Locality Interdisciplinary Teams

Scotland

The Govan SHIP (Social & Health Integrated Partnership) Project

The Govan SHIP is developing a new model of care in General Practice which has been live since 1st April 2015. At its heart is integrated working, principally between general practice and social work. But it is integrated care in the widest sense involving joint working with hospitals, the 3rd sector, voluntary agencies and other community based agencies as well. Link, PDF Presentation by Dr John Montgomery Link.

Enhanced Community Support: Perth & Kinross Health & Social Care Partnership

The goal of this program and partnership is to facilitate proactive, multidisciplinary management of health risks across agencies thus enabling people to maintain health, independence and wellbeing in the community for as long as possible. They set out to develop a model of care that was proactive in addressing an escalation of health and social care needs in the community, relevant to the needs of the person. Link.

Nuka Alaskan Model Adapted in Scotland

The Nuka model of care from Alaska has influenced the model the Forfar population in Angus, Scotland is developing. Multidisciplinary teams provide integrated health and care services in primary care centres and the community. These are coordinated with a range of other services and combined with a broader approach to improving family and community wellbeing. Link

Tayside’s older people locality model and enhanced community support service

Tayside has combined its older people locality model that aligns consultant geriatricians to GP practices, with an enhanced community support service. [link]

The Enhanced Community Support model has been endorsed by NHS Tayside Older People Clinical Board (OPCB) as the future model of care across Tayside. This is a multi-disciplinary team (MDT) approach to frail elderly care based around General Practice populations within the localities of the three health and social care partnerships (HSCPs). This report gives an update on the current position of the Enhanced Community Support model in South Angus (population 52,000).

ECS Nov 2016.doc

Report on the Buurtzorg Model of Health and Social Care in Scotland

Buurtzorg at one level is very simple: it is localised, self managed teams where relationships and wellbeing are at the heart of the model. At another level it’s a radical approach to organisation. Both views provide the opportunity for learning. Creating a person centred approach is very consistent with the integrated organisational model currently being pursued in Scotland. But Buurtzorg is fundamentally about an integrated model of care, not structures. It’s about fostering human connections and holistic care rather than systems. [link]
**England**

**Wigan, Manchester’s Integrated Neighbourhood Teams project**

In April 2013, the Integrated Neighbourhood Teams (INT) project went live in Wigan. Its aim is to streamline the approach to case managing care for patients with multiple long-term conditions. Each INT has a core team consisting of representatives from GP practices, community matrons/clinical facilitators, district nurses, and social care and mental health services; it also seeks input from a range of other specialist health and social care services as and when required. [link]

**A community-based emergency multidisciplinary unit (EMU) service in Oxford**

The Emergency Multidisciplinary Unit based at Abingdon Community Hospital is an innovative service in ‘interface healthcare’. It has been designed carefully to meet the urgent assessment and treatment needs of patients with multiple, often complex problems, many of whom are frail and elderly. The unit provides comprehensive medical, nursing, therapist and social care assessment, supported by advances in 'point-of-care' diagnostic technology that provide test results within minutes of patients' arrival. [link]

**Greenwich: team-based approaches to supporting people at home**

Greenwich has had success with a model that offers rapid response to emergencies (within two hours) as well as a proactive approach to discharge. Integrated teams based in localities are supported by specialist teams for emergency response and early discharge. These are able to call on a range of specialist services. The teams combine health and social care staff and have a high degree of multi-professional working while managing to get the right balance between using specialist skills and generic working. [link]

**Birmingham: Healthy Villages programme**

Example of a Healthy Villages project – the Complete Care Model (CCM) The Complete Care Model uses innovative ways to connect people, places and services to promote wellbeing. It looks at the whole person needs of older adults in three key stages (below), and will test the clustering of effort and services around those phases to offer the maximum benefit for patients. The CCM is designed to shift the system bias from ‘caring’ to ‘coping’ and ‘feeling well’ for longer. Critically, the model will operate a ‘no hand-off’ policy. This means that the most vulnerable people will no longer be simply signposted to other services but will receive a co-ordinated and seamless programme of care. Linked to this is the development of a community-based Medical Assessment Unit and Care Co-ordination Centre. [link]

**Case study: Islington – Locality model of integrated health and care**

In October 2014, a number of ‘test and learn’ sites were launched as part of the area’s development of a locality model of integrated health and care services. This involves eight GP practices in two aligned pilots in Islington, one in the north locality, the other in the south west. In the south, the pilot is working with University College Hospital to find ways to improve the primary/secondary interface. The pilots build on multi-disciplinary work that has already been established through teleconferencing. [link]
The Better Together Programme in Dorset

The Dorset-area Partnership is committed to transforming health and social care services across the Dorset area, to enable and deliver a sustainable improvement in health and care outcomes. A priority project within the Better Together programme is to develop integrated Locality Health and Social Care Teams for Frail Older People and People with Multiple Long Term Conditions [link]

Impact of ‘Virtual Wards’ on hospital use: a research study using propensity matched controls and a cost analysis

The purpose of this study was to assess the extent to which multidisciplinary case management in the form of virtual wards led to changes in the use of health care and social care by patients at high predicted risk of future unplanned hospital admission. [link]

Further References

Multidisciplinary team, working with elderly persons living in the community: a systematic literature review

The effectiveness of inter-professional working for older people living in the community: a systematic review

Program of all-inclusive care (PACE): past, present, and future

Hospitalization in the Program of All-inclusive Care for the Elderly (PACE): Rates, Concomitants, and Predictors

PRISMA: a new model of integrated service delivery for the frail older people in Canada