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POSTER ABSTRACT

Impact of “enhanced” intermediate care located in a health & wellbeing hub at the integrated care organisation (ico) in torbay and south devon, uk

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Introduction: Torbay and South Devon NHS Foundation Trust, an Integrated Care Organisation, re-designed its Intermediate Care (IC) service to manage more complex, older patients in the community and facilitate earlier hospital discharge and reduce admissions from the community. The “Enhanced” IC service (EIC) employed GPs, pharmacists and the voluntary sector to work with social and community services (the traditional model) in locality ‘hubs’. It was assumed that EIC would deliver a more strengths-based, person-centred, coordinated care (PCCC) ‘closer to home’, whilst reducing system demand and costs.

Methods: A mixed-methods case study, using embedded Researchers-in-Residence (RiR), compared the first established service (Coastal EIC) with four other localities, over time (natural experiment). Quantitative data: service input data (n=72); two ad-hoc validated surveys (n=672 and n=17) of PCCC in staff and patients; assessment of service use prevented (n=1001), including a ‘cost-offset’ analysis, calculating ‘notional’ annualised cost-saving; and routine data used to calculate rates in over 70 year-olds for referrals (acute and GP), bed-capacity, admissions and length of stay (LOS). Findings were co-produced with stakeholders to drive change and to explore explanations for differences in outcomes.

Results: Service data showed GPs inputted into 36% of cases (not including GP contacts), pharmacists 15% and the voluntary sector 13%. Moderately high need service users reported fairly high levels of PCCC, with an average score of 66%. The PCCC practitioner survey (response rate 39%) showed higher levels of PCCC in 19/27 questions, compared to an Australian benchmark. PCCC was strongest in the domains of ‘treating people holistically’, ‘supporting activation’, ‘feeling joined-up’ and ‘involving the family’. ‘Care planning’, ‘single point of contact’ and ‘telling your story once’ required improvement.

EIC prevented 1,940 incidences of service use (1.9 per referral). Most of this fell outside the ICO (Out of Hour GP and nursing services (45.1%), a GP telephone consultation (13.6%), Residential nursing (4.0%) and social services (3.2%)). Prevention of ICO service use equated to 2-3% of emergency attendances. The notional average cost saving was £149.17 per person, mostly due to secondary care avoided.

Coastal EIC had persistently shorter LOS, lower bed-day and emergency attendance rates and more care at home than other localities, but fluctuations over time weaken attribution solely to EIC.

Discussion: Coastal EIC was managing more complex patients in the community. Greater clinical and pharmaceutical input and personal information at the daily MDT, record sharing and pro-active links with GPs and the hospital, enabled more PCCC, impacting on LOS and demand.

Conclusion: EIC has the potential to deliver better patient experience for complex, older patients, whilst reducing demand and costs.

Lessons learned: Implementing EIC consistently across localities presented challenges for leadership, GP engagement, record sharing, and links with community and acute services. RiRs can help facilitate relationships, learning and service development.

Limitations: Implementing complex integrated interventions often precludes rigorous study designs. Although case studies and participatory research are prone to bias, they can provide rich insights and support change.

Suggestions for future research: How can the RiR model support implementation of other complex integrated care initiatives?

Keywords: intermediate care; multi-disciplinary teams; person-centred care; voluntary sector; gp