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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19th International Conference on Integrated Care, 1-3 April 2019, San Sebastian, Basque Country

http://clahrc-peninsula.nihr.ac.uk/research/researcher-in-residence

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volunteering in health ...reaching out

Torbay and South Devon NHS NHS Foundation Trust

Torbay Medical Research Fund

UNIVERSITY OF PLYMOUTH

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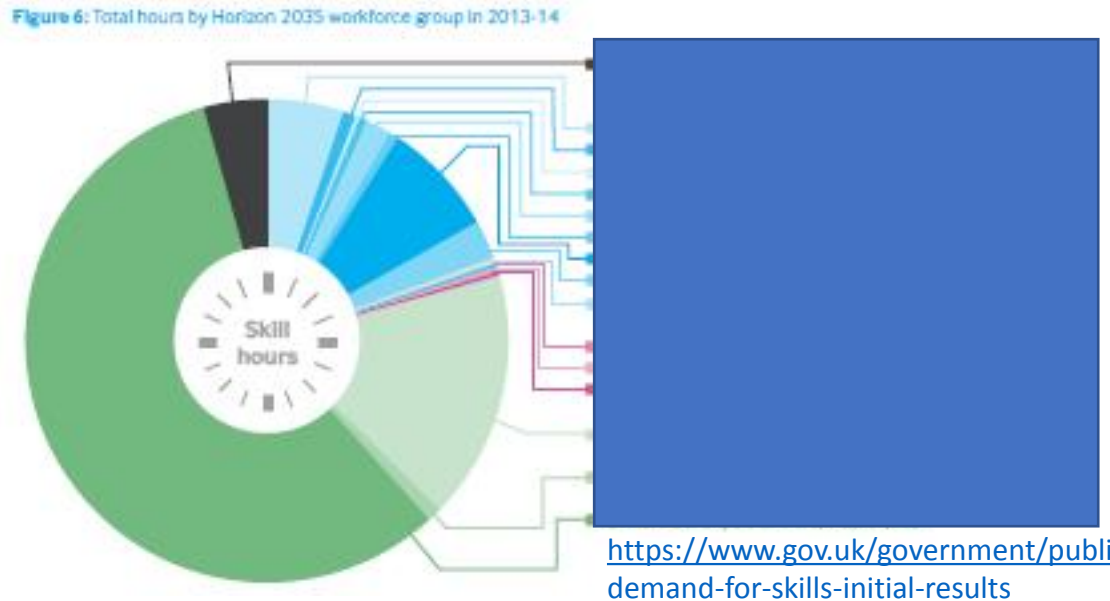
‘Humble Pie’ Chart

- **CENTRE** FOR **WORKFORCE INTELLIGENCE (Aug 2015)**
- **Future demand for skills: Initial results [Horizon 2035]**



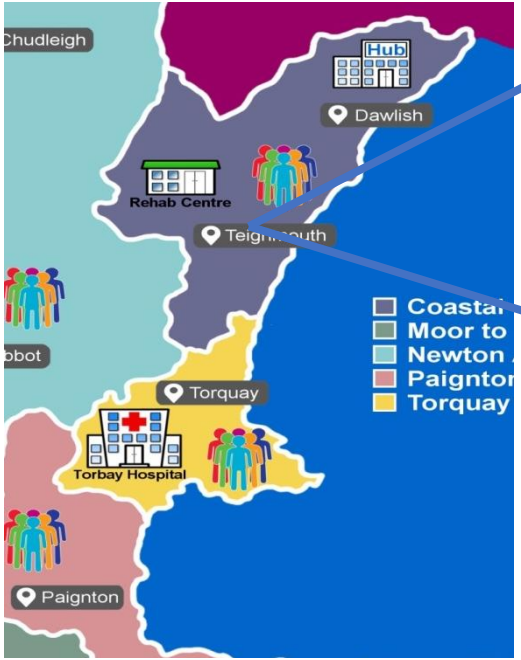
https://www.gov.uk/government/publications/horizon-2035-future-demand-for-skills-initial-results

“In 2013 there was a total of 9.0 billion hours of health, social care and public health activity. **Unpaid and voluntary care account for 61 per cent** of total time...” (p.16, Quantifying workforce groups)

Background

- NHS Long-term plan: Integrated Care Systems, Primary and Community Services, Personalised Care ('social prescribing', p.1)
- Joint (DHSC, PHE, NHSE) review/recommendations on voluntary, community and social enterprise (VCSE) (https://voluntarycommunitysocialenterprisereview.files.wordpress.com/2018/05/vcse-review-action-plan-may-2018.pdf)
- Embedded Research – 45 NHS orgs currently (https://www.embeddedresearch.org/resources.html)

Enhanced Intermediate Care (EIC) and Wellbeing Coordination (WBC) in Coastal locality



- Every morning from 9-10am
- Enhanced IC MDT attended by **GPs**, Nurses, Occupational Therapists, **Community Pharmacist**, Physios, **Social Workers** and a **Wellbeing Co-ordinator** from Volunteering In Health
- Discuss new and existing patients on the Intermediate Care Team caseload, and those approaching discharge in acute and community hospitals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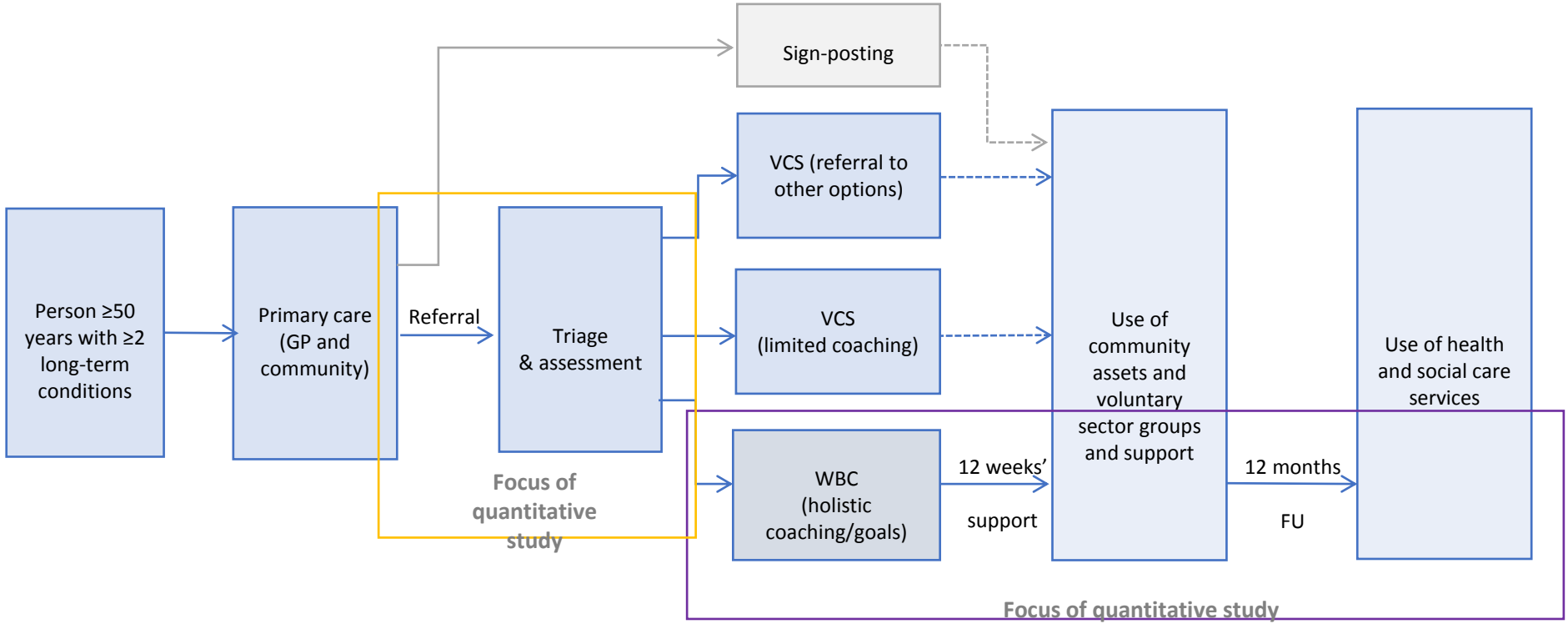
Wellbeing Co-ordination Service: evaluation focus



Who received the WBC programme?

No. of people in study

- 12 week b/a outcome – 49
- 12 month b/a activity - 49

Mean age = 77.4 years (52-99)

- Mostly living alone (37), if not:
- 6 were caregivers
- 6 being cared for

Sex

- 33 (67%) female and 16 male clients

Referral routes

- 29% Internal VIH referral (N=14; i.e. transport, befriending, home help, memory café, community hospital link workers);
- 29% from the hub (N=14; i.e. Intermediate Care team, nurses);
- 18% from primary care (N=9);
- 12% through self-referral (N=6);
- 10% social care (N=5)

How does it work?

- Complex presentation of comprehensive, **bio-psycho-social** need

(of 49: 47 Social, 39 Bio, 38 Psycho)

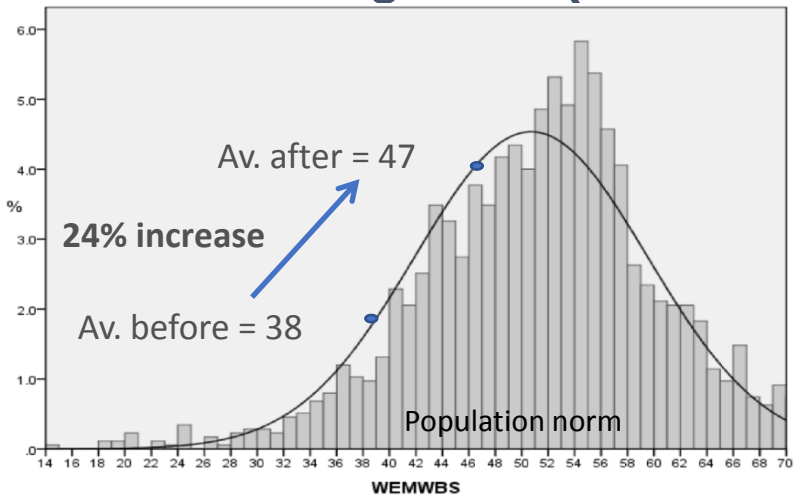
- WBCs operate as holistic link-workers, make time + build trust + give choice,

facilitate goal-setting, tailor inputs, providing access to/continuity of care:

1. **Practical support – 35%:** Home Help (27), Prevention/Equipment (18), Housing/Paperwork (14), Transport (6)
2. **Social Isolation – 26%:** Befriending (24); Social Prescriptions (16), Caregiver Support (8)
3. **Care Coordination – 20%**
4. **Mental Health Support – 19%**

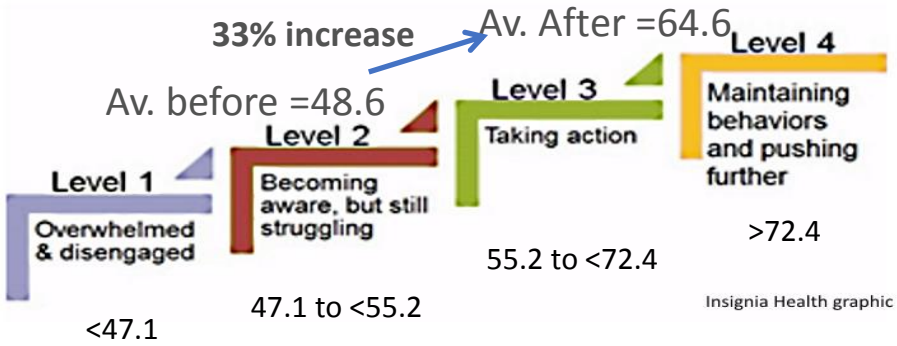
Impact on health and well-being and activation

Warwick Edinburgh Mental Health and Well-being scale (WEMWBS)



There was a statistically significant improvement in quality of life (n=49)

Patient Activation Measure (PAM)



Impact on frailty

Rockwood score scale

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

Dependency for Activities of Daily Living

Av. score 4.6

Reduced 1-2 levels

Av. score 3.9

Independence

Coastal Locality Sub-Groups
Cost patterns 12mths b/a (N=49)

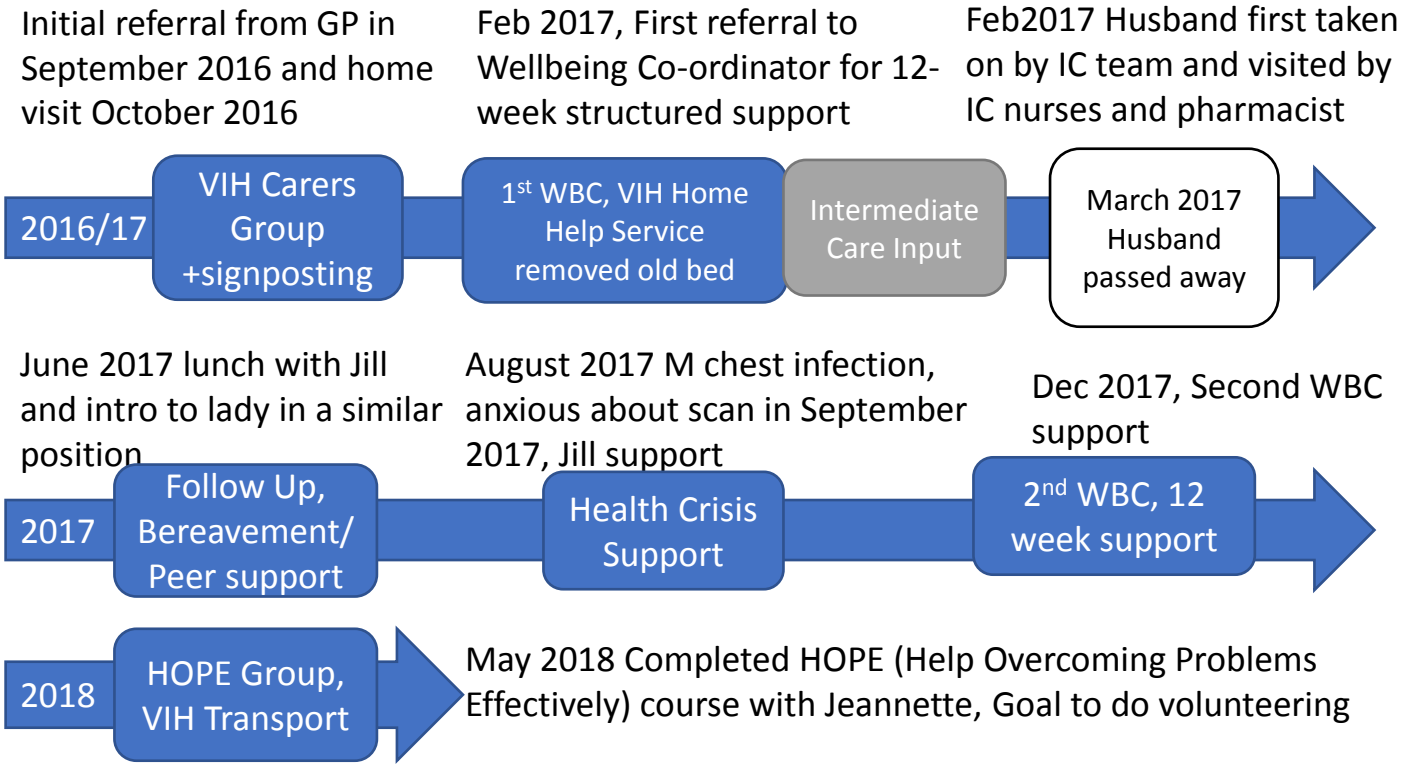
Core Function of WBC (and hub input)	Av H&SC Cost pp yr before*	Av H&SC Cost pp yr after*	Difference pp
1. Maintaining mental health (N=5)	£9,149	£2,895	-£6,254
2. Caregiver/bereavement support (N=9)	£2,800	£3,435	£634
3. Social supporting mainly (N=9, incl. 2 IC)	£810	£2,431	£1,621
4. Mobilising + Intermediate Care (N=7; inc. 2 IC, 2 3xIC)	£1,441	£1,732	£290
5. Declining + Intermediate Care (N=10; 1 IC, 5 2xIC, 3 3xIC)	£1,516	£14,794	£13,279
6. Ending + Intermediate Care (N=9; 2 IC, 1 2xIC, 2 3xIC)	£7,375	£19,365	£11,990

- Average cost increase per person of £4,544 with a total cost increase of £231,758
- Partly (9%) offset through IC incidents prevented for 20 cases: £20,962

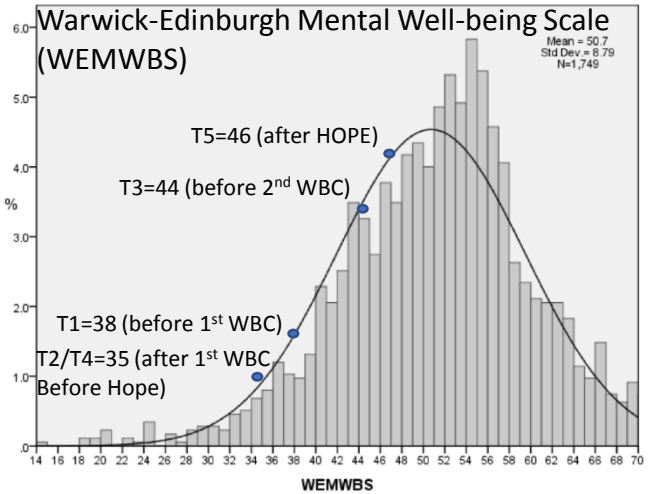
*Emergency Department, Inpatients, Outpatients, Social Care and Community Services (incl. Hospitals)


Mary was supported by a Wellbeing Co-ordinator whilst caring for her husband who had dementia, and after he passed away. She is now on our first HOPE course.

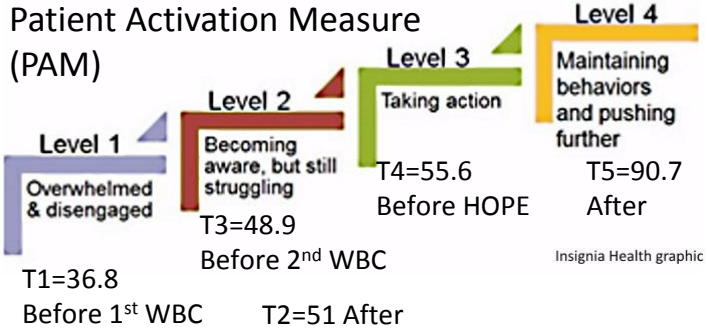
Timeline Sept 2016-March 2018



Activation/Wellbeing Outcomes



HOPE, Session 4, March 2018
M taking home learning



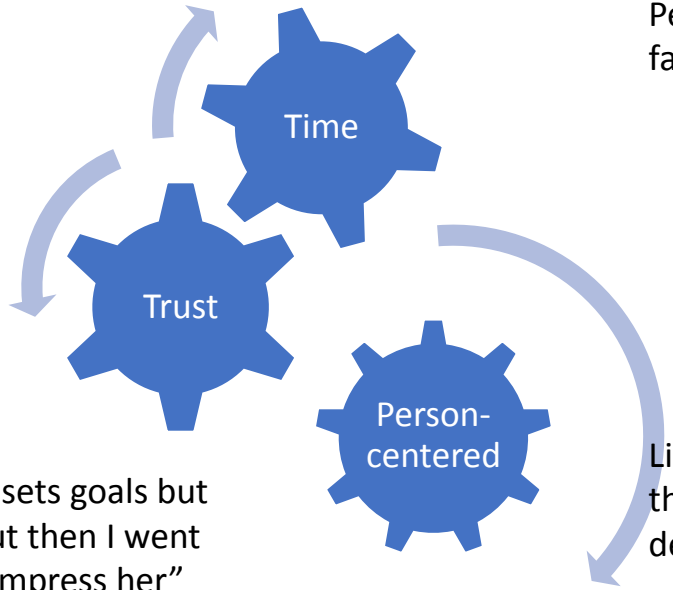
How does it work?
Research Observation M/Jill 15.02.18

How does it feel?

Loneliness/ Dependency: “look forward to phone calls” “miss her terribly”

Relationship: “trust her, just like a friend” “more intimate, she talks about herself”

Person-centeredness: “part of family” “it’s in my space”



Strengths-based/non-judging approach: “not saying you should have moved on by now”

Continuity of care: “they care , I can rely on them” “they are the lifeline”

Goal setting/Nudging: “she sets goals but is happy to come along – but then I went on my own, as I wanted to impress her”

Listening and Direction: “ ‘why don’t you try that?’ Someone giving you direction” “not demanding but encouraging”

Mary and Jill on ITV News

ITV Westcountry News, 02.05.18

Early findings - Conclusion

Enhanced Intermediate care and wellbeing coordination appears to:

- **Facilitating timely discharge and reducing admissions**
- **Also benefiting wider health system**
- **Keeping relatively more people at home**
- **Providing good level of person-centred coordinated care (although some room for improvement)**
- **Key elements of EIC:**
    - **Championing**
    - **Co-ordination**
    - **Communication**
    - **colocation**
    - **Contracting**
- **Building of trusting relationships and crossing of organisational and professional boundaries**

HSJ AWARDS 2018 Partnered with AGRI
FINALIST

Summary

- **WBC programme** helped over 3,640 people over 50 years ≥ LTCs, many frail and elderly!
- **Health and well being improved** significantly for the 1 in 7 people who receive the 12 week WBC programme, with many positive stories of lives turned around

https://www.torbayandsouthdevon.nhs.uk/services/wellbeing-co-ordinators/