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CONFERENCE ABSTRACT

Integrating Community Health and Social Care Services in Fife

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Ron McDowall, Aileen Whyte, Jill Dow, Lorna MacKenzie

NHS Fife, United Kingdom.

Introduction: Fife is the third largest local government region in Scotland with a growing population of 366,957, of which 18% are over the age of 65, and with a mix of urban communities and sparsely populated rural communities. Social care services are delivered by Fife Council and healthcare services by National Health Service Fife in a partnership working arrangement but with separate workforces, management structures and funding. Unplanned admissions to hospitals and care homes account for nearly 30% of the resources that Fife spends on health and social care for older people. To address these demographic and associated funding pressures, a programme to redesign and integrate community health and social care services was implemented.

Description: The Scottish Government introduced a Reshaping Care for Older People programme to create a vision and offer some funding for service change. The programme aims to increase care in community settings resulting in reductions in demand for hospital inpatient and care home facilities. This should allow disinvestment to enable successful community services and projects to be sustained. The Government programme does not prescribe how community services should be redesigned, devolving responsibility and empowering organisations to do that with their local knowledge.

In Fife, community service redesign is informed by Stakeholder Events where health and social care professionals are joined by third and independent sector, patient and carer representatives to map existing pathways and identify ways of integrating teams, reducing handovers and avoidable hospital and care home admissions. The aim is to empower teams to encourage patients and their carers to take control of their own health and wellbeing personal outcomes.

The redesign has created an Integrated Community Assessment and Support Service (ICASS) combining professionals and blurring roles (nurses, physiotherapists, occupational therapists and care assistants) into multidisciplinary teams with shared care plans, resources and support systems. A number of related projects focus on prevention of admission (Hospital-at-home, day hospital rapid assessment, falls response, re-ablement, third sector capacity building, Local Area services Co-ordinators). Other projects focus on discharge planning and support (hospital discharge planning hubs, Short Term Assessment and Rehabilitation beds, special needs housing, discharge-to-assess, third sector supported discharge)

Service managers facilitated integration and scaling up of services, developed a culture of integrated multi-disciplinary working in teams of co-located health and social care workers, created a generic support worker role, introduced performance management measures and consistent delivery processes across Fife.

Evaluation is focussed on achieving personal outcomes, including conversations training for staff, and an IT patient management system that records outcomes goals. National tools such as Indicators of Relative Need (IoRNs) are used, and a university research project, PEPPERs, is measuring the effectiveness of proactive community interventions compared with unplanned hospital admissions in a randomised trial.

Key findings: Successful integration of multidisciplinary ICASS teams and collocation of professionals has improved communication and empathy resulting in better co-ordinated patient care and more effort on prevention of admission to hospital. Assessing homecare needs at home or in STAR beds is reducing the costs of packages of care or care home admission.

However this success is countered by accelerating growth in demand for services and increasing complexity of people living longer with multiple long term conditions.

Highlights: Redesign of community services was already underway in 2011 when the Reshaping Care for Older People programme was launched and the process of evolution is continuing. The huge complexity of health and social care service integration needs a structured project management methodology to plan and implement change. Resistance to change in the workforce, and differences in practices between localities is being overcome with ongoing engagement, using reference groups, training needs analysis and upskilling, shadowing and mentoring.

Clear communication of vision and change plans, and full engagement of the workforce in the change process is the key to success. Implementing change will take longer and cost more than you expect.

Conclusion: Fife is continuously evolving and improving integrated community health and social care services that are focussed on proactively helping older people live safely and independently in their own homes for as long as possible. A new operational management structure for intermediate care that is scalable and transferrable across Fife communities, ensures a consistent service experience for patients across Fife . Community teams' activities are shifting from responding to crisis to proactively managing frailty and long term conditions. To create a more enabling environment for integrated care, in April 2016 NHS Fife and Fife Council will launch a new Integration Authority with strategic priorities for prevention and early intervention, integrated and co-ordinated care, tackling health inequalities and improving mental health services. The journey continues…..

Keywords: intermediate care; multi-discipline teams; anticipatory care; community service; patient centred

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