Integrated Care: International examples of good practice

System: Coast Locality, Torbay and South Devon Foundation NHS Trust, ENGLAND				
Contact details: Felix Gradinger, c/o ificscotland@integratedcarefoundation.org				
Name of good practice: Enhanced intermediate care				
Select (x) all areas that apply to your good practice (select more than one if applicable)				
CLIENT GROUP	Children and young people		Older adults	x
	Younger adults	x		
SETTING	City		Remote & rural (incl islands)	x
	Corporate		Urban	
SERVICE AREA	Addictions		Management team	
	Admission avoidance	x	Mental health	x
	Community care services incl care at home/care homes		Physical disabilities	
	Day services		Physical health	x
	Housing incl Homelessness		Primary care	x
	Intermediate Care incl Hospital at Home	x	Rehabilitation	x
	Justice services		Social care services	
	Learning disabilities		Supported discharge	
	Other – please specify			
ELEMENTS of FRAMEWORK	Anticipatory care planning		Live independently at home or in a homely setting	x
	Assets based approach		Manage own care	x
	Connect with communities		Reablement	x
	First point of contact		Seamless working with acute	x
	Enhanced care in care homes / supported accom		Short term targeted interv to meet more complex needs	x
	Fully integrated community teams	x	Teams aligned with general practice	
	Other – please specify			
ENABLERS	Agile working		Information sharing	x
	Aligned plans		Infrastructure	
	Clarity of vision		Management information	
	Clinical and care governance	x	Shared accountability	
	Collaborative leadership		Strong team ethos	x
	Culture and values		Technology	
	Fit for purpose premises		Well-developed lead professional roles	
	Improvement capacity		Well-developed relationships	x
	Other – please specify			

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Summary of situation	Torbay and South Devon Foundation NHS Trust, one of the first Integrated Care Organisations in England, provides acute and community services for approximately 286,000 people living in six rural market and coastal towns served by 34 general practices in five localities. The proportion of people aged >60 is higher than the national average, with very high numbers of people over 85 years. The local population increases by up to 100,000 over summer months. Historically, the Trust's model of intermediate care performs above average on most of the 18 NICE performance indicators, and at lower cost per service user compared to National Audit of Intermediate Care benchmarking average. In 2016 the Trust introduced an enhanced multi-agency model of intermediate care to manage more complex patients in the community, avoid emergency hospital admissions and facilitate earlier hospital discharge.
Actions taken	From 2015, the Trust adopted a phased approach to community hospital bed reductions allied with introduction of enhanced intermediate care teams operating from community wellbeing hubs. The service was 'enhanced' by employing GPs and pharmacists to work alongside the traditional nursing, AHP and social workers team. In addition a voluntary sector partner was introduced to provide a wellbeing coordinator role. Coastal locality, with a population of around 35,000 and over 25% aged over 60 years, made this shift in 2016 - a year ahead of the neighbouring localities. The Coastal enhanced intermediate care team operates from the Teignmouth Community Hospital and meets five days / week to discuss a caseload of around 30 patients at high risk of admission / recently discharged from hospital. The team comprises community matrons, district nurses, AHPs, social workers, mental health liaison staff, GPs (five sessions), pharmacists (4 sessions), community hospital liaison and voluntary sector wellbeing coordinator. The MDT can access information from the GP records. Voluntary sector wellbeing coordinators are trained to use goal setting tools to co-produce a strengths based person centred plan with individuals and their families and to offer focused coaching, advocacy, navigating and social prescribing functions. Wellbeing coordinators, directly or with other members of the team, respond to mental health issues; offer caregiver and bereavement support; address social isolation; housing / benefits issues; and help with transport, mobility and end of life care. A 'researcher in residence' partnership, with local academics from the University of Plymouth, offers timely, applied and transferable embedded research on development, evaluation and adaptation of innovations where the evidence base is weak or uncertain. Two part time researchers prospectively collected qualitative

	service and clinical outcomes data over 17 months in a nested case study that formed part of a mixed methods evaluation to assess the impact and costs of the service model in Coastal, compared with the natural 'controls' of the other localities. Indicators considered include service activity levels, health and care costs, and detailed patient level outcomes including the Person-Centred Co-ordinated Care Experience Questionnaire (P3C-EQ), the 7 domain Outcomes Star Motivational Chart, the Patient Activation Measure, The Warwick Edinburgh Health and Wellbeing Scale and the Clinical Frailty Scale. Through an ethnographic approach, the 'researchers in residence' identified key contextual and organisational factors that contributed to successful implementation: ➢ a history of collaboration and trusting relationships between GPs and community teams; ➢ a well-developed voluntary sector, providing a range of community support services; ➢ well boundaried manageable population size enabling all referrals to be managed within one MDT; ➢ co-location of the MDT enabling iterative informal MDT working; ➢ a person-centred culture, focused on early mobilisation and independent living; ➢ devolved and distributed clinical leadership with dedicated support from a GP in a system-wide leadership post to support acute and primary care integration.
Outcomes / impact	Around a third of referrals required GP input. Pharmacists were involved in 1:7. The enhanced intermediate care team was associated with perceived prevention of GP telephone consultations and out-of-hours visits, social care visits, nursing and residential care stays and emergency calls. While these benefits accrue across general practice, acute and community services, it is the small number of A&E attendances and acute admissions prevented that contribute most to the system costs avoided. If the prevented episodes are costed using national tariff costs, the service more than pays for itself with an annualised 'cost offset' benefit estimated at £149,323 (£127,169 - £167,866). Compared to neighbouring localities where the enhanced model was introduced a year later, and in some cases only partially achieved, the Coastal locality observed: • significant increase in referrals to intermediate care, including by GPs • more people being cared for in intermediate care at home v bed based care • shorter duration of intermediate care episode • lower rates of GP referrals to the Emergency Department • lower inpatient bed-day rates in ≥70 year olds

	The subgroup with high needs for mental health support were younger with lower wellbeing scores and higher healthcare costs at baseline. Post intervention this younger group experienced the greatest percentage increase in wellbeing scores and the greatest cost reductions.
Links to presentation and recording	 Recording
Related publications	The researchers and clinical team have published a series of papers providing more detail on the model of care and impact. ***Impact of 'Enhanced' Intermediate Care Integrating Acute, Primary and Community Care and the Voluntary Sector in Torbay and South Devon, UK.*** https://www.ijic.org/articles/10.5334/ijic.5665/ ***Integrating the voluntary sector in personalised care: mixed methods study of the outcomes from wellbeing co-ordination for adults with complex needs.*** https://www.emerald.com/insight/content/doi/10.1108/JICA-02-2020-0010/full/html ***Capturing the Role of Context in Complex System Change: An Application of the Canadian Context and Capabilities for Integrating Care (CCIC) Framework to an Integrated Care Organisation in the UK.*** https://www.ijic.org/articles/10.5334/ijic.5196/ ***Reflections on the researcher-in-residence model co-producing knowledge for action in an Integrated Care Organisation: a mixed methods case study using an impact survey and field notes*** https://doi.org/10.1332/174426419X15538508969850

Even better if …

- **there is further development of the enhanced intermediate care team to deliver a Virtual Ward / Hospital at Home element with involvement of secondary care clinicians**

Similar international examples of enhanced intermediate care

Dublin - *Is Pathfinder a safe alternative to the emergency department for older patients? An observational analysis*
https://academic.oup.com/ageing/article-abstract/50/5/1854/6263924?redirectedFrom=fulltext

Acute care at home and Intermediate care, Southern Trust, N Ireland

Recording

***Community frailty team workforce development – a personal reflection*, ENGLAND**
Journal of Integrated Care, Vol. 29 No. 4, pp. 464-468.
https://doi.org/10.1108/JICA-04-2021-0021

Bed based intermediate care - models in the Netherlands and Barcelona

Recording

SE Sydney LHD, New South Wales ***Teaming up for more comprehensive care: case study of the Geriatric flying squad and emergency responders (Ambulance, Police, Fire and Rescue)***
https://www.emerald.com/insight/content/doi/10.1108/JICA-05-2021-0025/full/html

Partnering with volunteers and the third sector in Ontario
https://vimeo.com/323555750

NATIONAL HEALTH AND WELLBEING OUTCOMES	
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.	x
2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	x
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	x
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	x
5. Health and social care services contribute to reducing health inequalities.	
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	x
7. People who use health and social care services are safe from harm.	x
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	
9. Resources are used effectively and efficiently in the provision of health and social care services.	x
Health and Social Care Scotland's 5 Essential Elements (click link to listen to statement of intent)	
1. Transforming the approach to improving health, wellbeing and independence	x
2. Building stronger community care systems and primary care services	x
3. Establishing a new focus on mental health	x
4. Securing a sustainable acute hospital service and specialist care service	x
5. Strengthening future partnerships to ensure a modern sustainable workforce	x

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