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CONFERENCE ABSTRACT

What are the essential ingredients to successful delivery of integrated care to help keep frail and complex patients well, and out of hospital?

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Introduction: In conjunction with the Northwest leadership academy, clinical and managerial leaders in South Manchester, UK observed and interrogated successful models of integrated health and social care in Washington DC, USA before the introduction of an innovative local model, and afterwards in Barcelona, Spain. The observation of others successful systems were a useful mirror to analyse, evaluate and implement the elements needed to make integration work. Our subsequent visit to Barcelona allowed identification of the missing ingredients that had meant our innovation had not been as successful as we had hoped. We will describe our learning, what worked, what didn't, and the essential ingredients we identified.

Practice Change Implemented: Our aim was to assimilate best practice, create a multidisciplinary approach to management of complex patients, evaluate the impact of those interventions and review effectiveness in the light of best practice.

A system of multidisciplinary 'neighbourhood team' working was implemented which brought together, general practitioners, social care professionals, practice & community nurses, mental health practitioners and managers on a regular basis to discuss the best care and person to lead as key workers. The use of personalised care plans developed with patients was a key platform of the implementation. Patients were identified using risk stratification tools.

Key Findings: There were impactful interventions for individuals, which radically improved their quality of life and the coordination of their care. All 25 general practices in the area were able to participate. The intervention was rolled out in a population of 166,000 people in urban south Manchester with at least 2% of the adult population receiving an intervention in the first year.

There was a reduction in acute admissions of around 20% in the under 65 age group but no change in the over 65 age group; this was not as high as anticipated and meant the service could not self-sustain in its original form. A non-integrated shared electronic care record was introduced but there was strong resistance to its use, particularly from general practitioners due to it's lack of integration with their systems and need for additional logins. Working relationships with voluntary and housing providers were very much improved.

Highlights: Key learning prior to implementation was:

• The effectiveness of integrated electronic care records.

• Prevention as everyone's business from reception staff to providers.

• The importance of strong Identity, brand, standards and values.

• The ability to place health and social care practitioners in the same room to manage patients together

• Clinical or social care professional leadership

Key Learning during the implementation was:

• We cannot assume that health and social care staff understand each other and their roles

• Doctors are not well trained in the writing of care plans

• Accountability of practitioners with key workers in multidisciplinary teams need clear identification

• New team configurations must be careful not to exclude existing members

• Incentives do not always align between providers and commissioners

Key Reflections following implementation were:

• Commissioning and contracts need to be based on outcomes and not processes of care

• New team development should have the longer term, 'business as usual' position in mind from the start of change

• The importance of interprofessional education should not be underestimated if a changed culture of integrated working is to be created.

• Assumptions should not be made about the abilities of experienced practitioners to work in new ways.

• Electronic care records must be truly integrated to be acceptable; this is within the realms of the possible.

Conclusion: All the right ingredients in the right amounts need to be present to create a successful recipe for integration of health and social care around the needs of the growing frail and complex patient population. Implementing our own programme and viewing those in existence in Washington DC and Barcelona helped us identify these as:

1. Truly integrated and shared electronic record systems

2. Strong identity, brand, standards and shared values

3. Outcomes based commissioning and contracts

4. Making prevention everyone's business

5. Health and social care practitioners working and learning together to understand how their services integrate

6. Strong clinical and social care leadership, all staff have a role in leadership

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7. Clear acceptance and attribution of accountability, individual and organisational

8. Incentives and rewards which are aligned

9. Patient-centred approach

10. A culture change, developed through learning and working together is needed for new and existing health and social care integration of teams to work successfully together

Keywords: integrated care; best practice