
CONFERENCE ABSTRACT

Integrating care in local neighbourhoods

16th International Conference on Integrated Care, Barcelona 23-25 May 2016

Richard Daly¹, Rebecca Demaine², Catriona Logan⁴, Paul Beech³

1: East Lancashire Clinical Commissioning Group, United Kingdom;

2: East Lancashire Clinical Commissioning Group, United Kingdom;

3: East Lancashire Hospitals NHS Trust, United Kingdom;

4: East Lancashire Clinical Commissioning Group, United Kingdom.

NHS East Lancashire Clinical Commissioning Group (CCG) along with its partners is driving the development of integrated care. Integrated care is a means by which we can co-ordinate care around the needs of individuals in our communities, residing in five localities, with over 382,000 residents. Successful delivery of integrated care will reduce inappropriate and unnecessary demand on services and support independence, effective outcomes and self care.

East Lancashire is an area with significant deprivation, poor quality of life, and poor health. The consequence of this, is a larger than average proportion of people with multiple health conditions and some of the highest rates of unplanned admissions to hospital in the country. Our challenges locally include an ageing population, increasing population diversity, extremes of socioeconomic deprivation and disadvantage, rising expectations and demand. Health and social care services for complex and long term conditions, as currently configured are not sustainable in the face of future projected need and increasing financial constraints.

The case for integrated care as an approach is well evidenced. Additionally, the integration of health and social care services potentially offers further means of supporting people with complex health and social care needs to live well in the community.

Locally, work is underway to establish the foundations for co-ordinated delivery across health, social care, public health, third sector and other local services however more needs to be done to ensure scale and pace of transformation.

The model for integrated care consists of three elements: Integrated neighbourhood working, an Integrated Home Support Service (IHSS) and an Integrated Discharge Service. A critical element of the approach is the Integrated Care Assessment Team (ICAT).

ICAT is a multi-disciplinary team who take referrals from a range of health and social care disciplines in the community and acute sector and allocate short term community care. This can be both, step up and step down.

Integrated neighbourhoods are a way of working where all health and social care professionals work together as a virtual team in each of the five localities of East Lancashire. The result is improved coordination and communication between GPs and the range of professionals that

support patients in the community. The integrated neighbourhood consists of GPs, practice nurses, therapy staff, social workers, mental health teams, intensive home support staff and voluntary sector staff. Care is co-ordinated by a care co-ordinator who ensures that all aspects of a patient's care is integrated, smooth and well managed.

IHSS consists of a team of clinical staff who provide responsive assessment, monitoring, investigations and support to help patients avoid unnecessary admissions and to help patients return home from hospital wherever possible. This support is delivered in patients' homes and working with the integrated neighbourhood approach, ensures that the right support is allocated to patients to live at home independently and safely. The IHSS model is co-designed with key partners to try and reverse the following trends:

- Inpatient high prevalence of frailty
- High frail elderly A&E attendance
- Longer length of stay for frail older patients
- High readmission rates
- High mortality rates

The underpinning model of care for Intensive Home Support rapid response which is an established tool in integrating services around the needs of individuals with long term conditions. This supports commissioning intentions, harnessing resources across the community infrastructure regardless of agency boundaries or culture ensuring that patients are treated and managed in an appropriate place of care which is closer to home. There is a need to work across health and Social care boundaries in partnership with mental Health Services to achieve this.

The IHSS service ensures the speedy delivery of a high quality service that meets the needs of those at risk of a potentially avoidable admission. It supports and empowers patients to manage their long term conditions in their home environment. It improves patient experience and minimising cause for complaint. The service works with GP Practices within neighbourhoods to identify frail elderly patients that require a multi-agency approach to case management. In addition, it works with health, therapy services, social care and voluntary sectors to identify suitable patients for the service caseload. It provides holistic assessment of need and necessary support, equipment and interventions to promote stability in the patient's condition and enable them to remain in their own home. Ultimately it works with partner professionals, agencies and organisations to enable the patient to be managed safely at home, and to support the discharge process when caseload patients attend or are admitted to Acute Services.

Keywords: integrated care; partnership; primary care; self care; outcomes
