pathways across Health and Social Care), Bradford's primary care led integration, based on zones of 35,000 to 45,000 people, with neighbourhoods of around 15,000 served with integrated health and social care, Torbay's elderly care - based on locality teams serving populations of 40,000, colocation of services in Barking and Dagenham with clusters of 6-7 GP practices, coordination and integration in Lambeth and Southwark.

BHFT had just re-organised in terms of 6 practice clusters in Reading (but no one at my table seemed aware of this - how integrated was this move?). Dignity in Care clusters and capacity and demand modelling were mentioned.

In Berkshire community services would share patient information with current RIO records until 2015 (?)

Note hospice places are in short supply - there are none at all for carers' respite.

4 Next Steps

Tables were given the task of selecting two practical next steps towards integrated care. Almost all tables chose colocation of community nursing and social care and establishemnt of a single point of contact for all mobile workers requestingservices for their clients/patients. Wider sharing of electronic patient records might have been on people's minds but was not much expressed - firstly, the RBH needs to get itself out of its current pickle and then perhaps significant investment will be needed at practices and for mobile working to go further.