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CONFERENCE ABSTRACT

Neighbourhood Care Development in Inverness, Highland, Scotland

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Introduction: NHS Highland is responsible for the delivery of all adult health and social care services in this area with the Highland Council responsible for the delivery of children's services under a Lead Agency model developed as part of health and social care integration in 2012.

Whilst integration had brought together adult health and social care services into a single organisation the real benefit was not realised in Inverness due to the comparatively large size of the teams this created. There was an extended length of stay in hospital and waiting lists for assessment and commencement of care packages.

Description of practice change: From 2 large district teams 7 community neighbourhood teams were formed with a single referral route to each team. The teams are responsible for all aspects of caseload management with decision making supported by multi-professional huddles.

Work in progress to support the teams includes the introduction of an electronic record MORSE, the inclusion of independent care at home providers in huddles, community asset building with Inverness Community Planning Partnership, coaching development for managers and the development of team performance and governance information.

Aim and Theory of change:

The change is based on the principles of the Buurtzorg model of neighbourhood care in the following ways,

Autonomous team decision making and caseload management

Neighbourhood teams with a community asset approach to delivering and sustaining care.

Coaching enabling team function and efficiency.

The aim is to prevent unnecessary admission to hospital and care homes, prevent delay in hospital, provide palliative, preventative and rehabilitative treatment for the neighbourhood population through the effective use of combined team and community resources.

We aim to improve staff and patient experience by increasing face to face time between staff and patients and reducing bureaucracy and duplication.

Targeted populations and stakeholders: All adults requiring health or social care support in Inverness.

Stakeholders are community team members, managers, GPs, independent sector care providers, acute and community hospitals in Inverness.

Timeline: The model has been developing since 2016 with further supporting changes planned over the next year.

Highlights: Builds on the foundations laid by the formation of the Lead Agency model which has not required cross organisational boundary work so restructure has been quick to effect.

Comment on sustainability: The model requires organisational and community planning support to be sustainable.

Comment on Transferability: Readily transferable to other integrated teams with effective cross-organisational working.

Conclusion: These are early days but the smaller teams have embraced the change with a real sense of responsibility for supporting their local communities. Metrics are in place to measure the impact which will be reported on in due course.

Discussions: What level of autonomy is desirable and possible in NHS organisations?

Challenges for social care inspection and registration bodies.

Lessons learned:

Large teams lead to silo working.

Clearer focus on meeting outcomes requires not just multidisciplinary but joint multi-agency and community engagement in its widest sense to be successful.

Keywords: neighbourhood; multiagency; community engagement
