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POSTER ABSTRACT

Implementation and impact of co-locating the voluntary sector with a multidisciplinary, cross-sector community hub at the Integrated Care Organisation (ICO) in Torbay and South Devon, UK

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Introduction: International policy is encouraging a re-design of health and social care services, including the use of social prescribing. Torbay and South Devon NHS Foundation Trust, an Integrated Care Organisation in the UK, commissioned a voluntary sector 'Wellbeing Coordination' service as a key element of the wider care model.

This case study seeks to understand how primary, acute, social, community and voluntary services are working together in a locality hub and the impact of wellbeing coordinators on service users' well-being, use and cost of health and social care services

Methods: A before-and-after study, supplemented with qualitative case studies, practitioner interviews/surveys, observations of multidisciplinary team (MDT) meetings and service user/caregiver interactions. Applying an action-based participatory approach, findings were co-produced with stakeholders and members of the public by embedded researchers-in-residence. Quantitative service user data were collected on health and social well-being outcomes and frailty on referral and 12 weeks. Comprehensive activity and cost data were collected at 12 months pre- and post-referral.

Results: Health outcomes and service activity data were collected on 49 participants receiving the wellbeing coordination programme. All person-reported outcomes showed statistically significant increases in mean change scores (Warwick-Edinburgh Mental Well-being Scale, Well-being Star™, Patient Activation Measure, Rockwood Clinical Frailty Scale, Living well goals met). Qualitative case studies and observations highlighted key mechanisms of the intervention and the hub working.

The impact on health and social care use and cost was more nuanced, with mean activity and cost increasing overall. Referrals from the Enhanced Intermediate Care MDTs (20/49) showed higher levels of use and cost.

At locality hub level, the practitioner survey, observations and interview findings show an increase in vertical and horizontal organisational integration and high levels of staff-reported person-centeredness while embodying a strengths-based approach.

Discussion: The study shows a positive impact on outcomes and mixed patterns regarding activity and cost. The findings indicate potential for more 'down-stream' and preventative work. The close links with the wider voluntary sector add to the hub offer in holding more complexity, providing access and continuity of care, and delivering holistic and personalised care in the right place and at the right time.

Conclusion: Key elements of how the hub works indicate the importance of leadership, co-ordination, communication, colocation, and contracting that allows the nourishing of trusting relationships and crossing of organisational and professional boundaries.

Lessons learned: Challenges included pooling resources, record sharing, information governance and engaging all stakeholders in a shared vision for a strengths-based, person-centred culture. Ownership and bottom up dynamics and formal and informal relationships between practitioners at all levels, including the community they work with, were key features for overcoming these.

Limitations: Case studies and participatory research approaches may be considered lesser to experimental study designs. However, context is crucial to integrated care and extrapolating generalizable findings. Co-production and triangulating varying data sources helps studying and implementing complex system wide transformation.

Suggestions for future research: The Researcher-in-Residence model could be rolled out across systems to facilitate learning, and to increase robustness of insights.

Keywords: care at home; social prescribing; community assets; cross-sector approaches; multidisciplinary teams