NHS

Health Education West Midlands

Health Education West Midlands Older Adults Workforce Integration Programme

SCOPING BEST PRACTICE IN OLDER ADULT AND INTEGRATED CARE

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Overview

Presentation structure:

- Project Scope and Products

- The Report
  - The Context
  - The Care Needs of Older People
  - Models of Integrated Care and Initiatives to Help to Avoid Hospital Admissions
  - Team Building and Workforce Flexibility
  - The Wider Workforce
  - Organisational Development and Culture
  - Making Change Happen
  - Conclusions: Sustainability, Barriers and Enablers

- Discussion

1. Project Scope

Workstream 1: Scoping best practice examples of the workforce for older adult integrated care

Exam question:

- Identify best practice examples of care, specifically the knowledge, skills and training the workforce need;
- Evaluate the evidence to support integrated care, focussing on practical workforce skills;
- Identify available training programmes;
- Evaluate the needs for culture shift and OD;
- Understand the implications for service contracts.

Supporting evidence:

- C400 documents/ case studies located , 92 texts included in the synthesis
  … there's always another document
- Telephone discussions

Products:

- Executive Summary
- Report
- Summary of Identified Functions for Integrated Roles
- Barriers and Enablers
- Supporting Documents:
  - Documents Database
  - Structured Discussions: Summary Notes
  - Identified Training Courses

2. Integrated Care – The Evidence?

- Integrated care is important for people with needs that are not just medical or social.
- Most of the evidence is not primarily concerned with workforce.
- Evidence of the effectiveness of integrated care is mixed eg cost, reducing emergency admissions.
- There is good workforce evidence in some areas eg new roles, responsibilities, which provides a starting point for developing further work

King's Fund and the Nuffield Trust 2011

… significant benefits arise where these are targeted at groups for whom care is currently poorly co-ordinated, eg, frail older people and those with multiple chronic and mental health illnesses.

***Skills for Care** (October 2013):*

*"The evidence relating to Integrated health and social care … **and workforce** issues has been problematic … there is a need for further research"*

***National Evaluation of DH's Integrated Care Pilots**, March 2012 (RAND):*

- *Staff believed process improvements ie increased care plans and new staff roles, led to care improvements*
- *Patients did not share the sense of improvement*

Kings Fund, March 2014

"It is becoming increasingly obvious that there need to be significant changes in the health workforce. There are issues about the shortage of community nurses and the ageing of this workforce. There is also a need for multi-skilled generic workers who can bridge the gap between health and social care and take responsibility for looking after the whole person rather than performing individual tasks."

Recommendations

Integrated Healthcare and the Workforce: The Context

The programme should work with:

1. Public and Patient Coalition and pioneers to **identify effective integrated working from the perspectives of users and stakeholders** and to adopt performance indicators that will support integrated care for older people.

2. Local organisations to **identify the workforce** that provide support to older people in the West Midlands. It should also **identify organisations which already provide integrated care** for older people.

3. The Care Needs of Older People

Age can define the health needs of older people

OLDER PEOPLE HEALTH AND SOCIAL CARE STATES:

- **Well: People with good physical and mental health and social wellbeing.**
- **Seems well but is asymptomatic: People who think they are well, but have an undiagnosed health condition or mental health need.**
- **Acutely ill: People suffering a short term health or mental health need which begins and progresses rapidly.**
- **Chronically ill: People with a long-term condition.**
- **Complex and/or multiple needs: People who have multiple long term conditions or other complex needs.**

CfWI, 2011

Some of the skills needed to care for older people are generic, others are more specialist. There are already a range of defined skills and competencies which are pertinent to the care of older people. A number of gaps have been identified.

IDENTIFIED GAPS

- Older people have different patterns of disease presentation and respond differently to treatment – their care requires particular clinical skills
- Some gaps in skills / competencies have been identified, ie appreciating the effects of aging on the body, understanding mental health issues, managing co-morbidities
- Pre and post-registration training for the regulated professions does not provide clinicians with the competencies re older people
- Basic "customer service" can be as important as the health impact of the care delivered ie, being on time, staff doing as they say they will etc
- Wider issues, including isolation, caring responsibilities or financial worries can also affect the health and well being of older people

Recommendations

Care Needs of Older People

The programme should work with:

3. The values based recruitment programme to ensure the programme takes account of the **values and behaviours** required for working in older people's integrated care teams, including ensuring that workers are equipped with the appropriate "customer service" skills for caring for older people.

4. Health Education England to support further work on **the development of pre and post-registration training for the regulated professions** to ensure that they provide clinicians with the competencies to meet the aspirations for older people.

5. Other workforce programmes with **related work programmes**, such as dementia, chronic conditions and end of life care to:
   - Understand commonalities and shared objectives;
   - Share learning and understanding;
   - Identify relevant tools that can be shared.

4. Models of Integrated Care & Avoiding Hospital Admissions

There is no one approach to integrating care that suits all situations. Local circumstances and the nature of the service user's needs shape how care is delivered.

Multidisciplinary Teams

Many of the case studies distinguish between:

- **a 'core' group of professionals and/or care teams** undertaking close and ongoing care of older people, and
- **a wider network of care providers** who can be drawn on to support care assessments or improve access to a range of services

Care coordination

Models tend to use a named care coordinator or case manager who takes personal and direct responsibility for supporting service users and usually informal carers/ family members.

- **Care co-ordinators** tend to be non-clinicians who facilitate access to care services and provide a point of contact
- **Case managers** have had specific training and expertise in caring for older people with complex needs. They co-ordinate care and provide some care directly.

Primary care

There are varying models of working with primary care, ranging from primary care being central, to being disengaged. However primary care are placed the work of integrated care teams needs to coordinate with primary care, and GPs need to be engaged to help ensure patients benefit from the services and care which are available.

Carers

The role of carers is very significant. Their needs also need to be considered alongside those of the service user.

Initiatives to Help Avoid Hospital Admissions

The Centre for Workforce Intelligence (CfWI) have identified models of integrated care intended to ensure that older people were not admitted into hospital. They have also identified the skills and training requirements to support the models.

CfWI consider that in the longer term a whole system approach is required, not just older people.

Recommendations

Models of Integrated Care

The programme should work with:

6. Pioneers and primary care to **understand how to harness the contribution of GPs and primary care** in integrating care for older people to ensure that services are coordinated most effectively for the benefit of older people and to understand the workforce implications.

Initiatives to Help Avoid Hospital Admission

The programme should work with:

7. Pioneers to test/confirm/ validate the **skills and competencies** required in order to care for older people in integrated teams.

8. Education and training providers and pioneers to further **develop detailed specifications for education and training** based on the findings of the review.

9. Pioneers and providers and the independent sector to discuss **how modular and customised training can best be delivered**.

5. Team building and Workforce Flexibility

- The main benefits of integrated care occur when **barriers between services and clinicians are broken down.** Co-locating teams and unified management can help, but it's more important that team members align their goals and work together.

- Organisations, teams and individuals should have **clear roles and responsibilities**. Building **effective working relationships between care co-ordinators, multidisciplinary teams and wider service providers** is important in coordinating services effectively around patients. Building a supportive team culture requires constant nurturing.

- **Service redesign and workforce development** go hand in hand to ensure that the workforce support the work. **Local knowledge** is important.

- Creating **new roles** can support developing integrated services and joint working. New roles must be designed and filled with care, and the support and buy-in of the wider team.

- The Integrated Care Pioneers Programme has found it is rare for integrated care teams to have ready access to **mental health support**. The missing part is mental health engagement with the community teams

The Staffordshire core principles were designed to support the development of new roles and have potential to be adapted for wider use.

Recommendations

Team Building and Workforce Flexibility

The programme should work with:

10. **Mental health organisations** to consider how best to ensure that mental health expertise can be harnessed in integrated care approaches for older people.

11. Pioneers to test/confirm/ validate the **skills and competencies** required within MDTs and for particular integrated care roles, using those identified in the review as a starting point. Based on this, the programme should also work with pioneers and pilots to identify the associated **training and development requirements**.

12. Pioneers to **test the Staffordshire core principles** in practice as a tool for supporting MDTs.

6. The Wider Workforce

- The **number of older people** is increasing and an increasing number of older people provide unpaid care.
- The **changing shape of the population** affects the number of people who require care and the pool of carers available to care for older people in the future.
- The **social care workforce** will become increasingly significant. The way care services are provided and the settings services are provided in are already changing, as are the skills which social care workers have. There are important implications for how the future social care workforce is trained.
- The **unqualified workforce, the third sector and the voluntary sector** will have increasingly important roles in future. Last but not least, carers have a vital role in supporting service users. They are an increasingly significant element of the wider workforce and their needs need to be considered alongside those of care users.

The Cavendish Review

Cavendish observed that there were benefits in training the caring workforce as one workforce:

"What is striking about the training of the caring workforce is that individuals are being taught different courses, or bits of courses, in silos. Yet from the public's point of view, it would surely make more sense to teach care workers the fundamentals of care in the same way and in the same language. Why is every care assistant not learning the best way to lift or move someone safely, from the experts? … . Why is every care assistant (to whom it is relevant) not learning the latest way of understanding dementia, from people who have figured out how to communicate this simply and powerfully? Why are healthcare assistants in the NHS not learning the same fundamentals of care jointly with registered nurses, in the same language?

Recommendations

The Wider Workforce

The programme should work with:

13. Pioneers and education and training providers to test out the Cavendish recommendations about **training as one workforce**.

14. Pioneers and the Public and Patient Coalition to **identify the potential contribution of the third sector, the voluntary sector and volunteers, carers and the independent sector** in supporting older people's integrated care.

7. Organisational Development and Culture

"Cultural, political and organisational differences and financial and other risks do not have to be deal breakers – they can be overcome."

Pete Thistlethwaite, Integrating health and social care in Torbay Improving care for Mrs Smith

- ICT is a potentially important enabler, but it is not a precondition for integrating services. It is important to get processes right before investing in ICT, and technical changes need to be supported by culture change. Even when there are functioning ICT systems, teams still need to support information sharing with strong interpersonal communication.

- Public and patient engagement is important to sustaining integrated services, to ensure that they are responsive and can adapt.

- Contracts could reflect what the people who use care and support deem to be value, including what they value about the workforce.

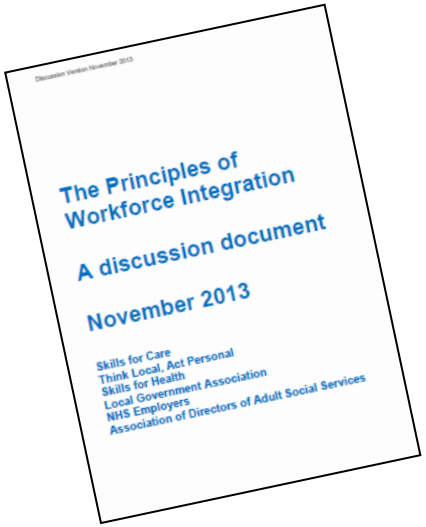
8. Making Change Happen

Don’t underestimate the importance of local context ….

Co-locating teams and unified management are important, but more important is the need for team members align goals and work together.

A key function of teams is to understand the local population and develop effective relationships with other local networks. Local knowledge can be as important as skills.

Leaders need to plan over appropriate timescales (at least 5 years and often longer) and to base their actions on coherent strategy.



Torbay:
“There is no textbook to guide the process because local context (especially the interplay of people, relationships and processes) is a key variable. Anyone embarking on this process needs to conceive of it as a learning process.”

Service redesign and workforce development need to go hand in hand to ensure that workforce supports redesign

9. Conclusions: Sustainability, Barriers and Enablers

The key lessons for **sustainability** are:

Service Redesign: Service redesign and workforce development go hand in hand. Local circumstances and path dependencies will be crucial in shaping the pace and direction of change.

Engagement: Services must be grounded in local communities and take account of the views and needs of older people themselves.

Team Working: Staff working with older people in multidisciplinary teams need the right skills, attitudes and behaviours, including openness and being receptive to adopting ways of working which are patient focussed and support the wider team approach. Multidisciplinary teams should be built around models of continuous and continual learning.

The **key operational factors** which affected integrated working fall within a number of themes: relations between partners; organisational culture; change management; enabling staff; professional behaviour; attitudes; outcomes.

The top four **barriers** were identified as:	**Enablers** of successful integration included:
• Lack of clarity of roles • Poor communication • Lack of clarity of procedures • Imbalances of power between individuals and agencies	• Consistent rules and policies at organisational level • Collaboration between disciplines • Co-ordination of services • Shared values