ICARES......our story so far

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We guarantee ......

✓ You can speak to a member of the team 8am – 8pm 7 days a week
✓ Anyone can refer; we have open access for life
✓ We will see urgent patients within 3 hours
✓ We will ring every patient referred to us and find out what they think their problems are
✓ We will respond according to the patient’s clinical need
✓ We will treat any adult irrespective of their age, location or diagnosis
Community Specialists

LTC, elderly care, frailty, neurology, stroke IMC, falls

Direct access to step up beds
Direct access to fast response social care
Direct access to equipment store, beds & mattresses
Rehab starts as part of admission avoidance
The purpose of our work not an interruption to it

“You hear about going the extra mile, they went an extra 200 miles”

“Don’t know where we would be without you”

“Every goal I wanted to achieve I achieved”

“Pat yourselves on the back, you are the best thing that ever happened to me”

“Like family walking through the door”
“Leaders seem to care”

“Autonomous working”
“Variety of caseload in community”
“Holistic working”
“Give them (patients) our all”
“Opinions are valued”
Outcomes

Patient experience

✓ 95% of patients rate the service as 8 or more out of 10 in the friends and family test
✓ 93% of Admission Avoidance referrals avoid admission to acute

Responsiveness

✓ Case management within 48 hours
✓ Rehab and Reablement within 11 days
✓ Community Bed occupancy at 93% (increase from 85%)

Sustainable

✓ 2300 admission avoidance referrals p/a
Care coordination is everyone's role

Make it easy

Wrap services around the patient

Reduce hand offs

Solution focussed care

Community as a speciality
Renowned as the best integrated care organisation

**Current state**

- The Trust provides a single organisation for acute and community episodic care models
- We have significantly reduced LOS but retain high relative levels of re-admission
- Our co-ordination with GPs varies more than makes sense to anyone involved
- Our IT does “interface”, but we do not have a single record, nor patient access to it

**Intended state**

- Patients and their families recognise a single service model that helps them coordinate their care
- We anticipate those at risk of acute care institutionalisation/admission
- Our ‘offer’ is as diverse as those we serve and their needs
- That success recruits our next generation of colleagues to our teams
Isolation as the biggest challenge we face

“It makes a big difference to talk to somebody”
“I feel that I’m not alone”
Everyone that we talk with is enthusiastic about the National Voices definition. What might stop us succeeding?

1. Too disproportionate a focus on inpatient models, where the expertise we need to liberate is trapped in three outpatient clinics each week. **Sequence of change matters.**

2. Adding ‘integration’ onto our current service models. As in ‘we need to appoint a community (insert name of specialty)....’ **This is instead of not in addition to.**

3. **Failing to ‘treat’ the family,** where the expertise we need to develop is in the social network around the person who we are caring for. This is a learned skill.

4. Deciding that someone else should do this and it is not our role. It is. We need to **reconnect our teams with the passion they felt when they joined up.** Everyone wants to play a part in success and we need to jump together.