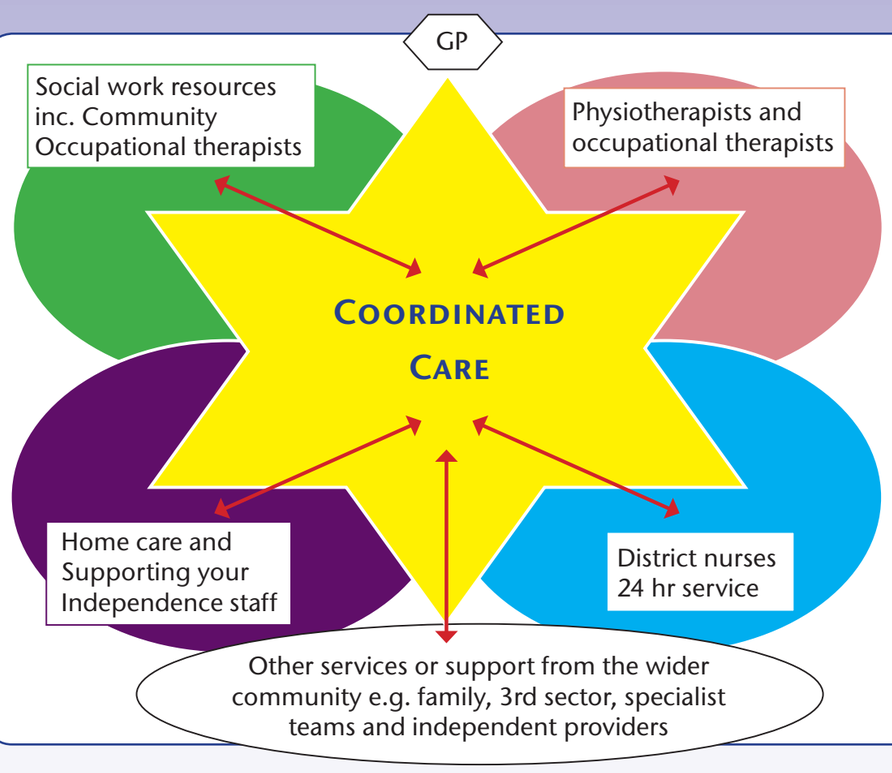
Integrated Community Support Team (ICST)

East Kilbride and Strathaven Pilot

Morag Hearty, Project Manager (morag.hearty@lanarkshire.scot.nhs.uk) and
Liz Swan, Service Manager (liz.swan@lanarkshire.scot.nhs.uk) ,NHS Lanarkshire (NHSL)



Background

A steering group of stakeholders developed this pilot project to address the key aims of the "Re Shaping Care", "Shifting the Balance of Care" and "National Delivery Plan for Allied Health Professionals" strategies.

Our Aim

For Multi agency professionals to work in an integrated way to support all older people with health and social care needs within a defined township.

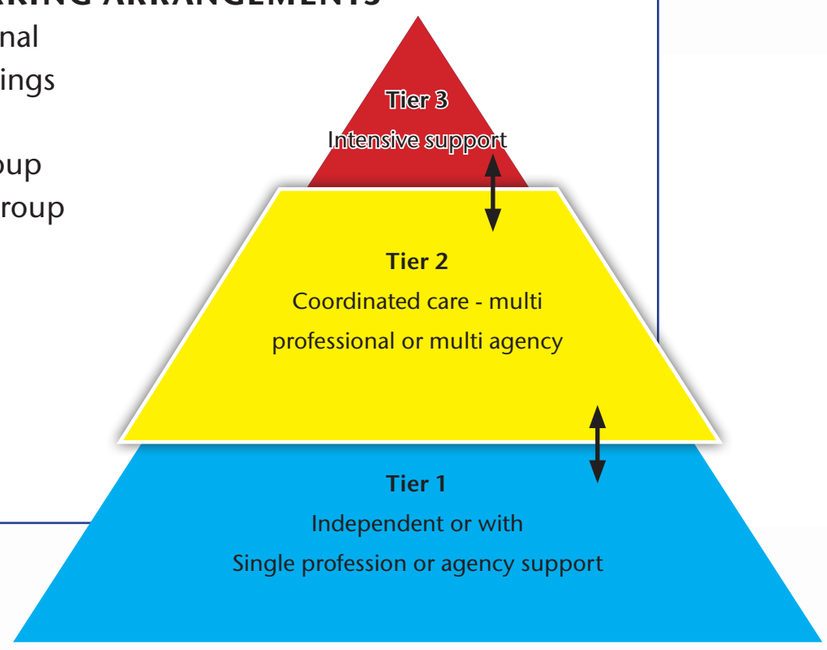
Methods

Coordinated Care (tier 2)

- Existing teams and services merged
- 24 hour nursing and home care service
- 24 hour telephone number direct access to health staff
- GP remains responsible medical officer
- Improved IT links to share information across all agencies
- Some additional staff recruited across all agencies/disciplines including clerical

Multi agency working arrangements

- Coordinating professional
- Multi disciplinary meetings
- Practitioner forums
- Resource allocation group
- Locality coordinating group



"I was very impressed to see 3 professionals working so well together -each with different skills"

"We both thought the worst -that this was a fob off -how wrong could we have been"

"The quick action of the staff prevented my dad from attending A&E"

"The 24 hour 7 day service has been amazing"

"she spoke to me and listened to me"

"can't imagine returning to the old way of working"

" I can see better quality and continuity of care"

Results and outcomes

- 730 referrals in first 40 weeks receiving coordinated care
- District nurse caseload complexity increased by 39.5%
- 30 day outcomes – 87.3 % older people remaining in their own home
- Routine physiotherapy waiting times reduced from 8-12 weeks to under 4 weeks
- Care of elderly admissions and length of stays in hospital reducing
- Increase in people referred by hospital for community care returning to own home
- Independent patient /carer evaluation –see comments
- Audit on impact for GP home visits –positive results
- Direct referrals from A&E to community increasing
- < 4 hour response by home care to prevent admission
- Increased involvement of carer support networks

Work in progress

- Provision of Tier 3 support
- Enhanced training and education
- Co location
- Joint management structures
- Use of Tele health/Tele care

Conclusion

This project has produced tangible results in respect of qualitative and quantitative data as shown.

An increasing number of frail older people with complex conditions are able to remain at home. The coordinated support achieves the best possible outcomes for them and their carers. This is evidenced by independent evaluations and supplemented by letters received.

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