Health Education West Midlands

Health Education West Midlands Older Adult Workforce Integration Programme:

SCOPING BEST PRACTICE IN OLDER ADULT AND INTEGRATED CARE

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EXECUTIVE SUMMARY: SCOPING BEST PRACTICE IN OLDER ADULT AND INTEGRATED CARE

The West Midland's Older Adult Workforce Integration Programme (OAWIP)[1] commissioned an evaluation of the evidence and best practice lessons for the workforce for older adult integrated care.

The key principle is that service redesign and workforce development need to go hand in hand to ensure that the workforce supports redesign. Knowledge of the local population and local services is also important.

1. The Context

Integrated care is important for people with long-term conditions and older people whose needs are often not just 'medical' or 'social'. Developing integrated care is central to initiatives to meet the demands of a growing number of people with chronic conditions and an aging population.

The evidence of the general effectiveness of integrated care is mixed on a number of measures, for example, on cost effectiveness and its impact on reducing emergency admissions. There is evidence that significant benefits can arise from integrating services when they are targeted at client groups whose care is currently poorly co-ordinated, including frail older people and those with multiple chronic illnesses.

Most of the evidence is not primarily concerned with workforce issues. It is often difficult to identify the workforce implications of integrated care. However, evidence about the workforce can be extrapolated from the general reviews. There are also some helpful studies of the integrated and multidisciplinary workforce.

2. The Care Needs of Older People

Age can define the health needs of older people. Older people can have different patterns of disease presentation, respond more slowly to treatment and need both health and social support. Addressing the health needs of older people requires particular clinical skills.

Various gaps have been identified in the skills and competencies of staff who are in contact with older people. These include gaps in understanding the effects of ageing on the body and lack of awareness and understanding about mental health issues for older people.

For older people, basic "customer service" aspects of how care is delivered are important, for example, staff being on time and staff doing as they said they would, can be just as important as the impact of the care they receive.

Problems such as living alone, having caring responsibilities or financial worries can build up over time and significantly affect the health and wellbeing of older people. Older people's care should be considered holistically and take account of the full range of services that can contribute to promoting the total wellbeing of older people.

[1] Health Education West Midlands has set up an Older Adult Workforce Integration Programme (OAWIP). It is one seven LETB Innovation Fund programmes that were approved in 2013/14.

3. Models of Integrated Care

There is no one approach to integrating care that suits all situations. The design of care should be shaped by local circumstances and the nature of the service user's needs.

Multidisciplinary teams have tended to be either a 'core' group of professionals and/or care teams who undertake close and ongoing care of older people; or a wider network of care providers who can be drawn on to support care assessments and/ or to provide a range of services.

The models also tend to use a named care co-ordinator or a case manager who takes personal and direct responsibility for supporting service users (and usually informal carers/family members). The jobholder coordinates all aspects of the user's care, medical, social and wider support, such as volunteers or housing services. Care coordinators have varying backgrounds but the role is broadly consistent across projects.

There have been varying models of working with primary care, ranging from primary care being central to the integrated model to primary care being disengaged. There is a need for integrated care teams to ensure that their work is coordinated with primary care and that GPs in particular are engaged in developing services and understand how their patients can benefit.

4. Initiatives to Help Avoid Hospital Admissions

The Centre for Workforce Intelligence (CfWI) identified a number of models of integrated care which were intended to ensure that older people were not admitted into hospital.

The CfWI analysis identified the skills and training requirements to support the models of integrated care. They include: developing advanced clinical skills, triage and assessment capability, management and co-ordination, case management skills, multidisciplinary skills and experience. They also identified some new roles which had been developed in support of the models of care.

Some of the models which CfWI reviewed addressed specific system issues in isolation. CfWI considered that these models would not be sustainable in the longer term and that to be sustainable models of care need should be developed across the whole system, covering services for all patients, not only older people.

CfWI have aggregated their findings to develop a checklist of questions for sites which are designing and implementing integrated services.

5. Team Building and Workforce Flexibility

The main barrier to integration is the differences between and within different parts of the health system and with social care. Effective multidisciplinary teams work across all sectors and across professional boundaries, and generalists and specialists collaborate together. The main benefits of integrated care occur when barriers between services and clinicians are broken down. Co-locating teams and unified management structures can be helpful, but it is more important that team members align their goals and work together.

The organisations, teams and individuals who provide integrated care 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 need to go hand in hand to ensure that the workforce support the redesign of new ways of delivering services. Knowledge of the local population and local services is as important as other skills.

The creation of new roles has supported the development of integrated services and joint working. New roles must be designed and recruited to with care, and with the support and buy-in of the wider team. The Staffordshire core principles were designed to support the development of new roles and have potential to be adapted for wider use.

6. The Wider Workforce

The changing shape of the population affects not only the number of people requiring care but also the pool of carers who will be 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 should be considered alongside those of care users.

7. Organisational Development and Culture

The use of ICT is a potentially important enabler, but it is not a necessary precondition for integrating services. It is important that processes are put in place before ICT systems are implemented and that technical change is supported by culture change. Even when there are functioning ICT systems, teams still need to support information sharing through 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 of value, including what they value about the workforce.

8. Making Change Happen

The NHS Change Model and the emerging TLAP principles of workforce integration are good starting points for supporting change.

Key messages from the literature include:

- Designing and making changes across a range of organisations takes time.
- It is important to spend time to ensure that professionals and agencies involved in new initiatives understand the aims and objectives of service change.
- Lessons from South Devon and Torbay suggest that it is possible to scale up locality-based approaches.

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

RECOMMENDATIONS
The following recommendations are intended to support the Older Adults Workforce Programme to take forward the findings of this report within the West Midlands.

Integrated Healthcare and the Workforce: The Context
The programme should work with:

- Representatives of patients, service users and carers, through pilots projects 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. This should include engaging with the proposed patient and public coalition in the West Midlands and the national HEE Patient Advisory Forum.
- Local organisations to **identify the workforce** that provide support to older people in the West Midlands. This should include identifying the **organisations that are already providing integrated care** for older people.

Care Needs of Older People
The programme should:

- Apply the values based recruitment approach and recommendations of the national initiative to ensure the programme takes account of the **values and behaviours** required for working in older people's integrated care teams. This should include ensuring that existing, as well as new, workers are equipped with the appropriate "customer service" skills for caring for older people. This will help to support developing a new culture.

- Establish links through Health Education West Midlands to support implementation work on **the development of pre and post-registration training for the regulated professions** to ensure that clinicians have the competencies to meet the aspirations for older people.
- Work closely with other workforce programmes, including the Innovation Fund programmes for **related areas of work**, 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.

Models of Integrated Care

The programme should work with:

- Pioneers[2] 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 that the workforce implications are understood.

Initiatives to Help Avoid Hospital Admission

The programme should work with:

- Pioneers and pilot sites to test, confirm and validate the **skills and competencies** that are required in order to care for older people in integrated teams.
- Education and training providers and pioneers to further **develop detailed specifications for education and training** based on the findings of this review.
- Pioneers and providers and the independent sector to discuss **how modular and customised training can be delivered most effectively**.

Team Building and Workforce Flexibility

The programme should work with:

- **Mental health organisations** to consider how best to ensure that mental health expertise can be harnessed in integrated care approaches for older people.
- Pioneers and pilot projects 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**.
- Pilot projects to **test the Staffordshire core principles** in practice as a tool for supporting MDTs.

The Wider Workforce

The programme should work with:

- Pioneers and education and training providers to test out the Cavendish recommendations about **training as one workforce**.
- Patients, service user/ carer representatives and voluntary organisations, through pilots projects and pioneers, to **identify the potential contribution of the third sector, the voluntary sector and volunteers, carers and the independent sector** workforce in supporting older people's integrated care.

[2] The term "pioneers" is used to include both the nationally funded Integration Pioneers and integration focussed initiatives that are being delivered through the Better Care Fund (see page 11 of the main report for more details).

Organisational Development and Culture
Organisational and cultural development is integral to the change management that needs to support and underpin integrating services for older people. The report underlines the close relationship of workforce integration, organisational development and service integration and their importance in effective system design. While organisational and cultural development is not the main focus of the report, it is recommended that the programme should:

- **Consider the findings on organisational development and culture** (Section 7), especially those that relate to patient voice, clear roles and responsibilities, ICT and contracting mechanisms and their relationship and potential impact on workforce integration

INTRODUCTION

1. Background

Health Education West Midlands has set up an Older Adult Workforce Integration Programme (OAWIP). It is one seven LETB Innovation Fund programmes that were approved in 2013/14.

The programme is taking forward work to develop a fit for purpose integrated health and care workforce to support the needs of the older adult population in the Birmingham and Black Country Local Education and Training Council (LETC) areas. The learning and outcomes of the programme are intended to be sustainable and rolled out at scale across the West Midlands region.

The West Midland's Older Adult Workforce Integration Programme (OAWIP) has commissioned an evaluation of the evidence and best practice lessons for the older adult integrated care workforce.

2. Scope

The remit of the evaluation was to:

- Identify and critically evaluate the evidence to support integrated care, vertical and horizontal, focussing on the practical workforce skills that are required.
- Identify exemplary work and best practice examples of care for the older adult/ frail and elderly populations, specifically the knowledge, skills and training required by the workforce, including examples from education, health and social care; public and privately funded care; and local, regional, national and international exemplars.
- Identify available training programmes, including their mode of delivery and their target audience.
- Evaluate the needs for cultural shift and organisational development.
- Understand whether the requirements of service contracts should be articulated in terms of the expectations of specific staff groups or simply the skills and competencies which staff require in order to achieve the outcomes.

3. Method

The review followed the rapid evidence assessment methodology[3]. Questions to be addressed were formulated and a conceptual framework was developed. A wide range of databases, web-sites and grey literature were searched and screened, using search terms related to older people, integration, multidisciplinary working, social care and health, and workforce, staff and training. Studies were excluded if they had no bearing on workforce aspects.

After screening studies, more than 80 full texts were included in the synthesis for the scoping study. A number of authoritative studies are composite reviews of the evidence and case studies. Some of these studies are cited as sources in their own right. A database of the documents referenced during the scoping exercise is held by the OAWIP programme manager.

[3] http://www.civilservice.gov.uk/networks/gsr/resources-and-guidance/rapid-evidence-assessment/what-is

Structured discussions were held as follows:

Organisation	Name	Position	Focus of discussion
Staffordshire & Stoke On Trent Partnership NHS Trust	Fiona Shield	Head of Organisational Development & Leadership	The Staffordshire Model
Gwent Frailty Project	Sarah Parker-Jones	Frailty Coordinator	Gwent Frailty Project
Midhurst	Jo Stuttaford	Joint Service Lead	Midhurst Macmillan
United Healthcare	Julie Wilkinson	Programme Director, Integrated Care	Work in South Derbyshire and US perspectives on the UK system
Health Education South West	Sue Simmons,	Frail Older People project	Scoping of respective work

The discussions are referenced in the document. Summary notes of the discussion are held by the Programme Manager. Other leaders in the field were approached during the course of the study but did not participate in structured discussions.

4. Structure of the report

The structure of the report is as follows:

1: **Integrated Healthcare and the Workforce: The Context** - an overview of the wider context and a summary of the evidence base for integrated care, including for workforce issues.
2: **Care Needs of Older People** - outlines the care needs of older people, identifies skills and competencies which need developing in order to support older people's care. It also highlights factors in how care is delivered which are important to older people.
3: **Models of Integrated Care** - shares emerging lessons from the models of integrated care that have been developed by staff using team based coordinated approaches, with an emphasis on horizontal models of integration.
4: **Initiatives to Help Avoid Hospital Admission** - provides an overview of the workforce implementation challenges identified by the Centre for Workforce Intelligence (CfWI) on a number of models of care for older people, with an emphasis on vertical models of integration.
5: **Team Building and Workforce Flexibility** - outlines the evidence around the development of effective multidisciplinary teams.
6: **The Wider Workforce** - outlines the issues around developing the wider workforce to support older people's care.
7: **Organisational Development and Culture** - outlines factors relevant to organisational development, such as partnership working, the use of ICT and public and patient engagement.
8: **Making Change Happen** - summarises the change models and key factors for change management.
9: **Sustainability, Barriers and Enablers** - outlines key lessons for sustainability and summarises the barriers and enablers that have been identified.
10: **Summary of Recommendations.**

5. Additional supporting documents

Additional supporting documents, including a literature database, notes of structured discussions and identified courses are held by the programme manager.

SECTION 1 INTEGRATED HEALTHCARE AND THE WORKFORCE: THE CONTEXT

This section gives an overview of the wider context and summarises the evidence base for integrated care, including on workforce issues.

SUMMARY

- Integrated care is important for people with long-term conditions and older people whose needs are often not just 'medical' or 'social'. Developing integrated care is central to initiatives to meet the demands of a growing number of people with chronic conditions and an aging population.
- The evidence of the general effectiveness of integrated care is mixed on a number of measures, for example, on cost effectiveness and its impact on reducing emergency admissions. There is evidence that significant benefits can arise from integrating services when they are targeted at client groups whose care is currently poorly co-ordinated, including frail older people and those with multiple chronic illnesses.
- Most of the evidence is not primarily concerned with workforce issues. It is often difficult to identify the workforce implications of integrated care. However, evidence about the workforce can be extrapolated from the general reviews. There are also some helpful studies about the integrated and multidisciplinary workforce.

1.1 CONTEXT

In 2013, the Department of Health (DH) launched a pioneer programme to help showcase innovative ways of delivering coordinated care and to help disseminate and promote lessons for wider, rapid adoption. DH has identified 14 "Integration Pioneers" nationally[4] to lead Integration. In the West Midlands, North Staffordshire and Worcestershire have been selected as national Pioneers. They are respectively looking at: integration around cancer and end of life; and bringing together all local NHS organisations.

In addition to the nationally selected Pioneers, work on service integration initiatives is continuing in most areas as part of the implementation of the Better Care Fund (BCF). It is important that the Older Adults Workforce Integration Programme is closely aligned to these initiatives and that the learning about workforce issues is transferred. Throughout this report we have used the term "pioneers" to include both the nationally funded pioneer projects and the initiatives that are continuing through the BCF.

OAWIP is supporting four projects:

[4] Care Minister announces details of fourteen areas leading the way in delivering better joined up care. 1 November 2013. https://www.gov.uk/government/news/integration-pioneers-leading-the-way-for-health-and-care-reform--2

Project Theme	Lead Organisation
Integrated Care Model	Pathfinder Healthcare Developments CIC
Falls and Fractures – Care Homes	University Hospitals Birmingham NHS FT
Falls Prevention – Health and Social Care	Walsall Council
Complete Care programme (Community)	Birmingham Community NHS Trust

A project to deliver a competency based education and training programme to care homes in Shropshire has also been aligned to the programme. It is anticipated that further pilot projects will be supported during the life of the programme.

These projects will be a testing ground for innovative practice in workforce integration and will provide regular feedback and learning to the OAWIP Board.

1.2 INTEGRATED CARE

Integrated care is important for people with long-term conditions and older people whose needs are often not just 'medical' or 'social'. Developing systems of integrated care is central to government reform and is being seen as a key enabler for making person-centred, coordinated care a reality and establishing an infrastructure which will help to meet the combined health and care needs of an aging population[5].

Integrated care means different things to different people. The Kings Fund has used the integrated care definition, "*care which is intended to improve the quality of care for individual patients, service users and carers by ensuring that services are well co-ordinated around their needs*"[6].

For the purposes of the OAWIP programme, the Think Local, Act Personal (TLAP) user statement has been adopted:

> ***I can plan my care with people who work together to understand me and my carer(s), allow me control and bring together services to achieve the outcomes important to me.***

1.3 EVIDENCE OF THE EFFECTIVENESS OF INTEGRATED CARE

Successive reviews by The King's Fund, the Nuffield Trust and other commentators have concluded that "… *significant benefits can arise from the integration of services where these are targeted at those client groups for whom care is currently poorly co-ordinated, including, frail older people, and those with multiple chronic and mental health illnesses"*. Conclusions include:

- Approaches to integrated care are likely to be more successful when they cover large populations (e.g. covering a city or a county) and a range of groups: older people; people with particular diseases or conditions; and people requiring access to specialist services.

[5] Integrated Care and Support: Our Shared Commitment, National Collaboration for Integrated Care and Support, May 2013
[6] Integrated care for patients and populations: Improving outcomes by working together, Kings Fund, Nuffield Trust - Nick Goodwin, Judith Smith, Alisha Davies, Claire Perry, Rebecca Rosen, Anna Dixon, Jennifer Dixon, Chris Ham, January 2012

- The evidence for case management and care co-ordination shows that it is more likely to succeed if it is part of a 'programme approach' to a specific population group that includes good access to extended primary care services, supporting health promotion and primary prevention, and co-ordinating community-based packages for rehabilitation, re-ablement and independent living.
- The evidence shows that the cumulative impact of multiple strategies for care integration are more likely to be successful in meeting the demands and improving the experiences of patients, service users and carers.
- There is no single 'best practice' model of integrated care[7].

Other systematic reviews suggest that there is a need for caution[8]:

- Studies largely focus on small-scale evaluations of local initiatives that are often of poor quality and poorly reported.
- Details about working practices and arrangements are often limited and/or the authors do not discuss the factors that promote and/or hinder joint working.
- Few studies are comparative in design, so differences between 'usual care' and integrated care are not assessed.
- There are no means of assessing the costs and benefits to service users and carers of integrated care versus standard care or different types of integrated services.
- The voice of service users and carers is largely absent. Their views are not routinely collected in evaluations, which make it almost impossible to comment on the outcomes that matter to the people who use services themselves. Where they are included, service users and carers are treated as an homogeneous group. This makes it difficult to unravel the impact of integrated services on groups who may have different and sometimes competing needs.

The conclusions of the ***National Evaluation of the Department of Health's Integrated Care Pilots***[9] were:

- Integrated care led to process improvements such as an increase in the use of care plans and the development of new roles for care staff. Staff believed that these process improvements were leading to improvements in care, even if some of the improvements were not yet apparent.
- Patients did not in general share the sense of improvement. The lack of improvement in patient experience was believed to be in part due to professional rather than user-driven change, partly because it was too early to identify the impact within the timescale of the pilots, and partly because some pilots found the complex changes they set for themselves were harder to deliver than anticipated. They also speculated that some service users (especially older patients) were attached to the pre-pilot ways of delivering care, although his may change over time.
- A key aim of many pilots was to reduce hospital utilisation. There was no evidence of a general reduction in emergency admissions, but there were reductions in planned admissions and in outpatient attendance.
- The costs of implementing change were varied and individual to each pilot. No overall significant changes were found in the costs of secondary care utilisation, but for case management sites there was a net reduction in combined inpatient and outpatient costs (reduced costs for elective admissions and outpatient attendance exceeding increased costs for emergency admissions).

[7] See, for example, Integrated care for patients and populations: Improving outcomes by working together, Kings Fund, Nuffield Trust: - Nick Goodwin, Judith Smith, Alisha Davies, Claire Perry, Rebecca Rosen, Anna Dixon, Jennifer Dixon, Chris Ham , Jan2012

[8] Factors that promote and hinder joint and integrated working between health and social care services, SCIE, Ailsa Cameron, Rachel Lart, Lisa Bostock and Caroline Coomber, May 2012

[9] Ernst & Young, RAND Europe and the University of Cambridge (2010) National evaluation of Department of Health's integrated care pilots. London: DH

The Kings Fund report, ***Co-ordinated care for people with complex chronic conditions***[10], concluded that there was a chronic lack of evaluation and measurement on which to judge the performance of care co-ordination programmes and that far greater attention was required to measure, evaluate, compare and reflect on performance. The preface to the report observed that "… *strategies for care co-ordination have been developed in many countries, yet evidence suggests that many such innovations have not achieved their objectives and the failure rate has been high*". This comment also reflects the statement made in many evaluations, which is that "… *it takes time to build an effective programme of care co-ordination*".

1.4 WORKFORCE AND INTEGRATION

There is a paucity of information around the workforce requirements of integrated care. A Skills for Care study[11] reviewed the evidence relating to workforce and integrated health and social care and concluded that:

"*The evidence relating to integrated health and social care more generally, and workforce issues more specifically, has often been described as problematic, and this review found it to be weak. Much of the work identified was not primarily concerned with workforce issues, and connections between workforce approaches and the impact and outcomes for service users were not always addressed. The majority of studies were based on interviews and questionnaires for staff working within or managing integrated teams; there were also a significant number of case studies and articles drawing out learning from pilots. Most of the evidence was from England, with a small number from other UK countries, and Europe*."

The findings are shown in the box below:

ORGANISATIONAL STRUCTURES AND BEHAVIOURS
Whilst evidence suggested that the form of integration does not necessarily affect the effectiveness of the service, there seemed to be clearer evidence of the importance of **the quality and style of organisational leadership**, both in terms of delivering change and maintaining an integrated approach to service delivery.

There was good evidence to support:
- Good leadership is key to successful integration, and should be distinguished from clinical or professional leadership.
- Effective management of integrated teams is also key.

There was some evidence to support:
- Importance of organisational approach to change management impacting on effectiveness of integrated approaches.
- Team management is different to, and should be separated from, clinical or professional management.

[10] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner, Oct 2013
[11] Evidence review - integrated health and social care - A Skills for Care discussion paper, Institute of Public Care, Oxford Brookes University Published by Skills for Care, October 2013

- Separate management structures do not support integrated approaches to delivery.

STAFF ROLES, STAFF RECRUITMENT AND RETENTION
The review considered a range of **different staffing models and types of joint working** and produced a similar range of recommendations around what works; the development of new cross-boundary roles seems to support integrated working by creating a link and acting as a shared resource.

There was good evidence to support:
- The creation of new roles working across professional boundaries supports integrated delivery.

There was some evidence to support:
- There is variation in success factors depending on the staffing model of joint working.
- A focus on the service user/patient helps overcome professional boundaries.
- Understanding different roles and responsibilities is important to successful integration within a team.

TRAINING AND EDUCATION
The need for **training** to meet specific requirements, such as staff taking on new responsibilities, seems to be clear; however the most effective form of training requires further research. In particular, a better understanding of the link between inter-professional training and effective integration would be helpful.

There was some evidence to support:
- Training is a key success factor for integrated working, particularly to reflect changing roles and responsibilities.
- Inter-professional training can support inter-professional working and hence enhance integrated services.
- Co-location can support team working.

In summary, the review found that the evidence relating to workforce and integration was often weak and based on the views of staff rather than relating to outcomes for service users. Approaches were often and probably most effectively developed locally, which makes comparative studies more difficult. There is clearly a need for further research to understand better how workforce management and development needs to be different in integrated settings.

1.5 RECOMMENDATIONS

The programme should work with:
- Representatives of patients, service users and carers, through pilots projects 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. This should include engaging with the proposed patient and public coalition in the West Midlands and the national HEE Patient Advisory Forum.
- Local organisations to **identify the workforce** that provide support to older people in the West Midlands. This should include identifying the **organisations that are already providing integrated care** for older people.

SECTION 2 CARE NEEDS OF OLDER PEOPLE

This section outlines the care needs of older people. It identifies skills and competencies which need developing in order to support older people's care. It also highlights some of the factors which are important to older people in how their care is delivered.

SUMMARY

- Age can define the health needs of older people. Older people can have different patterns of disease presentation, respond more slowly to treatment and need both health and social support. Addressing the health needs of older people requires particular clinical skills.
- Various gaps have been identified in the skills and competencies of staff who are in contact with older people. These include gaps in understanding the effects of ageing on the body and awareness and understanding of the mental health issues of older people.
- For older people, the basic "customer service" aspects of how care is delivered are important, such as, staff being on time and staff doing as they said they would, can be just as important as the impact of the care they receive.
- Problems such as living alone, having caring responsibilities or financial worries can build up over time and significantly affect the health and wellbeing of older people. Older people's care should be considered holistically and take account of the full range of services that can contribute to promoting the total wellbeing of older people.

2.1 CONTEXT

By 2035 the number of people in the West Midlands who are 65 or older is expected to rise from 17% to 23%, compared to 21% for England.

There are fewer people aged 65 and who live alone (a decrease from 34% in 2001 to 31% in 2011). More older people are providing 50 hours or more unpaid care a week (up from 4.3% in 2001 to 5.6% in 2011). The proportion of the population aged 65 and over who live in communal establishments is declining (from 4.5% in 2001 to 3.7% in 2011).

The changing shape of the population will affect not only the number of people who may need care in the future, but also the pool of people that will be able to care for them.

2.2 AGE AS A DEFINING CHARACTERISTIC OF CARE NEED

Age can define the health needs of older people. There is evidence that there are specific health needs which are associated with age. For example[12]:

[12] Department of Health Strategy Group, "Policy for Older People Guidance", (2010). Department of Health

- By 2033 almost 25% of the population will be over 65.
- The population which suffers from dementia is projected to double to 1.4m by 2030.
- The median age of people in hospital is 68.
- An estimated 52% of over 65s have a long-term condition.
- Approximately 72% of social care recipients are over 65.
- Older people account for 43% of the NHS' total budget.
- An estimated 45% of health and community services expenditure is on people over 65.
- People over 65 consume 50% of the total drugs spend.
- Falls injuries account for more bed days in hospital than heart attack, stroke and heart failure combined.

The British Geriatrics Society has identified factors which call for a particular kind of care for older people: "*Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support, call for special medical skills*"[13].

Using age alone as a categorisation is unhelpful as older people are not homogenous. However, ignoring age is problematic given the evidence that there are specific needs which are associated with old age. The Centre for Workforce Intelligence (CfWI)[14] devised five 'states' based on the general state of people's health and the care they require:

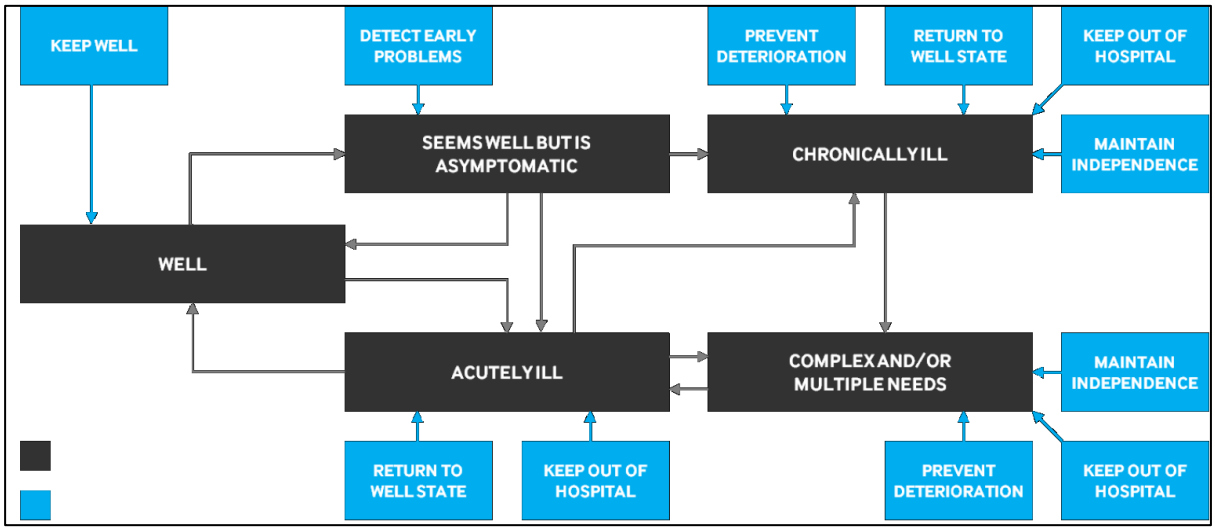
OLDER PEOPLE HEALTH AND SOCIAL CARE STATES:

- **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.

Older people will move between states and their progression between states will not necessarily be linear. Their needs can be met, at least in part, by health and care staff and from differing agencies. Some of the skills that are needed to care for older people are generic, others are more specialist.

CfWI have also drawn out the policy goals for people in each state:

[13] An introduction to the role and work of the BGS, British Geriatric Society, 2009
[14] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011



This is a useful framework for navigating the nature and intensity of the care and support which may be required by older people and their carers and understanding the workforce requirements.

Most programmes have targeted people who are already acutely or chronically ill, or have complex and/or multiple needs. The policy focus is starting to redress this balance by beginning to promote a greater focus on prevention and re-ablement.

2.3 SKILLS AND COMPETENCIES FOR CARING FOR OLDER PEOPLE

The skills and competencies for caring for older people are delivered in a range of settings and by a range of carers, support workers and practitioners. Skills for Health have developed workforce competencies, many of which are appropriate for use in both health and social care settings, for example OP/ F1 Assess older people's risk of falls. These are available on the Skills for Health website[15].

In addition common core principles have been developed to reflect national policy, for example End of Life Care and Dementia Care. Skills for Care have developed a set of Common Core Principles for End of Life Care which is available on the Skills for Care website. There are also a range of skills and competencies which have been developed by specific professions to support the delivery of care either to older people or conditions which are associated with older people

The National Service Framework (NSF)[16] for older people is more than a decade old; there is a National Dementia Strategy[17], and the National Institute of Health and Clinical Excellence (NICE) has produced guidance and quality standards for the so-called 'geriatric syndromes' including: instability (guidance on falls)[18]; immobility (rehabilitation and post-acute care)[19]; incontinence[20]; dementia[21] and confusion (delirium)[22].

[15] http://www.skillsforhealth.org.uk/about-us/competences%10national-occupational-standards/
[16] Department of Health 2001
[17] Department of Health 2009
[18] National Institute for Health and Clinical Excellence 2004
[19] National Institute for Health and Clinical Excellence 2009
[20] National Institute for Health and Clinical Excellence 2007
[21] National Institute for Health and Clinical Excellence 2006
[22] National Institute for Health and Clinical Excellence 2010

The Silver Book[23] suggests that generic skills for the assessment and care of older people are:

- Communication skills, including under challenging conditions e.g. taking detailed history from the person, ability to explain things in more than one way, give encouragement.
- Listening skills.
- Compassion, empathy and respect.
- Clinical reasoning and assessment skills.
- Time/patience and the ability to build a rapport/relationship quickly.
- Awareness of community services.
- Risk assessment/management skills surrounding discharge planning.
- Multidisciplinary team working skills.
- Personal care training skills.
- Moving and handling skills.
- Basic life support skills.
- Ability to balance contrasting needs of a complex individual.

2.3 GAPS IN SKILLS FOR CARING FOR OLDER PEOPLE

Age UK in ***Healthcare Workforce Skills and Competencies for an Ageing Society***[24] identified three broad areas which appeared to be general skills gaps in respect of the aspirations for older people:

- Skills relating to **multi-disciplinary team working**, supporting patient transitions and providing patients with sufficiently clear communication about their treatment and care pathways (and doing so in a timely way and in a way that recognises patients' own preferences).
- Skills relating to **empathy, listening and relationship building**. These ultimately relate to healthcare professionals being able to put themselves in the older person's position.
- A clear gap in **knowledge and understanding about the likely needs and experience of older people** (outside of specialist geriatric roles). It is a substantial gap in the sense that it plays out from a clinical perspective as a tendency for specialised healthcare professionals to fail to treat older patients (with multiple health needs) in a holistic manner.

They also highlighted areas where clinicians did not meet older people's clinical needs. Much of what was reported related to managing multiple conditions:

- **Broad lack of knowledge and understanding about the effects of ageing on the body**. Interviewees reported that parts of the workforce (such as nursing) lacked basic knowledge of the effects of ageing on the body, and what this means for various medical procedures such as taking blood.
- **Mental health conditions**: Lack of awareness of the early signs of dementia was a key issue. There was a lack of understanding of the effects of mental health problems on the cognition of service users. This meant that aspirations such as respect for preferences and belongings were not being met.
- **GPs have issues assessing "capacity"**, that is, the mental awareness of a service user and their ability to make decisions.

[23] QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS ("Silver Book"), June 2012,
[24] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010

- **Poly-pharmacy**: many clinicians, including GPs and nurses are not able to help older people manage multiple medications.
- A general **gap in managing co-morbidities** was present across the workforce. This was identified as being particularly prevalent among AHPs who can focus on their part of the care pathway without knowledge of other conditions that may affect the service user.

There was also a general consensus[25] that pre and post-registration training for the regulated professions did not provide clinicians with the competencies to meet the aspirations for older people.

An early finding from the Integrated Care Pioneers Programme is that it is rare for integrated care teams to have ready access to mental health support and individuals within teams rarely have the skills themselves – the missing part is mental health engagement with the community teams[26].

2.4 OLDER PEOPLE'S VIEWS AS SERVICE USERS

A review of the evidence of the effectiveness of professional groups working with older people living at home[27] found that:

- Factors such as timeliness, completing actions as promised, perceived expertise in tasks and the quality of relationships were as important as the ultimate agreed outcomes for care.
- At times of escalating ill-health or crisis older people's need for effective interprofessional working is particularly significant. Effectiveness is closely linked to:
    - Continuity of care through a recognised or named key person from health or social care.
    - Relationship styles of working that support co-production with the older person.
    - Ongoing shared review.
    - Functioning ties or links across a wider primary care service network.

A study of the nursing contribution to chronic disease management[28] found a number of factors which were important to patient and carers:

- Patients and their carers' valued nurse case management for the nurse's clinical expertise, the nurse's assistance in providing continuity of care and acting as intermediary with multiple services and the therapeutic effect of the nurse's as psycho-social support.
- Patient defined outcomes of nurse case management were articulated as increased confidence in managing their conditions, acquiring self-management techniques that made their lives easier, their (patient and carer) priorities were addressed, patient and family carer time and energy was saved and having a professional delivering their care who knew their 'story'.
- Some patients who received community matron case management were concerned that it was a form of surveillance. The evidence suggested that some patients and carers asserted their independence by refusing services offered by nurse case managers.

[25] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010
[26] Health Education England, Briefing in a minute – Integrated Care Pioneers Support programme, 02 December 2013
[27] A study of the effectiveness of interprofessional working for community-dwelling older people, NIHR - Professor Claire Goodman, Professor Vari Drennan (St Georges, University of London), Professor Heather Gage (University of Surrey), Professor Stephen Iliffe (University College London), Professor Jill Manthorpe (King's College London), December 2012
[28] The nursing contribution to chronic disease management: a whole systems approach. National Institute for Health Research Service Delivery and Organisation programme. Kendall S, Wilson P, Procter S, Brooks F, Bunn F, Gage H ,McNeilly E. 2010

- Community matrons and district nurses talked of being careful not to overwhelm patients with numerous questions and being cautious about leading patients to feel they were the subjects of assessment. Several intimated that the assessment documentation was not the main source of information for how they worked with the patients, preferring to rely on getting to know the patient and their carer over time.
- The study also found that the transition from being a patient who could benefit from case management to that of a patient in need of palliative care could be problematic, threaten continuity of care and create confusion as to who was the nurse case manager, particularly in service delivery models that had a specific disease focus.
- Patients also highlighted the disadvantages of receiving a service that was interrupted by holidays and nurses not being available outside of office hours.
- The involvement of a nurse case manager, particularly the community matrons, was often as significant a support for the family carer as for patients themselves. None of the nurses saw their work as being primarily to support the carer; almost all recognised that often the carers had equivalent needs and were themselves in danger of becoming ill.

A study on the support and services that older people want[29] identified a number of themes which are relevant to how older people's services are provided:

- Older people stressed that they were individuals, with different histories, different hopes and dreams, and different priorities in the management of their lives.
- People from black and minority ethnic groups equally wanted access to individualised services and may have particular needs, e.g. for interpretation, sharing experiences in community centres or information. Other people share some of these possible access problems in different ways, e.g. those who have disabilities such as deafness or visual impairment
- Older people want to be involved in debating the level of resources to be made available and the ways in which resources are to be allocated. They do not share the same views.
- Meeting the needs of older people, whether by relatives, friends, volunteers or paid staff, must be grounded in local communities. Planning at community level must find ways to deal with the realities of people's lives however they cross service or organisational boundaries

Developing integrated care is most likely to lead to improved processes. The needs and preferences of end users can be lost in building organisations and organising new methods for delivering professional care. Using performance metrics focused on the end user and strengthening the user voice in the platform for integration might avoid this[30].

Older people's wider needs

Alongside the medical reasons that bring older people in contact with care services, problems which affect their general wellbeing may have been building up over time. These include social problems, such as living alone or having heavy caring responsibilities, financial worries, difficulty in maintaining and managing their home, loneliness and isolation. Addressing these needs is also important.

As well as statutory services, voluntary sector organisations can help older people to maintain as much control as possible over their own lives, to resume or engage in social activities that are

[29] The support older people want and the services they need, Joseph Rowntree Foundation - Roger Clough, Jill Manthorpe, OPRSI (Bert Green, David Fox, Gwyn Raymond and Pam Wilson), Vicki Raymond, Keith Sumner, Les Bright and Jinny Hay, 2007
[30] National Evaluation of the Department of Health's Integrated Care Pilots, RAND Europe, Ernst & Young LLP, March 2012

important to them and reduce isolation. Such support can improve general wellbeing and help reduce the likelihood of needing to call on urgent or emergency services in the future.

The Housing Learning and Improvement Network (HLIN)[31] outlined options for better supporting independence for older people, in particular, allowing older people to better choose how they are cared for and receive care. They highlighted the importance of also considering the role of the housing sector. This suggests a wider relationship around the well-being of older people than just health and social care.

Many older people prefer to remain living in mixed-age housing and communities. This can offer advantages such as being able to keep pets and continuing to receive emotional and practical support from neighbours and local organisations. However there is also evidence that moving, especially to housing with care, can improve quality of life, physical health and social well-being. An older person's health can benefit from a move to more suitable housing as long as it is an informed choice and they remain in control[32].

OLDER PEOPLE REMAINING INDEPENDENT

A small scale evaluation of an independent service[33] offering advice and information for older people, their families and carers about housing and care options in later life found that the most frequent types of intervention were supporting people with chronic health problems to remain independent (16 out of 21) and supporting people to move (15 out of 21). It also found:

- For people in crisis, support to move to suitable accommodation led to significant improvements in living conditions, health, including mental health, and the general wellbeing of the individuals who received the support.
- Assistance to access adaptations and repairs for those staying put in order to maintain independence had a positive long term impact on wellbeing and health, particularly after hospital discharge.
- Face to face contact with the case worker was crucial in improving wellbeing. Having someone to talk to and to support clients through difficult changes reduced stress and provided comfort to people who were often in considerable distress.
- The provision of holistic support and advice contributed to improved health and wellbeing over the long term. Most clients had one main issue they required assistance with, such as the need to move, but case workers assessed cases holistically and identified other ways in which clients could be supported.
- A factor which contributed to the success of the service was local knowledge of its existence and what it did.

[31] Assisted Living Platform - The Long Term Care Revolution, nthea Tinker, Leonie Kellaher, Jay Ginn and Eloi Ribe at the Institute of Gerontology, Department of Social Science, Health and Medicine, King's College London for the Technology Strategy Board, Reproduced by the Housing Learning and Improvement Network, September 2013

[32] Older People's Housing: Choice, Quality of Life, and Under-Occupation, Joseph Rowntree Foundation - Jenny Pannell, Hannah Aldridge and Peter Kenway, New Policy Institute, May 2012

[33] Analysis of FirstStop Local Partner Client Case Studies: Did clients benefit long term from the housing options support they received? Cambridge University - Cambridge Centre for Housing and Planning Research, Gemma Burgess, April 2013

Rurality

Rurality is also important in looking at how older people access care[34]. Many older rural residents do not seek out preventative health care or even acute treatment, and in some cases avoid seeking care even in moments of emergency and health crisis. Reasons for this include a reluctance to voice need due to many positive experiences with health providers, for example, with local pharmacists or GPs. Older rural residents also tend to display a 'make do' attitude, as well as explicit and implicit fear of emerging age-related health issues. This poses significant challenges for health services providers. More intensive, immediate, invasive and complex responses are required when many older residents come into contact with services.

Tailored care

In the Oxleas Advanced Dementia Service[35] there is no standardised care package for patients with advanced dementia and other complex needs; care is tailored to each person based on their primary need and the range of services which are available locally. As the disease progresses, their needs are re-assessed and the care package is adjusted accordingly.

The Kings Fund Chronic Conditions[36] study found that at a personal level, a holistic focus that supports service users and carers to become more functional, independent and resilient, and to live well by managing their conditions in the home environment, was preferable to a purely clinical focus on managing or treating medical symptoms.

2.5 RECOMMENDATIONS:

The programme should:

- Apply the values based recruitment approach and recommendations of the national initiative to ensure the programme takes account of the **values and behaviours** required for working in older people's integrated care teams. This should include ensuring that existing, as well as new, workers are equipped with the appropriate "customer service" skills for caring for older people. This will help to support developing a new culture.
- Establish links through Health Education West Midlands to support implementation work on **the development of pre and post-registration training for the regulated professions** to ensure that clinicians have the competencies to meet the aspirations for older people.
- Work closely with other workforce programmes, including the Innovation Fund programmes for **related areas of work**, 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.

[34] 2013 Rural Ageing Research Summary Report of Findings, Published by DEFRA, research conducted by TNS BMRB in conjunction with the International Longevity Centre (ILC), 2013

[35] Oxleas Advanced Dementia Service Supporting carers and building resilience, Kings Fund - Lara Sonola, Veronika Thiel, Nick Goodwin Dennis L Kodner, October 2013

[36] Co-ordinated care for people with complex chronic conditions: Key lessons and markers for success, Kings Fund, October 2013

SECTION 3 MODELS OF INTEGRATED CARE

This section shares emerging lessons of how models of care are being developed by staff using team-based co-ordinated approaches, with an emphasis on horizontal models of integration.

SUMMARY

- There is no one approach to integrating care that suits all situations. The design of care should be shaped by local circumstances and the nature of the service user's needs.
- Multidisciplinary teams have tended to be either a 'core' group of professionals and/or care teams who undertake close and ongoing care of older people; or a wider network of care providers who can be drawn on to support care assessments and/ or to provide a range of services.
- The models also tend to use a named care co-ordinator or a case manager who takes personal and direct responsibility for supporting service users (and usually informal carers/family members). The jobholder coordinates all aspects of the user's care, medical, social and wider support, such as volunteers or housing services. Care coordinators have varying backgrounds but the role is broadly consistent across projects.
- There have been varying models of working with primary care, ranging from primary care being central to the model to primary care being disengaged. There is a need for integrated care teams to ensure that their work is coordinated with primary care and that GPs in particular are engaged in developing services and that they understand how their patients can benefit.
- The role of carers is very significant and their needs also need to be considered alongside those of the service user.

3.1 CONTEXT: MODELS OF INTEGRATED CARE

There is no one approach that suits all occasions. Local circumstances and path dependencies are crucial. Integration often involves finding multiple creative ways of reorganising work[37].

Most community-based projects are integrated "horizontally", i.e. integration between community-based services such as general practice, community nursing and social care. Services focus on maintaining independence for the individual. More "vertically" integrated models of care in which e.g. primary and secondary care work together, are discussed in Section 4.

[37] National Evaluation of the Department of Health's Integrated Care Pilots, RAND Europe, Ernst & Young LLP, March 2012

3.2 MULTIDISCIPLINARY APPROACHES TO INTEGRATED CARE

In the UK, integrated care is typically provided through case management/ care co-ordination and multidisciplinary and community-based health and social care teams, working to improve care post-discharge from hospital and/or to avoid hospitalisations by focusing on 'at-risk' individuals in the community.

The case studies suggest that there is a broad "best practice" model for delivering integrated care. The model is broadly consistent across a number of user groups, including older people, chronic conditions, end of life, dementia and specific risk groups. It comprises:

Element	Description
Support from a team of multi-disciplinary carers	Professionals working together in multidisciplinary teams or provider networks, generalists and specialists, in health and social care. Many of the models 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
A named care co-ordinator/ case manager	A care co-ordinator or a case manager acts as a single point of contact and works to develop a care plan. • **Care co-ordinators** tend to be non-clinicians who facilitate access to care services and provide a point of contact • **Case managers** tend to have had specific training and expertise in caring for older people with complex needs. They co-ordinate care and provide some care directly.

How coordinators and multidisciplinary teams are deployed depends on:

- Local circumstances, including the differing roles of local organisations and the strengths of varying factors;
- The nature of the need that is being addressed, for example, whether it is supporting preventative/ proactive services for older people with non-complex needs, or supporting complex and severe conditions in home or community settings.

A high level summary of models drawn from case studies is shown in the table:

Project	Target Client Group	Care Coordinator	Case Manager	Core Group	Wider Team
Torbay	Older people at risk	√		√	
Pan Gwent Frailty Service	Vulnerable elderly people, people with long term conditions and individuals with health and social care or housing need.	√		√	
Midhurst Macmillan Community Specialist Palliative Care Service	Patients needing end-of-life care in the area.		√		√
Oxleas Advanced Dementia Service	People with moderate to severe advanced dementia, complicated by complex mental and physical comorbidities	√			√

Sandwell Integrated Primary Care Mental Health and Wellbeing Service	People on the SMI register.	√			√
Community Resource Teams (CRTs), Pembrokeshire, Wales	People with multiple health and social care needs at risk of hospitalisation. Usually frail older people with dementia and multiple co-morbidities.	√		√	
Poole Intermediate Care Services (PICS)	Adults and older people at risk of hospital admissions or admitted to hospital who could remain in their community.	√		√	

A more detailed case study summary is at **Annex A**.

3.3 THE MULTIDISCIPLINARY TEAM

From the studies[38] there is a distinction 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.

The nature of the 'core group' depends on whether the approach focuses on care management (direct to service users through multidisciplinary teams) or care co-ordination (indirectly, across networks of care providers to facilitate access and care co-ordination).

The 'core' team is multidisciplinary in nature, with a remit of managing and providing a range of care and cure services to older people directly, often within their own homes. In the report***, Co-ordinated care for people with complex chronic conditions***[39], all five programmes used multidisciplinary and community-based teams as a means of achieving an explicit focus on supporting people to live at home. The teams typically utilised the skills of specialist nurses, primary care professionals, social care staff, allied health professionals and the voluntary sector, to conduct holistic assessments which take health and social care needs into account.

In many studies the emphasis is on ensuring that whoever visits the user in their home is able to meet all their needs, reducing the need for handover of care or multiple visits[40]. Staff are trained to be able to work beyond their professional roles.

3.4 CARE CO-ORDINAT ION

The Kings Fund in ***Co-ordinated care for people with complex chronic conditions***[41] concluded that the care coordination role appeared to have been crucial in enabling programmes to deliver their objectives effectively. The key functions of the care co-ordinator were consistent across five programmes, despite differences in the nature of the patient group being served and whether they

[38] Providing integrated care for older people with complex needs: Lessons from seven international case studies, Kings Fund - Nick Goodwin, Anna Dixon, Geoff Anderson, Walter Wodchis, January 2014
[39] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner, Oct 2013
[40] Structured discussion with Jo Stuttaford, Midhurst, 24 February 2014
[41] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner

were located in rural or urban settings, affluent or deprived communities, or dealing with smaller or larger caseloads. The functions included:

- Providing personal continuity of care to the patient/carer, acting as a key point of contact for care;
- Being the patient's advocate in navigating across multiple services and settings;
- Providing care directly in the home environment (by case managers with advanced skills);
- Ensuring that professionals within the multidisciplinary team are kept informed of the patient/carer's situation;
- Taking accountability for the provision of care and ensuring that care packages are put in place and delivered;
- Communicating with the wider network of providers (outside of the core multidisciplinary team) so that information about the patient/carer is shared and any actions required are followed up.

The functions identified above require good communications and interpersonal skills.

The type of person acting as care co-ordinator varied greatly. Most care co-ordinators had been community or specialist nurses, but the role was taken on by non-clinical 'link workers' in Sandwell and health and social care co-ordinators in Torbay.

In the studies in ***Co-ordinated care for people with complex chronic conditions,*** none of the care co-ordinators had received special training for the role, but all reported having good 'people skills' and in-depth knowledge of the local community. Most had lived and worked in their community for several years, acquiring a good understanding of the local health or social care system, which helped them to support patients in negotiating between care providers. Building effective working relationships between care co-ordinators, multidisciplinary teams and wider service providers has been important in supporting better co-ordination.

In Torbay[42], the appointment of health and social care co-ordinators was an important innovation in harnessing the contribution of all team members in improving care. Care co-ordinators provide valuable additional skills and capacity to the teams. It is also noteworthy that the Devon and Torbay Virtual Ward[43], where patients are identified via predictive modelling, uses a case manager. Patients have been identified as at risk of hospital admission and therefore have a greater intensity of need. The case manager role is often filled by a community matron who may have pre-existing knowledge of the patient, but the role can be filled by other members of the virtual ward team.

The Kings Fund study, ***Case management: What it is and how it can best be implemented***, found that case managers came from various backgrounds, including nursing, social work, physiotherapy and occupational therapy. What was important was that the individual was equipped and trained with the necessary skills. These included:

- Interpersonal skills.
- Problem-solving skills .
- Negotiation and brokerage skills .
- Prescribing qualifications[44].

[42] Integrating health and social care in Torbay: Improving care for Mrs Smith Kings Fund, Peter Thistlethwaite, March 2011
[43] South Devon and Torbay: Proactive case management using the community virtual ward and the Devon Predictive Model, Kings Fund - Veronika Thiel, Lara Sonola, Nick Goodwin, Dennis L Kodner, October 2013
[44] Case management: What it is and how it can best be implemented, Kings Fund, Shilpa Ross, Natasha Curry, Nick Goodwin, Nov 2011

At Midhurst[45], the coordinator role is delivered through the allocated Clinical Nurse specialist (CNS) and the patient. The CNS holds overall responsibility for organising and co-ordinating care, while other team members retain responsibility for their aspect of the service and can arrange additional services without initial sign-off from the CNS. The flexibility of the service derived from its structure facilitates decision-making, enabling professionals to act quickly to fill gaps in care and adapt the care plan when circumstances change without going through the CNS. It relies on mutual respect and trust between staff within the Midhurst team.

In the Kings Fund report, ***Providing integrated care for older people with complex needs: Lessons from seven international case studies***[46], in all the models a named care co-ordinator or case manager took personal and direct responsibility for supporting service users (and usually informal carers/family members). Each worker/team had a defined caseload of patients, the size of which varies depending on the intensity and complexity of patients' needs and the admission/ discharge criteria for the programme. Registered nurses and community social workers jointly shared this role in Te Whiringa Ora (New Zealand). In Quebec, case management for the elderly has traditionally been undertaken by social workers. Within PRISMA (Canada) nurses and rehabilitation therapists also became case managers.

A study of the nursing contribution to chronic disease management[47], in which expert nurses undertook all elements of case management, found that care was valued by patients and carers but was expensive. The study confirmed that case management interventions needed to be integrated with other primary care based initiatives and that the nurse case managers encountered difficulties when operating without a multi-disciplinary (including medical staff) team as support. There was little evidence to suggest that the nursing contribution was unique or that to achieve their role a specific level of education or experience was required. It also highlighted that nurse case managers with an appropriate mandate can act as a force for integration, continuity of care and effective collaboration between very disparate professional groups and organisations.

3.5 THE ROLE OF PRIMARY CARE IN INTEGRATED CARE

Links with primary care can be important for older people (see section 2). An NIHR review on the effectiveness of interprofessional working[48] found that there was more likely to be effective interprofessional working when there was a functioning link with wider primary care services.

The Kings Fund study, ***Providing integrated care for older people with complex needs***, [49]noted that the literature on care co-ordination for older people with complex medical problems and/or multi-morbidity placed high importance on the role of primary care. Many studies have suggested that the most effective approaches have a GP or primary care physician at the centre of a team-based approach. However, the Kings Fund study suggested that primary care physicians were rarely part of

[45] Midhurst Macmillan Community Specialist Palliative Care Service - Delivering end-of-life care in the community, Kings Fund, Veronika Thiel, Lara Sonola, Nick Goodwin, Dennis L Kodner, October 2013
[46] Providing integrated care for older people with complex needs: Lessons from seven international case studies, Kings Fund - Nick Goodwin, Anna Dixon, Geoff Anderson, Walter Wodchis, January 2014
[47] The nursing contribution to chronic disease management: a whole systems approach. National Institute for Health Research Service Delivery and Organisation programme. Kendall S, Wilson P, Procter S, Brooks F, Bunn F, Gage H ,McNeilly E. 2010
[48] A study of the effectiveness of interprofessional working for community-dwelling older people, NIHR - Professor Claire Goodman, Professor Vari Drennan (St Georges, University of London), Professor Heather Gage (University of Surrey), Professor Stephen Iliffe (University College London), Professor Jill Manthorpe (King's College London), December 2012
[49] Providing integrated care for older people with complex needs: Lessons from seven international case studies, Kings Fund - Nick Goodwin, Anna Dixon, Geoff Anderson, Walter Wodchis, January 2014

the 'core' team that provided coordination of care or a case management function for service users. In most of the case study programmes, care co-ordination was being delivered alongside rather than by primary care physicians. This suggests that patients with complex needs that span health and social care may require an intensity of support that is beyond what primary care physicians can deliver.

The question is whether medical care in the community for older people with complex multiple conditions requires a generalist profession such as a GP or whether it is a specialist task, while the management (or integration) of medical and non-medical services is carried out by a co-ordinating case manager. The Kings Fund study suggested that GPs' work processes, funding mechanisms and expertise are generally not well suited to meeting the requirements of treating and managing older patients with complex chronic medical and social needs. There is a risk that expectations of what GPs can achieve in this regard may be unrealistically high.

In ***Co-ordinated care for people with complex chronic conditions***[50], a concern of all programmes was the apparent disengagement of GPs, which sometimes made effective information exchange difficult and prevented them from bringing the GPs' general knowledge of the patient/ family into discussions about their care.

Lack of GP engagement has led to slower progress in developing effective care co-ordination and to ensuring referrals into programmes. A variety of strategies to improve GP engagement have been used e.g., financial incentives, information sessions and attending regular GP meetings. In many cases they have still not achieved the desired engagement with GPs.

In South Devon and Torbay CCG[51] community virtual wards are hosted by GP practices. It has been suggested that this has facilitated GP engagement. However, for some time Torbay has benefitted from strong primary health care services that were influenced by whole-system thinking and this has benefitted local developments. The virtual wards have also benefited from existing good working relationships between care professionals across health, social care and voluntary sector and their knowledge of locally available services.

In the Midhurst service[52], GPs' level of involvement varies, with some very actively engaged in patient management and care coordination in partnership with the Midhurst service, while others take a more passive role. However, Midhurst sees the GP and community role as significant and ensures that all their (Midhurst's) activities are communicated with GP practices and their teams and that they work with them closely[53].

In The Oxleas Advanced Dementia Service[54] liaising with services in primary care and in the community is integral to the model. Staff have developed strong links with other professional groups and relevant specialist services. However, engagement with local GPs is variable and generating referrals has been problematic. This may be due to a lack of understanding or awareness of the

[50] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner, Oct 2013
[51] South Devon and Torbay: Proactive case management using the community virtual ward and the Devon Predictive Model, Kings Fund, Veronika Thiel, Lara Sonola, Nick Goodwin, Dennis L Kodner, October 2013
[52] Midhurst Macmillan Community Specialist Palliative Care Service - Delivering end-of-life care in the community, Kings Fund - Veronika Thiel, Lara Sonola, Nick Goodwin, Dennis L Kodner, October 2013
[53] Discussion with Jo Stuttaford, Midhurst, 24 February 2014
[54] Oxleas Advanced Dementia Service - Supporting carers and building resilience, Kings Fund - Lara Sonola, Veronika Thiel, Nick Goodwin, Dennis L Kodner, October 2013

service. The service has attempted to actively engage GPs however; levels of engagement have not improved.

In many areas integrated care is being introduced either as part of or alongside risk stratification systems. There is a view that the proactive/ preventative approach which is embedded in risk stratification may be the means of engaging GPs and demonstrating the value of integrated care to primary care[55].

3.6 THE ROLE OF CARERS

A critical component of care co-ordination for people with complex needs is the unpaid support of informal carers, family and volunteers from the local community. Supporting people to live at home, or ensuring that effective 'early warning' systems are in place before they fall into crisis, requires 24/7 support that cannot be provided by the limited resources available to health and social care teams. This seems especially important for highly vulnerable patients nearing the end of life.

The Midhurst Macmillan Service[56] and Oxleas Advanced Dementia Service[57] have invested in building the resilience of carers to support patients at home and in engaging with the wider community to provide a range of essential 'low-level' support services that help people remain independent and at home for longer.

A key facet of the Oxleas service[58] is its focus on supporting carers to cope with caring for their relative and providing palliative care in the last year of their life. Caring for a person with dementia differs from other conditions and carers are twice as likely to experience anticipatory grief (i.e. before the patient dies). On the first visit the psychiatrist and nurse conduct a full carer assessment and provide additional support on subsequent visits. When the patient's clinical situation begins to deteriorate, the care co-ordinator or psychiatrist talks to the patient and family about dying and what to expect. These discussions often take place in isolation from other care professionals, who may be unwilling to initiate an end-of-life conversation. The care co-ordinator can refer carers to support groups or charities, and after death can provide bereavement support for relatives if requested.

The Oxleas service design places patients alongside their families and carers at the heart of the care co-ordination relationship with their needs considered alongside that of the patient. This dual focus engenders trust, with carers able to share their fears or worries with staff. The Oxleas study also noted that access to the right equipment, support for relevant medication, food, and social care needs were essential elements of caring for advanced dementia patients at home. Carers were often blocked from accessing support due to a poor understanding of the needs of advanced dementia care. As a result they valued regular visits from a care co-ordinator who understood these pressures and could give advice if needed.

[55] Discussion with United Healthcare, 24 February 2014
[56] Midhurst Macmillan Community Specialist Palliative Care Service - Delivering end-of-life care in the community, Kings Fund - Veronika Thiel, Lara Sonola, Nick Goodwin, Dennis L Kodner, October 2013
[57] Oxleas Advanced Dementia Service - Supporting carers and building resilience, Kings Fund - Lara Sonola, Veronika Thiel, Nick Goodwin, Dennis L Kodner, October 2013
[58] Oxleas Advanced Dementia Service - Supporting carers and building resilience, Kings Fund, Lara Sonola, Veronika Thiel, Nick Goodwin, Dennis L Kodner, October 2013

In ***The nursing contribution to chronic disease management*** [59] in patient interviews it was apparent that the involvement of a nurse case manager, particularly community matrons, was often as significant a support for the family carer as for patients themselves. None of the nurses saw their work as being primarily to support the carer; almost all recognised that often the carers had equivalent needs and were themselves in danger of becoming ill.

One district nurse commented that it was "natural" to look after the carers and in one site the district nurse was undertaking a form of carers' assessments alongside patient assessments. Nurses said that they provided emotional support through "simply listening", signposting carers to services and coordinating assistance. There were several examples of where the case manager would actively seek services, such as additional social care, for the carer as well as the patient. In some situations having a case manager was seen as the difference between a carer being able to continue in that role or not. In this example the case manager represents herself as being the "backup" and reassurance should the carer no longer be able to continue as the patient's actual case manager.

3.7 RECOMMENDATIONS

The programme should work with:

- Pioneers[60] 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 that the workforce implications are understood.

[59] The nursing contribution to chronic disease management: a whole systems approach. National Institute for Health Research Service Delivery and Organisation programme. Kendall S, Wilson P, Procter S, Brooks F, Bunn F, Gage H ,McNeilly E. 2010

[60] The term "pioneers" is used to include both the nationally funded Integration Pioneers and integration focussed initiatives that are being delivered through the Better Care Fund (see page 11 for more details).

SECTION 4 INITIATIVES TO HELP AVOID HOSPITAL ADMISSION

This section provides an overview of the workforce implementation challenges identified by the Centre for Workforce Intelligence (CfWI) on a number of models of care for older people, with an emphasis on vertical models of integration.

SUMMARY

- The Centre for Workforce Intelligence (CfWI) identified a number of models of integrated care which were intended to ensure that older people were not admitted into hospital.
- The CfWI analysis identified the skills and training requirements to support the models of integrated care. They include: developing advanced clinical skills, triage and assessment capability, management and co-ordination, case management skills, multidisciplinary skills and experience. They also identified some new roles which had been developed in support of the models of care.
- Some of the models which CfWI reviewed addressed specific system issues in isolation. CfWI considered that these models were not be sustainable in the longer term and that to be sustainable models of care need should be developed across the whole system, covering services for all patients, not only older people.
- CfWI have aggregated their findings to develop a checklist of questions for sites which are designing and implementing integrated services.

4.1 CONTEXT

The Centre for Workforce Intelligence (CfWI)[61] reviewed models of integrated care. The models provided care for older people in their homes and were intended to ensure that older people did not have to be admitted into hospital. Some of these models are examples of "vertical" integration, that is, they are predicated on working between primary and secondary care.

CfWI identified 65 sites. The sites fell into eight broad categories, or "point" models and whole system models. CfWI then gathered information from each of the sites via email and/or through face to face or telephone interviews. CfWI considered the effectiveness of each model in terms of costs, quality of care, productivity and efficiency and the workforce implications of each model.

CfWI found that the sites were making progress on making savings and redesigning services, but that there was a risk that the "point" models created 'bolt on' solutions that did not address the wider issues around identifying systems of care for older people.

This section focuses on the workforce aspects of the CfWI study. The CfWI workforce conclusions are high level. This section identifies the themes of the report.

[61] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011

4.2 "POINT' MODELS"

The eight "point" models which were identified were:

- **Ambulatory emergency care (AEC)**: Ambulatory models create a 'virtual ward' of patients who stay at home under clinical supervision. There is integrated working between primary and secondary care teams.
- **Single point of access (SPA)**: A telephone triage service refers and discharges chronically ill patients with complex/ multiple needs to community, social and health care services.
- **Virtual wards (VW)**: VWs target preventive care at people 'at-risk' and support existing community services to provide care at home.
- **Personalised budgets (PB)**: Personal budgets enable people to employ personal assistants, choose care that best suits their needs and have those needs met more creatively via a support planning process.
- **Hospital at home (HaH)**: Health care professionals provide time limited treatment at home for a patient who would otherwise need acute in-patient care. Referrals are from a range of sources and can be used to provide both step-up and step-down services.
- **Rapid response team (RRT)**: Delivers critical care to a patient experiencing a crisis. The patient is assessed by a member of a multidisciplinary team, who draws up a plan for short-term treatment and care in the patient's home.
- **Extra care housing (ECH)**: Housing designed, built or adapted to facilitate support and care for the people who live there. Access to care and support is 24/7, either on site or by call.
- **Acute admissions unit (AAU)**: An acute ward in a hospital which allows short-term patient monitoring and treatment. The AAU deals with admissions only and acts as a gateway between a patient's GP, the emergency department and in-patient wards.

The models are intended to reduce unplanned hospital admissions by redirecting people through re-organised and streamlined community services or targeting people predicted to be at high-risk before they become acutely ill. Services are delivered by integrated and multi-disciplinary care teams in different settings.

Each model, other than AAU, shares the goal of organising services so that people are looked after in their own homes, by using a community of multidisciplinary workers, working in partnership.

Workforce Implications

The high level workforce requirements for each model are set out below:

- **Ambulatory emergency care (AEC):** AEC requires a senior clinical decision maker at the "front of house". Community teams ensure people receive follow up treatment. They may require training and support to do this.
- **Single point of access (SPA):** The SPA provides telephone triage from a clinician with strong diagnostic skills. An SPA is made up of staff from different disciplines. It works across health care, social care and the third sector to join up care.
- **Virtual wards (VW):** The VW uses the staffing, systems and daily routines of a hospital ward to reduce the risk for patients of unplanned hospital admission. It comprises health and social care providers across primary, community and intermediate care settings with relationships with GP

practices and acute centres. A multidisciplinary team provides joined-up health and social preventive care to patients in their own homes.

- **Personalised budgets (PB):** Care managers support self-directed support. Personal assistants deliver high quality new and innovative services.
- **Hospital at home (HaH):** Services are usually provided by a multi-disciplinary team, with input from a doctor or consultant. Multidisciplinary staff work independently in a patient's home. Staff have enhanced decision making, risk assessment and clinical skills.
- **Rapid response team (RRT):** Staff work independently in the community. They have a generalist skill set to cope with a range of situations. The team as a whole has knowledge of local resources and services and a network of contacts.
- **Extra care housing (ECH):** There needs to be waking and sleeping staff. A flexible workforce deals with shift demands and people's needs.
- **Acute admissions unit (AAU):** The workforce has the traditional skills associated with working in a secondary setting.

Examples of the workforce implications of some of the models at specific sites are set out in the examples below:

The Newcastle Single Point of Access: The SPA Coordinator needs sound clinical decision making skills because a wide range of health and social care professionals ask them for advice. Experience in the care of older people and in a wide range of settings is also important. Assessors need in depth knowledge of community services including pathways and criteria for all teams, excellent communication and networking skills and experience in bed management.

Manchester Personal Budgets: Care managers in Manchester no longer prescribe care packages but act as facilitators. This has involved a culture change and a shift in the core skills required by care management staff. They now have to listen to the customer and document and facilitate the support planning process.

Ashton Leigh and Wigan Hospital at Home: Independent working requires enhanced decision making and risk assessment skills to ensure patient safety is guaranteed at all times. It is not appropriate to employ newly qualified staff in this model; staff need a range of backgrounds so they have the range of skills required to address many diverse situations. In addition to a wide skill set, staff need risk-taking skills and to be able to use a wider range of equipment than normal community workers.

On joining the team staff undergo a 6 week training programme to acquire additional skills such as blood transfusions and DVT care. Staff also cross fertilise their skills among professions, which improves the efficiency of the service and allows the team to deliver more care in the community. The assistant practitioners also have additional skills, which means that they can administer care plans and free up the time of more qualified staff.

The Newcastle Rapid Response and Discharge Team: The team benefits from diverse backgrounds e.g. acute care and community nursing. As a result they have a wide variety of connections. They also need a generalist skill set – they need to be 'masters of everything'. Two liaison sisters are vital for integrating with other teams.

Staff work independently in the community and require assessment and decision making capabilities to do this effectively. A wide skill mix in the team provides a resource to both patients and other health professionals. It also aids integrating with other teams and can facilitate nurse to nurse referrals, therapist to therapist referrals or therapist to nurse referrals, offering a holistic assessment. The team integrates with a large network of community and acute based teams including the interface team at the emergency unit Royal Victoria Hospital, District Nurses, Community Matrons, GP's Out of hours Doctors and Social Services.

Rowanberries Extra Care Housing: Greater care and support available within Rowanberries led to a reduction in unplanned care and support such as GP, nurse and hospital visits. Use of day centre, meals on wheels and lunch clubs were eliminated due to on site facilities for social interaction, including provision of meals if required. Extra care therefore has the potential to reduce the resources needed to be drawn from the health and social care workforce outside of the scheme.

The South Tees Acute Admission Unit: The AAUs have an experienced team of nurse Practitioners, staff nurses and health care assistants who have extended their scope of practice to meet the patients' needs. The AAUs are consultant led, with consultants carrying out two ward rounds each day. The AAUs emphasise prompt assessment of patients to assess the need for care and deliver any necessary treatment.

A summary of the skill requirements identified for the development of the 'point' models are set out below:

- **Advanced skills:**
    - For ambulatory care, nurses in the community require advanced skills to provide acute care in the community
    - For virtual wards, clinicians require the skills/ experience to make decisions on higher acuity patients and community matrons develop more skills to diagnose and prescribe
    - For hospital at home, there is a need for enhanced decision making and risk assessment skills and additional skills to allow them to carry out complex procedures and provide a fuller service to their patients e.g., intravenous therapies, blood transfusion and inserting cannulas.

- **Triage and Assessment:**
    - For ambulatory care, strong senior clinical decision-making is needed to identify and triage patients
    - For single point of access, clinicians make decisions based on telephone triage
    - For rapid response teams, staff require independent assessment and decision making capabilities
    - For acute admission units, assessment skills are required.

- **Management and co-ordination:**
    - For single point of access, team leaders need to coordinate closely with other community and acute teams
    - For virtual wards, the ability to manage multi-disciplinary teams is required
    - For personal budgets, new brokerage and advocacy skills need to be developed

- For rapid response teams, all nurses and therapists in the team are responsible for liaising with other health professionals and coordinating the support required

- **Case management skills:**
  - For virtual wards, all staff require case management skills

- **Multidisciplinary:**
  - For ambulatory care, staff in secondary and community settings work together to provide ambulatory care
  - For virtual wards, training will enable different staff members to perform simple interventions for each other (e.g. physiotherapists performing certain nursing assessments and interventions) to maximise each patient visit
  - For hospital at home, cross fertilisation of skills among the professions can maximise the time of highly qualified staff
  - For rapid response teams, multidisciplinary skill and knowledge is essential to ensure patients have the best opportunity to remain independent. In addition, the team needs skills to be able to facilitate support for a variety of patient needs from physical exercise to psychological support of the dying and grieving. It is important the workforce have clear job descriptions and understand the nature of the role to ensure they feel comfortable with what they will be required to do.

- **Experience:**
  - For single point of access, of older people and from a wide-range of settings, in depth knowledge of wider community services including pathways and criteria, excellent communication and networking skills and experience in bed management.
  - For rapid response teams, it may be helpful for staff to be drawn from both secondary and community sectors so that the team as a whole has knowledge of the resources and services available and has networks of contacts.
- **New roles:**
  - For personal budgets, personal assistants need training and support to ensure that they deliver high quality care and enable new and innovative services to be designed
  - For Hospital at Home, assistant practitioners require additional skills so that they can administer care plans and free up the time of more qualified staff
  - For rapid response teams, integration and communication with other community teams and the acute sector can be aided by specialist liaison roles (e.g. liaison sisters)
  - For rapid response teams, support staff work closely with nursing and therapy staff to gain skills in re-ablement and care of the dying and grieving family.
  - For extra care housing, skills needed include: care management, housing management, health symptoms recognition, building communities, managing staff, funding and finance, marketing and promotional skills.

Outside the CfWI work, the Gwent frailty project[62] identified a recruitment barrier. A&E nurses considered they got kudos from working in a busy A&E and did not see work in the community as attractive. They only changed their mind-sets when they understood the skilled work that was taking place in the community, eg IV at home etc.

[62] Discussion with Sarah Parker-Jones, Gwent frailty Project, 24 January 2014

4.3 WHOLE SYSTEMS MODEL

CfWI also looked at a small number of "whole system" models. These consider care for the whole population, not just older people. The model systematically assesses and changes the local health system as a whole, rather than introducing new elements in silos. CfWI considered that implementing a new model of care that helps manage older people in individual patient states is not a long-term solution. It is suggested that a whole system approach can ensure the delivery of integrated care across the older people pathway, improving outcomes for this population.

A whole system approach focuses on integrating services across social care and health settings. The whole system approach was seen at a number of the CfWI case study sites, including Torbay Care Trust, Hampshire Community Health Care and NHS Norfolk. In these sites it is leading to, or is targeted to lead to, reductions in admission rates and hospital bed days for older people.

The case studies reviewed in the CfWI report were:

- **Torbay Care Trust**: Single provider organisation, complete integration between primary, community, secondary, and adult social care. This is a highly mature model. Evidence from Torbay is cited elsewhere in this report.

  In Torbay, each team is co-located and has a single manager, a single point of contact and uses a single assessment process. Health and social care co-ordinators liaise with users and families and with other team members to arrange care and support. Budgets are pooled and are used by team members to commission care. This includes investing in intermediate care services to help avoid hospital admissions and developing a team that reviews patients in hospital and works with hospital staff to discharge patients when there is pressure on beds.

- **Hampshire Community Health (HCHC)**: planned to move to a sustainable integrated health and social care system by 2014/15, integrated care partnership with primary care, social care and acute sector. The emphasis on older people. At the time of the review HCHC was not mature.

  HCHC is bringing existing community staff into Complex Care Teams aligned with primary care. Teams manage patients on the basis of risk, focussing on admission avoidance, promoting independence, facilitating discharge and managing patients with chronic conditions. HCHC hopes to deliver clinic-based models of care that will drive up standards, increase productivity and provide better opportunities to meet the holistic needs of patients

- **NHS Norfolk**: At the time of the CfWI review this was not a mature model. Norfolk has developed a vision of a whole system model across primary and community health and adult social care to prevent older people with complex conditions being admitted to hospital. The PCT and the County Council were one of the integrated care pilot studies in the RAND evaluation[63]. The whole system was planned to be fully implemented in 2013/14.

  Case Managers were given specific training in an orientation week covering general case management skills and tools, overview of offers by social services or other advocacy services, assessing for complex assistive technologies, mental health, risk stratification and specialist shadowing.

[63] National Evaluation of the Department of Health's Integrated Care Pilots, RAND Europe, Ernst & Young LLP, March 2012

Learning from Norfolk includes: workforce planning could have been completed earlier, including considering roles by competencies and whether they would be able to recruit for these or would need to train for them; lack of applicants to roles because the reward offer was not attractive could have been mitigated by closer workforce development and HR support from the start.

CfWI also reviewed evidence from other sites. A summary of the skills identified at the three sites and in CfWI's wider review associated with developing the whole system models are set out below:

- **Advanced skills:**
  - In HCHC, ensuring the right skills mix exists in the community.
  - In Norfolk, dementia training for all workers not only for those working in mental health.
  - Wider review: Upskilling the community workforce to allow care to shift from acute and nursing homes to the community and reduce admissions.
  - Wider review: GPs and community medical staff receive additional specialist training in geriatrics and working jointly with acute consultants to enhance clinical skills relevant to older people.
  - Wider review: Specialist skills for nurses such as advanced prescribing, intravenous therapies and practitioner skills to perform higher acuity interventions in the community setting.
  - Wider review: Improving clinical confidence to conduct better risk assessment and management across every element of the integrated and whole systems model.

- **Triage and Assessment:**
  - Wider review: Single joint-assessment across different disciplines to minimise duplication and reduce the need for multiple staff to visit the patient.
  - Wider review: Rapid diagnosis and treatment by one clinician of any discipline.
  - Wider review: Clinical and non-clinical assessment.

- **Case management skills:**
  - Norfolk, clinical training of case managers.
  - Wider review: Case management training across all disciplines.

- **Multidisciplinary:**
  - In Torbay, ensuring people are trained across all specialties.
  - In Torbay, some staff have been trained in health and social care to be able to provide service users with one person providing multiple services.
  - Wider review: Staff holistically manage disease and cases, rather than provide 'one-off' interventions, improving care for older people with multiple co-morbidities.
  - Wider review: Additional specialist nurses in geriatrics, dementia, COPD and falls form part of multi-disciplinary teams, usually working under primary or secondary care.
  - In Norfolk: improved awareness of the importance of early intervention among Personal Health Advisors

- **New roles:**
  - In Torbay, new roles included community care workers, health and social care coordinators across health and social care, support workers in intermediate care

Torbay also reported that getting people to work in a different way was challenging at first, especially because the organisational development was rapid. Equally, people felt that 'they were in a midst of a revolution' and that positively encouraged them.

The CFWI report also noted the need for a wider introduction of targeted prevention to shift the focus of workforce activity from treatment and rehabilitation, to prevention and stabilisation. Strong clinical leadership and change management will be required to realise this shift in behaviour.

CfWI concluded that while the "point" models may form part of a whole system, implementing each in silo would not deliver the full potential benefits. Instead, the system needed to be designed so that it provides care across the older people pathway, including all of the key enablers identified from the individual models of care.

4.4 IMPLEMENTING NEW MODELS OF CARE

CfWI considered high-level but practical information about what to consider in moving towards a more joined-up health and social care system and have done further work[64] to build on the high-level framework. CfWI have aggregated the findings into a framework of checklist questions which may be helpful to sites which are designing and implementing integrated care models for older people.

In their framework, CfWI raise questions about identifying the additional skills and training requirements for delivering new services which are also relevant to OAWIP. These are:

- Is formal training needed? How long will training take e.g. running time? What type of training is required e.g. clinical, management, etc.
- Who will provide the training and what approach will be used e.g. train the trainer approach?
- How often is training required and how much will it cost?
- What type of informal training is required and who will provide this?
- Is there an element of training that should be included as part of the formal curriculum e.g. adding new skills to the training curriculum for physiotherapists?
- Have you considered implementing informal interdisciplinary training to ensure that different staff members can perform simple interventions for each other?
- What type of background/previous skills does the workforce need to fulfil the requirements of the role(s) for your model?

These can be used by OAWIP to help to shape the strategic role of developing the Older Adult Workforce. This is considered in the section below.

A summary of the knowledge, skills, service and competency requirements identified in the report is at **Annex B**.

[64] For example, Think integration, think workforce: Three steps to workforce integration, CfWI, 2013

4.5 RECOMMENDATIONS

The programme should work with:

- Pioneers and pilot sites to test, confirm and validate the **skills and competencies** that are required in order to care for older people in integrated teams.
- Education and training providers and pioneers to further **develop detailed specifications for education and training** based on the findings of this review.
- Pioneers and providers and the independent sector to discuss **how modular and customised training can be delivered most effectively**.

SECTION 5 TEAM BUILDING AND WORKFORCE FLEXIBILITY

This section outlines the evidence around the development of effective multidisciplinary teams.

SUMMARY

- The main barrier to integration is the differences between and within different parts of the health system and with social care. Effective multidisciplinary teams work across all sectors and across professional boundaries, and generalists and specialists collaborate together. The main benefits of integrated care occur when barriers between services and clinicians are broken down. Co-locating teams and unified management structures can be helpful, but it is more important that team members align their goals and work together.

- The organisations, teams and individuals who provide integrated care 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 need to go hand in hand to ensure that the workforce support the redesign of new ways of delivering services. Knowledge of the local population and local services can be an important skill.

- The creation of new roles has supported the development of integrated services and joint working. New roles must be designed and recruited to with care, and with the support and buy-in of the wider team. The Staffordshire core principles were designed to support the development of new roles and have potential to be adapted for wider use.

5.1 CONTEXT

The key barrier to integration is the persistence of cultural differences between primary, community and secondary care, lack of mutual understanding and the dominance of performance measures that are thought to relate exclusively to one sector or another[65]. Across the sector, there needs to be closer collaboration between specialists and generalists, hospital and community, and mental and physical health workers. The NHS and social care sector need multi-skilled staff to work across these boundaries.[66]

High-quality integrated care depends on team working that makes use of the skills of a range of health and social care professionals. Team-working creates opportunities to vary skill-mix and use staff substitution, e.g. nurses and pharmacists taking on roles previously performed by doctors. There are also opportunities to establish new roles, such as the health and social care co-ordinators employed in Torbay's integrated teams.

[65] Integrated care in Northern Ireland, Scotland and Wales: Lessons for England, Kings Fund, Chris Ham, Deirdre Heenan, Marcus Longley, David R Steel, July 2013

[66] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013

The main benefits of integrated care occur when barriers between services and clinicians are broken down. [67]

MULTIDISCIPLINARY TEAM WORKING – A CASE STUDY: NOTTINGHAM CITYCARE PARTNERSHIP

In the Nottingham CityCare Partnership[68] qualified nurses, social workers, occupational therapists and physiotherapists are trained in each other's disciplines up to the level of a general assistant practitioner. In practice it means, eg, a nurse can undertake a full nursing assessment during a visit and, while there, sort out basic occupational therapy issues such as equipment to get in and out of bed or to cook safely in the kitchen. Similarly, a physiotherapist could teach an exercise programme and do a basic tissue viability assessment at the same time.

A pilot was established in 2009 to redesign an intermediate care team into a crisis response service. When the pilot started to receive referrals it became clear that each crisis was different and required a tailored response.

Staff became anxious about their individual ability to respond to the wide range of situations they experienced and the service struggled to provide the right clinician at the right time to meet the individual or family's presenting emergency. Eg, someone experiencing a healthcare crisis relating to nursing needs would have an initial assessment done by a different professional if the nurse in the team was already busy responding to another situation. Most people had multifaceted health and social care issues. Each single need at assessment tended to be at a lower level than originally expected – it was the combination of needs and the resultant dynamics in the home that created the crisis. The team decided to establish to give each individual a basic grounding across the professions of their colleagues.

The national assistant practitioner competency framework[69] offered a set of core skills. The whole team took part in each identifying skills that they would teach to their colleagues. The next step was to develop a training framework, which included occupational therapy, physiotherapy, nursing and social work. Core elements from each profession's national competency framework up to a band 4 level were included. Team members delivered the training, and trainees were assessed for theoretical understanding and practical safety. Finally, each professional assessed their colleagues' competence to practice core skills within his or her own discipline.

At first there were concerns around professional identity and about becoming too "generic". These have given way to a hugely positive impact on the team, especially in the responsiveness of care. Individual confidence levels have improved. A deeper understanding of each other's profession and contribution has led to greater valuing of skills. The main intention of the project was quality of outcomes but part of the end result was the release of resources. More can be done in a single visit and less time is taken in referring between disciplines.

CityCare is exploring the development of this model in consultation with the Nottingham City Council as part of its integrated care programme. Team members have reported greater job satisfaction, as they now feel more prepared to take on daily challenges and to do more for each person they work with.

5.2 TEAM BUILDING

Teams need to work in ways that will support collaborative behaviours between staff with different backgrounds and who will sometimes work for different organisations. Team-building and regular

[67] Making integrated care happen at scale and pace, Kings Fund, Chris Ham, Nicola Walsh, March 2013
[68] http://www.hsj.co.uk/home/commissioning/a-multitalented-approach-to-delivering-community-care/5067234.article#.U0fETSxOXIX
[69] http://www.skillsforhealth.org.uk/about-us/competences%10national-occupational-standards/completed-competences/

meetings have been used to create common purpose, allocate and discuss cases and provide an opportunity to share information to support the functioning of the team.

In ***Co-ordinated care for people with complex chronic conditions***[70] all five programmes placed considerable emphasis on team-building and networking within the core multidisciplinary teams providing care. It was reported that building a supportive team culture required continual nurturing over time to reinforce the shared vision and personal commitments needed to enable the programmes to succeed.

In each programme a common characteristic was the personal commitment of staff – both managers and professionals – to go that 'extra mile' by working beyond the boundaries of their job description in order to achieve the best results for their patients, and in supporting colleagues to do the same. We found a range of explicit strategies that promoted a strong ethos among staff to 'do the right thing' – for example: promoting the needs of patients before their own needs; supporting knowledge-sharing; and enabling role substitution through staff empowerment.

The nature and frequency of meetings depends on the nature of the service and the model being used. In Midhurst meetings are daily and are actively used to manage the care of service users with severe and complex needs and to coordinate care with wider services from GP and community services[71]. Other services use weekly meetings. Regular team meetings were also seen as a means to foster understanding about different professional roles, overcome professional differences and build trust and rapport between different groups. [72]

The study, ***Ten principles of good interdisciplinary teamwork***[73], identified the characteristics of a good interdisciplinary team.

CHARACTERISTICS OF A GOOD INTERDISCIPLINARY TEAM

1. Leadership and management: Having a clear leader of the team, with clear direction and management; democratic; shared power; support/ supervision; personal development aligned with line management; leader who acts and listens.

2. Communication: Individuals with communication skills; ensuring that there are appropriate systems to promote communication within the team.

3. Personal rewards, training and development: Learning; training and development; training and career development opportunities; incorporates individual rewards and opportunity, morale and motivation.

4. Appropriate resources and procedures: Structures (for example, team meetings, organizational factors, team members working from the same location). Ensuring that appropriate procedures are in place to uphold the vision of the service (for example, communication systems, appropriate referral criteria and so on).

5. Appropriate skill mix: Sufficient/appropriate skills, competencies, practitioner mix, balance of personalities; ability to make the most of other team members' backgrounds; having a full complement of staff, timely

[70] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner, 2013
[71] Discussion with Jo Stuttaford, 24 February 2014
[72] Factors that promote and hinder joint and integrated working between health and social care services, SCIE, Ailsa Cameron, Rachel Lart, Lisa Bostock and Caroline Coomber, May 2012
[73] Ten principles of good interdisciplinary team work, Susan A Nancarrow, Andrew Booth, Steven Ariss, Tony Smith, Pam Enderby and Alison Roots. Human Resources for Health 2013, 11:19

replacement/cover for empty or absent posts.

6. Climate: Team culture of trust, valuing contributions, nurturing consensus; need to create an interprofessional atmosphere.

7. Individual characteristics: Knowledge, experience, initiative, knowing strengths and weaknesses, listening skills, reflexive practice; desire to work on the same goals.

8. Clarity of vision: Having a clear set of values that drive the direction of the service and the care provided. Portraying a uniform and consistent external image.

9. Quality and outcomes of care: Patient-centred focus, outcomes and satisfaction, encouraging feedback, capturing and recording evidence of the effectiveness of care and using that as part of a feedback cycle to improve care.

10. Respecting and understanding roles: Sharing power, joint working, and autonomy.

5.3 WORKFORCE FLEXIBILITY

A study by Sheffield University, ***The relationship between workforce flexibility and the costs and outcomes of older peoples' services*** [74], looked at the workforce needs of community based services for older people (in the statutory sector). It found:

Patient outcomes were positively and significantly associated with five key staffing variables:

- Having care delivered by a higher proportion of support workers.
- Being treated by staff from a team which has fewer senior staff.
- Being treated by fewer different types of practitioners during the episode of care.
- Being treated by staff who belong to a larger team.
- Increasing total amount of face to face contact time with the patient.

Staff outcomes:

- Better staff outcomes (satisfaction and intention to leave employer and / or profession) were associated with smaller team size; higher levels of staff integration with peers and colleagues; better team working; better management structures and styles; having a specific line manager; a perception that the team delivered high quality care; and at least weekly team meetings.
- Staff who are more autonomous are less likely to leave their profession.

Staff working in integrated teams reported less role conflict and fewer contradictory demands than those working in other types of team. They also considered integrated teams to be more innovative and supportive of new ideas.[75]

Inter-professional working/ merging professional boundaries

To achieve a better alignment between the workforce and the work, workforce and service redesign need to go hand in hand.[76]

[74] The relationship between workforce flexibility and the costs and outcomes of older peoples' services, University of Sheffield: Professor Susan Nancarrow, Professor James Buchan, Professor Simon Dixon, Professor Pamela Enderby, Ms Anna Johns, Dr Caroline Mitchell (University of Sheffield), Professor Stuart Parker, April 2010

[75] Factors that promote and hinder joint and integrated working between health and social care services, SCIE, Ailsa Cameron, Rachel Lart, Lisa Bostock and Caroline Coomber, May 2012

The Kings Fund report, ***Providing integrated care for older people with complex needs: Lessons from seven international case studies*** [77] summarised, among other things, the lessons for the adoption of integrated care at professional level as follows:

- Professionals need to work together in multidisciplinary teams or provider networks – generalists and specialists, in health and social care.
- Within teams, professionals need to have well-defined roles, and to work in partnership with colleagues in a shared care approach.

In Scotland professional tensions have been compounded by public perceptions of the differing roles of health and social work professionals. Effective joint working is also seen to challenge conventional hierarchies and reporting lines; and there are difficult issues to be overcome in harmonising terms and conditions of employment, including the 'wicked issue' of equal pay. [78]

In Northern Ireland a 'parity of esteem' model afforded to each profession gives everyone involved the opportunity to take the lead in management. Individual professional competencies are maintained and enhanced, and all staff have a right to professional supervision. This management structure enables and encourages health care professionals to move across to management roles, and a clear benefit of the integrated structure is that it widens the pool of potential managerial talent. [79]

Role overlap

Sheffield University's report, ***Dynamic role boundaries in intermediate care services***[80] observed two types of role overlap. 'Qualified staff' (nurses, physiotherapists and occupational therapists) identified areas of overlap across the roles of other disciplines. This is described as horizontal substitution, where a discipline moves outside of its traditional boundaries to adopt tasks that are normally performed by other health service providers, or inter-disciplinary change. Vertical substitution was seen through the delegation of traditional nursing and therapy tasks to support workers. Also most qualified staff had adopted some management roles which could be seen as a form of vertical substitution from managers to non-managers.

Therapists had the greatest areas of overlap whereas nursing roles were seen as being more discrete. The social worker did not report role overlap to the same extent as the nurses or therapists. The ability to discuss issues with clinicians from other disciplines provided staff with a range of perspectives on care. Occasionally nurses and therapists reported that they had conflicting priorities in determining the goals of the patient.[81] Therapists acknowledged that their knowledge of medication had increased by working closely with the nurses, which they felt was useful from a safety perspective.[82]

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[76] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013
[77] Providing integrated care for older people with complex needs: Lessons from seven international case studies, Kings Fund - Nick Goodwin, Anna Dixon, Geoff Anderson, Walter Wodchis, January 2014
[78] Integrated care in Northern Ireland, Scotland and Wales: Lessons for England, Kings Fund, Chris Ham, Deirdre Heenan, Marcus Longley, David R Steel, July 2013
[79] Integrated care in Northern Ireland, Scotland and Wales: Lessons for England, Kings Fund, Chris Ham, Deirdre Heenan, Marcus Longley, David R Steel, July 2013
[80] Dynamic role boundaries in intermediate care services, Sheffield University Susan Nancarrow, 2004
[81] Dynamic role boundaries in intermediate care services, Sheffield University Susan Nancarrow, 2004
[82] Dynamic role boundaries in intermediate care services, Sheffield University Susan Nancarrow, 2004

5.4 ADDITIONAL ROLES SUPPORTING INTEGRATED CARE

The development of integrated care has also led to new roles being developed.

Support Assistant Roles

There are a number of case studies about how support assistant roles have been developed in a number of environments to support the care of older people or other vulnerable people in various environments.

St Monica Trust[83] is a charity, providing care, residential and nursing care and supported housing to older people, with a range of needs. The Trust created a new senior nurse care assistant (SNCA) role that incorporated a range of basic, clinical skills in addition to the core care and support skills. Staff were given initial training at a local hospital, to develop their underpinning knowledge and were then assessed at NVQ level 3 in their workplaces. Trained workers provide basic clinical assistance under the supervision of the on duty registered nurse. The nurse delegates responsibility where the SNCA has been assessed as competent in the relevant area. SNCAs carry out a range of tasks including: administering medication, wound, tracheotomy, catheter, ileostomy and colostomy care, enteral feeding, diabetes monitoring, booking in and disposing of drugs. The impact of the role is:

- The role has increased the levels of clinical care provided and increased personalisation, with fewer handovers.
- There is a reduction in the number of residents being admitted to hospital and some residents have been discharged from hospital more speedily.
- Fewer GP callouts have been required to the homes.

Assistive Technology Practitioner (ATP) [84]

Norfolk council created a new assistive technology practitioner (ATP) role. The ATP role is an expert practitioner, who can combine technical understanding of equipment with the ability to work with vulnerable people in a person centred way. The role is integrated within the Council's services. AT is available to all adults and is mostly used by people over 65 who are physically frail or have dementia. In Norfolk this group makes up 20% of the population (against a national average of 16%). AT is used in the community to support people, either in their own homes or living in 'Extra Housing' complexes to improve their quality of life, maximise and maintain independence and to help carers. Practitioners, such as social workers, make a referral to the AT service where they think it will be beneficial. An ATP then visits, makes an assessment and recommendations. The benefits identified are:

- Care is delivered closer to home, individuals have more involvement in their own care, and are more empowered in managing their own life.
- Carers can be more easily involved when they live at a distance and are supported in their role.
- The number of GP visits is reduced, unplanned acute hospital admissions and acute outpatient admissions are reduced.
- Admissions to residential care are either delayed or reduced.

[83] New job role delivers seamless service St Monica Trust, S4H/ S4C, http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/Workforce-integration/16SeamlessService(v2).pdf

[84] Using assistive technology to improve lives - Norfolk County Council, S4H/ S4C , http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/Workforce-integration/24UsingAssistiveTechnology.pdf

Developing new roles

A lesson from the many workforce modernisation initiatives of the 2000s was that roles developed in isolation are difficult to sustain. Not only are these roles too reliant on individual goodwill that can then disappear when an individual leaves their post, the lack of a nationally recognised competence framework limits the capacity for individuals to deploy their skills elsewhere and build their careers. It is also important that the freedoms created by national bodies, such as the opportunities for nurses to prescribe or order x-rays, are exploited[85].

A study[86] of the contribution and potential impacts of assistants (at Agenda for Change bands 2, 3 and 4) in delivering care to adult patients by community nursing services found:

- Assistants promote flexibility in the community nursing workforce so as to respond to changing demands on these services.
- Lack of consensus in defining the roles of community nursing assistants has created inconsistency in how these roles are deployed and are developing nationally.
- Ad hoc development of the assistant roles has created variations in numbers of assistants, the roles that they play and preparation for practice.
- Assistants are core members of the community nursing team but there is a lack of clear structure for career development and progression.
- Community nursing teams value the maturity and life experience of assistants.
- Line management of assistants in community nursing teams is identified as creating challenges when trying to balance the management of risk while promoting innovation.

The lessons from the work to develop an Integrated Support Worker in ***Staffordshire*** are also relevant[87]. The development of the Framework arose from the recognition that new support roles could not be implemented unless the necessary organisational development was carried out to support it. A national survey was carried out on the back of Modernisation Agency work about integrated roles. The survey showed that new integrated support worker roles consistently reverted back to HCA roles. This was often because either roles weren't developed by the current team of healthcare professionals (who then didn't understand the need and use for these staff) or because roles in support of traditional nursing roles were given priority by non-multidisciplinary staff. The conclusion was that historically attempts to introduce a new integrated role had not worked. The key point was that in order to create new integrated roles there had to be a team behind them and that the team had to want the role, create the role and to do the training.

Similarly, at Midhurst[88], the key learning was the need to take on staff gradually, ensuring that the roles being recruited to were well understood and that the right people were recruited.

A review of the changes following the NHS reforms in 2000[89] found that redesigning the health care workforce was not a quick fix to control costs or improve the quality of care. Changes in skill mix and role definitions should be preceded by a detailed analysis and redesign of the work performed by health care professionals. New roles and responsibilities must be clearly defined in advance, and teamwork models that include factors common in successful redesigns such as leadership, shared

[85] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013
[86] Spilsbury K, Pender S, Bloor K, Borthwick R, Atkin K, McCaughan D, et al. Support matters: a mixed methods scoping study on the use of assistant staff in the delivery of community nursing services in England. Health Serv Deliv Res 2013;1(3).
[87] Discussion with Fiona Shield, 16 January 2014, see also *A Framework of shared core principles and functions to support a competent and capable workforce: The Staffordshire Model*
[88] Discussion with Jo Stuttaford, 24 February 2014
[89] Lessons From England's Health Care Workforce Redesign: No Quick Fixes, Richard M.J. Bohmer, and Candace Imison

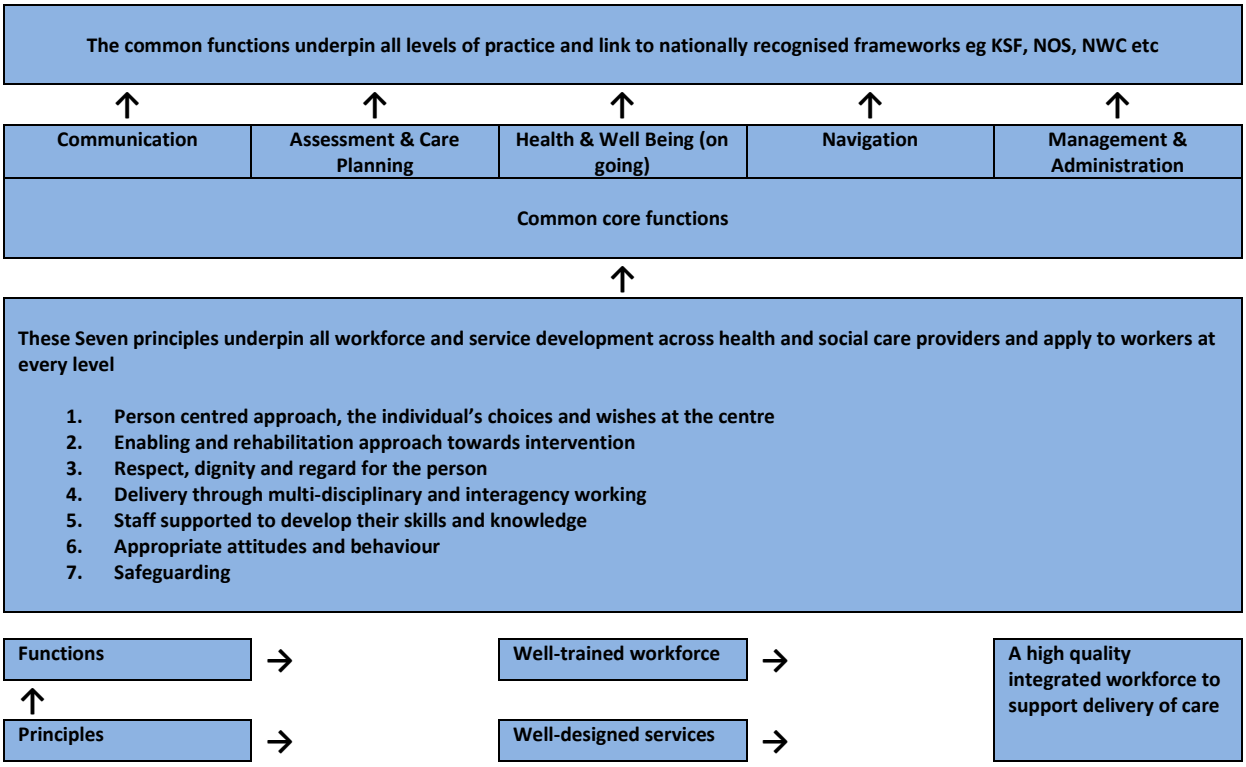
objectives and training should be promoted. The focus should be on retraining current staff instead of hiring new workers. Finally, workforce redesign must overcome opposition from professional bodies, individual practitioners, and regulators. Experience suggests that progress is possible if workforce redesigns are planned carefully and implemented with skill.

5.5 THE STAFFORDSHIRE CORE PRINCIPLES

The Staffordshire Core Principles[90] ***(Annex C)*** are a locally developed framework of core principles and functions to support design and delivery of services for care closer to home. They were developed in 2009/10 in consultation with staff from local health and social care providers across Staffordshire and built on the findings and learnings of national groups. The development process also took account of the need to agree a language that was meaningful and acceptable to health and social care organisations and to the people who use services. The principles have not yet been used in practice as wider organisational changes took place shortly after publication.

The framework was developed to support the development of new roles and necessary organisational development. It identified seven principles, which underpin a set of essential functions which are required from an integrated workforce.

THE SHARED CORE PRINCIPLES AND FUNCTIONS (OVERVIEW)



The principles and core functions are supported by detailed explanations of each.

[90] A framework of shared core principles and functions to support a competent and capable integrated workforce, Fiona Shield, Mandy Mellor

The shared principles and functions can be used as a conceptual framework for developing the workforce around service models. The core principles are intended to support the ongoing development of an integrated workforce.

RECOMMENDATIONS

The programme should work with:

- **Mental health organisations** to consider how best to ensure that mental health expertise can be harnessed in integrated care approaches for older people.
- Pioneers and pilot projects 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**.
- Pilot projects to **test the Staffordshire core principles** in practice as a tool for supporting MDTs.

SECTION 6 THE WIDER WORKFORCE

This section outlines the issues around developing the wider workforce to support older people's care.

SUMMARY

- The changing shape of the population affects not only the number of people who require care but also the pool of carers who will be 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 should be considered alongside those of care users.

6.1 CONTEXT

The number of older people is increasing and an increasing number of older people are providing unpaid care. The changing shape of the population will affect not only the number of people who may need care in the future, but also how they will be cared for and the pool of people that will be able to care for them.

There is a need to invest in the current workforce so that staff have the skills to move into different service settings as future user services require.

6.2 THE SOCIAL CARE SUPPORT WORKFORCE[91]

The biggest growth in need is likely to be in hands-on, out-of-hospital, and social care. The social care support workforce plays an essential role in supporting the vulnerable and reducing the strain on the NHS.

A relatively small proportion of the population live in care homes (less than 4%), however, residents have increasingly severe care needs. The skill requirements for staff in care homes are also likely to be skills that will be needed in the community.

The qualities and knowledge needed by care-home[92] staff includes knowledge of the ageing

[91] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013
[92] MY HOME LIFE: PROMOTING QUALITY OF LIFE IN CARE HOMES - A review of the literature Prepared for Help the Aged by The National Care Homes Research and Development Forum, 2007

process, good communication skills, an ability to promote independence and autonomy in activities of daily living, identifying and meeting nutritional needs, managing incontinence and constipation, maintaining skin integrity, medicines management, managing mental health issues including dementia and depression and encouraging participation and involvement of older people and their families.

Training is variable. Social care employers have developed their own in-house courses and retrained new staff irrespective of the training they have had elsewhere.[93]

Cavendish noted[94] that in care homes, the average resident is now 85 years old and often very frail. The definitions of "residential" and "nursing" care are becoming blurred: residential care homes are no longer hotels with access to nursing support, but places with more and more very frail residents, many with dementia. People who would have been in hospital or a nursing home 10 years ago are increasingly coming into residential homes.

> *"It used to be clearly specified what could be delivered in a care home, that was changed because it had meant forcing people to move to a different setting when very ill. But the result is that we are now seeing PEG feeding in domiciliary care, and catheterisation in care homes."* (Sheila Scott, National Care Association)

The Study, ***Residential Care Home Workforce Development: The rhetoric and reality of meeting older residents' future care needs, Joseph Rowntree Foundation***, suggested that there was scope to consider more fully how training care home staff can enhance social care and the health of older people in UK residential homes[95].

The study suggests that the development of 'new role' carers could help to make a reality of choice, control and quality of life for older people. There is potential to enable those in residential care homes to remain there much longer, and perhaps to end their lives there, rather than having to move unnecessarily into a nursing home or hospital.

A literature review for Help the Aged, ***My Home Life: Promoting Quality of Life in Care Homes*** [96], concluded:

- The changing nature of the workforce in care homes needs to be scrutinised in order to ensure quality of life and care for residents.
- Care assistants comprise the major workforce in care homes but little is known about the education and training they receive. There is some evidence that training enhances competence, self-confidence, job satisfaction, morale and teamwork.
- There is a strong body of evidence to support the strengthening of management and leadership skills in nursing homes.
- Care homes are increasingly being used for student nurse placements but creating an enriched environment requires sufficient resources, solid leadership, continuity of staff, self-awareness and a passion for gerontological nursing to engender excitement and enthusiasm.

[93] The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings, Camilla Cavendish, July 2013

[94] P24, The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings, Camilla Cavendish, July 2013

[95] Residential Care Home Workforce Development: The rhetoric and reality of meeting older residents' future care needs, Joseph Rowntree Foundation, Deidre Wild, Ala Szczepura and Sara Nelson, May 2010

[96] MY HOME LIFE: PROMOTING QUALITY OF LIFE IN CARE HOMES - A review of the literature, Prepared for Help the Aged by The National Care Homes Research and Development Forum, 2007

- Relationship-centred care is important, both as a therapeutic intervention in delivering quality of life for frail older people and as a framework for evaluating the learning environment and help staff to gain motivation and satisfaction.
- Education and training need to be relationship centred and concerned with developing the whole of the care-home workforce on site, as part of overall quality improvement initiatives, rather than external bite-sized educational inputs for personal and professional enhancement only.
- Registered and nonregistered workers need to learn together as a learning force for change, rather than a means of qualification.
- The importance of learning for residents must also be considered. Central to the process is the need for residents, relatives and staff to share their experiences of quality of life in care homes when living and working together.
- The potential of care homes to provide good learning environments for staff and students must be recognised and, in order to develop the necessary knowledge and skills among staff, there needs to be closer working links between local communities, institutes for higher education and the care-home sector.

If care homes are to be used as placements for pre-registration nursing programmes[97], enabling students of nursing to develop knowledge and skills in the continuing care of older people, there needs to be closer working between institutes for higher education and the care home sector.

6.2 THE WIDER WORKFORCE

The unqualified workforce

There is an urgent need to develop and invest in the unqualified workforce, such as health care assistants in hospitals, and care workers in the community. Given the growing shortage of informal carers we also need to consider new ways to attract and support volunteers in health and care[98].

There are no national funding streams for training the unqualified workforce, such as health care assistants, who have no real professional pathway. There is a separate work stream to take forward investment in this staff group by making the work more attractive, giving career development opportunities, developing a grade structure for people to aspire to, and encouraging a team approach to high-quality care.

Third sector

A report commissioned by the National Care Forum[99] argues that an ongoing commitment to supporting staff is a fundamental characteristic of the not-for-profit sector, and that this helps ensure that the sector remains at the leading edge of innovative workforce policy and good practice, particularly at a time of great change and financial pressures.

The not-for-profit sector workforce has had significant growth in the workforce in the previous decade, and at a higher rate than the public and private sectors. There are other changes too:

- Increased professionalisation of the sector: 33% had a degree or equivalent qualification. Between 1996 and 2005 this had increased by 43%.

[97] MY HOME LIFE: PROMOTING QUALITY OF LIFE IN CARE HOMES - A review of the literature Prepared for Help the Aged by The National Care Homes Research and Development Forum, 2007
[98] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013
[99] Leading the Way: The Distinctive Contribution of the Not-for-Profit Sector in Social Care, The Institute of Public Care, Oxford Brookes University (IPC), commissioned by the National Care Forum (NCF), July 2012

- A more female workforce: Over 69% of the workforce was female, similar to the public sector (64%) but much higher than the private sector (40%).
- A higher proportion of part-time workers: Part-time employees accounted for 39% of voluntary and community sector employment - higher than in the public and private sectors (29% and 23% respectively).
- A higher proportion of disabled staff: Nearly one in five people (18%) working in the sector had a disability, higher than the public (14%) and private sectors (13%).

The "Not For Profit" governance is also believed to create a culture in the sector which encourages organisations to: uphold strong developmental values in their recruitment and retention of staff; use their flexibility to offer employment conditions designed to enhance the quality of care; and see employment practice as part of a long-term investment in care practice and service quality.

Examples of Third Sector operations include:

The Orders of St John Care Trust[100] (OSJCT) operates 73 care homes in Oxfordshire, Wiltshire, Gloucestershire and Lincolnshire. It delivers care to elderly people in Nursing Home, Residential and Extra Care settings and employs 3,700 staff. OSJCT believes strongly in a direct link between training investment, service quality and good staff retention. Accordingly it maintains a high commitment to staff training and development, with 4 Regional Training Managers, a Head of Qualifications and a QCF Centre with Assessors from within the organisation. OSJCT regard formal qualifications as crucial to quality as well as staff recognition and confidence. It believes that many of its staff will continue to offer high quality service over many years if they are able to progress their careers with them, rather than having to move to seek advancement. It is very committed to the development of a supported career path for staff with leadership and management potential.

The St Monica Trust[101] provides a wide range of services for older people in the south west of England. In 2011 it supported 1,206 older people in its care homes and sheltered housing, as well as aiding 1,000 people with gifts or grants through its charitable funding. The Trust takes induction of new staff very seriously with a 15 day programme which includes all statutory skills but also the policies and values of the agency. New staff both shadow and are shadowed in their early stages, and the new worker can expect a good deal of support and feedback. The overall St Monica Trust approach reflects a commitment to the idea of 'relational care'. This embraces the entire relationship between caregiver and care recipient, including the physical, social, emotional and spiritual dimensions of human connection. This approach is reflected in the Trust's person centred approach to staff support and development, and the belief that whatever the individual's role is they need to be 'inspired' as well as having the right skills. Crucial elements of ongoing support include regular good quality supervision, feedback on an ongoing basis, effective appraisals and a mixed approach to training, which makes use of a small central training team but also involves all managers and supervisors in contributing to the training programme.

Voluntary sector

The ability to support people to live at home, or to ensure that an effective 'early warning' system is in place before they fall into crisis, requires 24/7 support that cannot be provided by the limited resources available to health and social care teams. This seems especially important for highly vulnerable patients nearing the end of life.

[100] Leading the Way: The Distinctive Contribution of the Not-for-Profit Sector in Social Care, The Institute of Public Care, Oxford Brookes University (IPC), commissioned by the National Care Forum (NCF) 01 July 2012

[101] New job role delivers seamless service St Monica Trust: A new job role, devised by St Monica Trust, successfully blends nursing with care assistant duties and effectively uses resources. Skills for Health and Skills for Care

Experiences from the Midhurst Macmillan Service and Oxleas Advanced Dementia Service show the central importance of family members and volunteers in fulfilling such roles. Both programmes have invested in building the resilience of carers to support patients at home and in engaging with the wider community to provide a range of essential 'low-level' support services that help people remain independent and at home for longer.[102]

Despite the pressures, charities, hospices and other social care organisations are pioneering innovative approaches to person-centred care. The NHS can learn from their approaches to responding to individual needs and recruiting people with the right values.[103]

The Midhurst Macmillan Service[104] has around 70 volunteers who take on a host of roles, from practical tasks, e.g., helping with the shopping or gardening, to complementary treatments, such as Reiki or aromatherapy. Volunteers are matched to the needs of the patients rather than providing a fixed set of services. Some volunteers have been trained in bereavement counselling and visit the family and/or carers after a patient has died. Others with legal expertise support patients and families with wills and related matters, and Macmillan Cancer Support provides access to a financial adviser from Citizens Advice Bureau, a charitable advice service. The volunteers within the Midhurst service fulfil the holistic component of this care co-ordination model, supporting patients and carers with everyday tasks to enable them to live well, and contributing to the skill mix of the core team.

In the South Devon and Torbay Virtual Ward[105], voluntary sector representatives attend virtual ward meetings and take forward referrals, liaising with a variety of organisations such as the Royal British Legion, Age UK and Devon Carers who can offer patients/carers access to targeted one-to-one support, befriending, community transport, day care services, bereavement support and assistance to access financial/housing benefit checks. Each quarter, their activity is reviewed as part of the zone team report. Across Devon, voluntary sector representatives have begun developing information-sharing mechanisms and a list of the most common support services used for patients on the virtual wards.

In the Community Resource Teams in Pembrokeshire[106], the Hywel Dda Health Board funds two part-time volunteer organisers who each attend two CRT meetings. Their role is to match patients to volunteer services available in the region to help them to stay in their home. They are employed by the Pembrokeshire Association of Voluntary Services, an independent association of voluntary and community associations. There is a broad range of services on offer, from organisations arranging social outings for older people to befrienders and day-sitters who offer respite care. Specialist charities, such as the Alzheimer's Society, provide information and peer support. There are some service-level agreements between the voluntary organisations, local authorities and the Hywel Dda Health Board. A current review of these agreements seeks to secure targeted and appropriate funding levels for the future.

[102] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner, Oct 2013
[103] The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings, Camilla Cavendish, July 2013
[104] Midhurst Macmillan Community Specialist Palliative Care Service - Delivering end-of-life care in the community, Kings Fund, Veronika Thiel, Lara Sonola, Nick Goodwin, Dennis L Kodner, October 2013
[105] South Devon and Torbay: Proactive case management using the community virtual ward and the Devon Predictive Model, Kings Fund, Veronika Thiel, Lara Sonola, Nick Goodwin, Dennis L Kodner, October 2013
[106] Developing community resource teams in Pembrokeshire, Wales - Integration of health and social care in progress, Kings Fund, Veronika Thiel, Lara Sonola, Nick Goodwin, Dennis L Kodner, October 2013

Team members describe the involvement of the voluntary sector as a key feature of the service as it provides the low-level support that is frequently needed to enable people to stay at home. While there is no quantitative evidence of its impact, this perception is in line with other integrated care projects involving the third sector.

6.3 THE INFORMAL WORKFORCE[107]

The extended informal workforce includes patients, carers and volunteers. In England, around three million people volunteer in health and social care (Naylor et al 2013), and there are more than 5.5 million informal carers (Carers UK 2012). This is almost three times the number of formal health and social care workers. With an increasing number of fit retirees there is an opportunity to foster a 'social movement' to support those in need. Organisations could and should take a much more strategic approach to the support and development of volunteers.

Caring is linked to[108] declining physical and mental health of carers, damage to their social relationships and isolation. The two million carers providing over 20 hours of care per week also risk impoverishment in midlife, finding they cannot juggle paid employment with caring and must reduce working hours or (for one in five carers) give up their job. Low income and financial worries exacerbate the stress of caring and many carers have to ignore their own health problems due to difficulty in finding or paying for substitute care. Despite carers' rights to an assessment of their own needs, not all received this in 2006/07 and of those who did only half received any service.

In the Kings Fund study, *Providing integrated care for older people with complex needs: Lessons from seven international case studies,* all seven approaches[109] sought to promote engaging service users and informal carers or family members.

6.4 SUPPORT AND TRAINING

Many of tomorrow's workforce are here today. Much greater priority needs to be given to developing the skills and competences of the current workforce, and the quality of team working, to better meet the needs of patients today and tomorrow.[110]

The Cavendish review observed (page 51) 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

[107] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013
[108] Taken from Assisted Living Platform - The Long Term Care Revolution, Anthea Tinker, Leonie Kellaher, Jay Ginn and Eloi Ribe at the Institute of Gerontology, Department of Social Science, Health and Medicine, King's College London for the Technology Strategy Board, Reproduced by the Housing Learning and Improvement Network, September13
[109] Providing integrated care for older people with complex needs: Lessons from seven international case studies, Kings Fund - Nick Goodwin, Anna Dixon, Geoff Anderson, Walter Wodchis, January 2014
[110] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013

jointly with registered nurses, in the same language? Nurses already learn basic life support/ resuscitation, infection control, moving and handling, and other elements of fundamental care. There is no reason why that learning should be acquired by nurses and HCAs in different places, using different curriculums. Training people in different places, to varying standards, is inefficient. It is also a safety risk. This is something that the aviation industry figured out long ago."

Guy's and St Thomas' NHS Foundation Trust[111] has run a substantial programme of joint training. At the heart of Guy's programme was a determination to build respect among members of the clinical team, and clarify roles and responsibilities. The example of Guy's makes clear that every Trust should be ambitious about building strong teams encompassing junior doctors, consultants, allied health professionals, nurses and support staff. All should be coming together regularly as a team; and reacting to problems as a team. At University Hospitals Birmingham (UHB) NHS Foundation Trust, the CEO calls in the entire ward team to explain itself if something goes wrong. This is a model that could be spread more widely.

Previous investments in the workforce have been heavily weighted to individual professional groups, in particular medical and nursing staff[112]. However, clinical staff work within multidisciplinary teams and the quality of teamwork is a major contributor to the quality of patient care. Developing team working may be more important than developing the roles of one professional group. Medical training also needs to move away from the traditional individual perspective and prepare students for multidisciplinary team working. Strong teams can also reduce dependence on any single professional group and so work can be shared. The Hospital at Night initiative is a good example of this: out-of-hours hospital cover is provided by a centralised multidisciplinary team, with the full range of skills and competencies to meet the immediate medical needs of patients. The central tenets include multi-specialty handovers; extended nursing roles (including prescribing); and bleep filtering through central co-ordination. In primary care, the extended team of GPs working with primary care nurse practitioners and health care assistants is another example.

The study, ***The nursing contribution to chronic disease management: a whole systems approach***, found different levels of training and support for the nurse case managers across the three sites. Nurses had varied levels of access to mentors and clinical supervisors. For many these contacts were intermittent and unstructured although the nurse case managers also talked about drawing support from colleagues and having contact with their immediate manager. The care home case manager had no access to mentorship or clinical supervision.

The greatest amount of training and education was reported by community matrons, who had all either just completed study modules in assessment and chronic disease management or were doing this alongside their daily work. They observed that this latter arrangement could negatively affect continuity of care for their patients and professional development activities could be stressful when course deadlines coincided with busy times at work.

By contrast, district nurses acting as case managers, relied on informal learning from other nurses. This group received little extra professional updating and skills development in the areas of assessment skills, symptom management, and coordination of care. The extent to which informal learning can be used to support development should be further explored.

[111] See Case study pp 67 – 68 Cavendish report

[112] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 13

At Midhurst[113] continuous improvement and learning are viewed as a core activity and this is reinforced through monthly team education sessions, which external care providers are invited to attend. The team attend a weekly multidisciplinary meeting to review the caseload and managerial /administrative issues are discussed once a month to update staff on policy issues and new guidance. The sessions are directed by one of the consultants with a special interest in education and training. Sessions include topical sessions and external speakers. An important lesson for Midhurst was the need to take time in designing new roles to ensure that they fulfilled the function required.

6.5 RECOMMENDATIONS

The programme should work with:

- Pioneers and education and training providers to test out the Cavendish recommendations about **training as one workforce**.
- Patients, service user/ carer representatives and voluntary organisations, through pilots projects and pioneers, to **identify the potential contribution of the third sector, the voluntary sector and volunteers, carers and the independent sector** workforce in supporting older people's integrated care.

[113] Midhurst Macmillan Community Specialist Palliative Care Service: Delivering end-of-life care in the community, Kings Fund - Veronika Thiel, Lara Sonola, Nick Goodwin, Dennis L Kodner, October 2013

SECTION 7 ORGANISATIONAL DEVELOPMENT AND CULTURE

This section provides and outline of factors which are relevant to organisational development, such as partnership working, the use of ICT and public and patient engagement.

SUMMARY

- The main benefits of integrated care occur when barriers between services and clinicians are broken down, not when organisations are merged.
- The use of ICT is a potentially important enabler, but it is not a necessary precondition for integrating services. It is important to get processes right before making an investment in ICT, and technical changes need to be supported by culture changes. 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 of value, including what they value about the workforce.

7.1 CONTEXT

In developing integrating activities there is no one approach that suits all occasions. Local circumstances and path dependencies will be crucial in shaping the pace and direction of change. Integration is not a matter of following pre-given steps or a particular model of delivery, but often involves finding multiple creative ways of reorganising work in new organisational settings to reduce waste and duplication, deliver more preventive care, target resources more effectively or improve the quality of care[114].

7.2 ORGANISATIONAL PARTNERSHIP ARRANGEMENTS

Structural changes in their own right are not sufficient to create an integrated approach to service delivery. The main benefits of integrated care occur when barriers between services and clinicians are broken down, not when organisations are merged[115]. Thistlethwaite[116] highlighted the importance of investing in a professional approach to organisational development/change management over an appropriate period of time when considering the success of Torbay Care Trust, and noted that "*cultural, political and organisational differences and financial and other risks do not have to be deal breakers – they can be overcome*."

[114] National Evaluation of the Department of Health's Integrated Care Pilots, RAND Europe, Ernst & Young LLP, March 2012
[115] Making integrated care happen at scale and pace, Kings Fund, Chris Ham, Nicola Walsh, March 2013
[116] Thistlethwaite, P (2011) Integrating health and social care in Torbay: improving care for Mrs Smith. Kings Fund

A study of care trusts[117] noted the response to separate management structures between health and social care "whilst this provided social care with a clear 'place' in the organisation, it was also a barrier to staff perceiving that health and social care practitioners were now integrated. This led to the organisational equivalent of multi-disciplinary staff being 'co-located' but not working closer together."

Integration as such – for example, through the establishment of a combined health and social care mental health trust – was reported to improve joint working[118]. In Torbay[119], Torbay Council and Torbay PCT established Torbay Care Trust (Torbay Council and Torbay Care Trust 2005), which is a fully integrated NHS organisation responsible for commissioning and providing community health and social care services.

A theoretical advantage for Wales is the existence of integrated health bodies responsible for the totality of health care provision for substantial populations[120]. Local authorities, however, remain separate, with different funding, accountability, eligibility and regulatory arrangements, albeit that they are required to plan jointly with their LHB[121].

7.3 CLEAR ROLES AND RESPONSIBILITIES

It is important at an operational and strategic level that all parties involved in a new joint initiative understand the roles and responsibilities of those involved. This includes budget management, administrative support and how material resources are co-ordinated. For example, having a comprehensive service-level agreement drawn up to underpin the placement of social workers in GP practices enabled agencies to identify respective responsibilities for the initiative.

Ensuring that there are clear frameworks, both legal and financial, underpinning the establishment of pooled budgets is supportive of partnerships. Equally, strategic commitment at an executive level to devolve responsibility has been identified as important to the outcome of joint initiatives.[122]

In Torbay[123],the roles and responsibilities of the Torbay Council and Torbay PCT were clarified during the legal and contractual negotiations necessary to establish Torbay Care Trust (Torbay Council and Torbay Care Trust 2005. As the accountable body the council keeps itself informed. An annual agreement allows the council to outline the resources it will transfer to support social care and the performance expectations, including a monitoring schedule.

For the Community Resource Teams in Pembrokeshire , Pembrokeshire County Council and the health board have integrated social and health care services operating under a director of health and a director of social services. A joint head of community health and social services holds managerial and organisational accountability for community adult health and social care services supported by

[117] Miller, R, Dickinson, H, Glasby, J (2011) The vanguard of integration or a lost tribe? Care trusts ten years on.. HSMC Policy Paper 10
[118] Challis, D. et al. (2006) 'Care management for older people: does integration make a difference?' Journal of Interprofessional Care, vol 20, no 4, pp 335–348.
[119] Integrating health and social care in Torbay: Improving care for Mrs Smith, Kings Fund, March 2011
[120] Integrated care in Northern Ireland, Scotland and Wales: Lessons for England, Kings Fund, Chris Ham, Deirdre Heenan, Marcus Longley, David R Steel, July 2013
[121] Integrated care in Northern Ireland, Scotland and Wales: Lessons for England, Kings Fund, Chris Ham, Deirdre Heenan, Marcus Longley, David R Steel, July 2013
[122] Factors that promote and hinder joint and integrated working between health and social care services, SCIE, Ailsa Cameron, Rachel Lart, Lisa Bostock and Caroline Coomber, May 2012
[123] Integrating health and social care in Torbay: Improving care for Mrs Smith, Kings Fund, March 2011

the assistant general manager. The project is delivered through an integrated management structure of health and social care teams, co-ordinated by a dedicated project manager. Service delivery is supported by customer services managers and the head of community nursing. The integrated structure ensures that the teams have a joint vision and managerial framework that enables them to work across organisational boundaries. A project board consisting of health, social care and third sector professionals provides strategic overview and planning advice for the development and organisation of the work streams.

7.4 COMMUNICATION AND INFORMATION TECHNOLOGY

Greater use of ICT is potentially an important enabler of integrated care, but does not appear to be a necessary pre-condition for it. In general, it also needs to be remembered that it is important to get processes right ahead of investing in technological processes.

Effective mechanisms to share information, including shared documentation and shared or compatible information technology systems were factors identified as improving joint working, leading to speedier and timelier assessments of need. Effective communication was also reported to lead to cases being prioritised more efficiently.[124]The key learning of this is that interpersonal communication is still an important enabler.

In Torbay[125], the work of co-ordinators is underpinned by a commitment to sharing data, enabling co-ordinators to access information about users from the hospital, general practices and the care trust. At first co-ordinators had to switch between different systems but eventually a single system was introduced for social care and community health services.

Named co-ordinators have access to the patient information system at the hospital, and certain practices offer similar access to link workers at the care trust. Health and social care co-ordinators were also appointed to certain key wards at the main hospital in order to improve working links with secondary care. They have access to Torbay Care Trust's IT system and work in conjunction with zone colleagues to co-ordinate or set up care to facilitate safe discharge.

In the South Devon and Torbay Virtual Ward[126], staff working within the community virtual wards in South Devon and Torbay CCG use differing IT systems; the GP system is separate from the integrated community health and social care information system, while the acute sector also has separate IT systems. The model has developed several mechanisms to facilitate information sharing. Each virtual ward co-ordinator has access to the different systems and patients can be identified by their NHS ID number and date of birth.

This information is used to inform the discussion about patients at MDT meetings. In addition, GPs complete a message on the out-of-hours system for all virtual ward patients. This message can be accessed by the out-of-hours provider, providing them with specific information on the patient when conducting a home visit or requesting an ambulance. The allocated case manager notes any changes which occur as a result of the case management process in the patient's GP record, and this

[124] Factors that promote and hinder joint and integrated working between health and social care services, SCIE, Ailsa Cameron, Rachel Lart, Lisa Bostock and Caroline Coomber, May 2012
[125] Integrating health and social care in Torbay: Improving care for Mrs Smith Kings Fund, Peter Thistlethwaite, March 2011
[126] South Devon and Torbay: Proactive case management using the community virtual ward and the Devon Predictive Model, Kings Fund, Veronika Thiel, Lara Sonola, Nick Goodwin, Dennis L Kodner, October 2013

information is shared with the rest of the multi-disciplinary team at subsequent meetings or over the phone.

At Midhurst[127], there is little integration in the use of shared or electronic health records outside of the Midhurst team. Staff rely on face-to-face communication, telephone or email to ensure relevant professionals are informed about patients and their care. After an initial assessment, the care plan is sent to the GP, community teams and other specialist consultants involved in the patient's care. In addition, a patient notebook is kept at the patient's home by the community nurses, which Midhurst staff update, providing an overview of the notes for other external professionals visiting the patient. Within the Midhurst team integration is supported by Crosscare which is used to record detailed patient information for use by the team. These records contain a rich narrative about the patient, including details of their family situation and their personal wishes. This system is the backbone of the service, although external providers do not have access to it. The Midhurst approach is described as 'high touch/low tech', relying on frequent communication through other channels to maintain continuity outside the service. This element of the service is a key lesson of the care co-ordination model as it suggests that integrated care is possible without up-front investment in ICT, particularly where the population is small and defined. At the same time, a huge effort has to go into communication to support information exchange, promote awareness, and ensure a more coordinated response which would be impractical on a larger scale.

Communication between staff in the Oxleas service[128] and with other care professionals is not facilitated by the electronic patient records systems used within the trust. Oxleas Foundation Trust has taken on a variety of community services that continue to use different health records. Although both the community health team and mental health staff use a web-based electronic care record, they cannot access each other's systems without special permission and patients have two separate records. They have developed mechanisms to ensure that both records are up to date by meeting face-to-face or telephoning to contact other services, followed by a completed form or faxed letter when needed. These personal interactions build rapport and trust between professionals and appear to be particularly useful in developing relationships with other care providers. In addition, care co-ordinators attend meetings with local GPs to share information. The service relies on 'low tech' solutions to overcome barriers to sharing data electronically. These methods are more time-consuming; however, they help to maintain strong links with professionals outside the service.

In the Kings Fund study, ***Providing integrated care for older people with complex needs: Lessons from seven international case studies*** , most of the models of care[129] involved close personal, often face-to-face contact between members of the care team, often a care co-ordinator or case manager and the client. There has been extensive use of telephone-based support in the United States, where disease management support has traditionally been provided by third-party companies (often linked to the insurer rather than providers). In most of the case studies, case managers/care co-ordinators had regular face-to-face contact with patients, often in physician offices, and undertook home visits as well as using the telephone. They varied the frequency and type of contact according to each client's needs. A highly personalised and flexible approach appears to be a common feature of the case studies examined in that report. Overall, these case studies suggest that high-touch, personalised care is more important than high-tech care, which relies on electronic patient records

127 Midhurst Macmillan Community Specialist Palliative Care Service - Delivering end-of-life care in the community, Kings Fund, Veronika Thiel, Lara Sonola, Nick Goodwin, Dennis L Kodner, October 2013

128 Oxleas Advanced Dementia Service - Supporting carers and building resilience, Kings Fund - Lara Sonola, Veronika Thiel, Nick Goodwin, Dennis L Kodner, October 2013

129 Providing integrated care for older people with complex needs: Lessons from seven international case studies, Kings Fund - Nick Goodwin, Anna Dixon, Geoff Anderson, Walter Wodchis, January 2014

or telehealth/telecare devices. While the latter may have their place in supporting co-ordinated care if they enable shared information between professionals in the wider care team and with the patient and carers, they are not essential to the successful delivery of integrated care.

Gwent frailty[130] implemented a bespoke system based around the development of a digital form. The IT was developed in-house and is still being developed. Some of the barriers to introducing the system have been cultural (concerns about time monitoring, staff preferences to write up notes away from the patient's home, a desire for profession specific records). However, there is a growing acceptance of the rationale for the system and recognition of the point that there is not service capacity for creating two sets of records.

The Pembrokeshire Community Resource Teams[131] use secure faxes, secure email and telephone calls to exchange information about patients and organise discharge and care. A large proportion of communication takes place face-to-face, over the telephone or via email. Some health staff and GP practices have access to the social care system called CareFirst but make little use of it because it is slow and cumbersome. Co-location of the south-west team makes face-to-face communication easier. Team members in all CRTs emphasised that relationships and hence information exchange had improved since the project started. This helps teams overcome the lack of IT integration.

Assistive technologies

In Te Whiringa Ora, in New Zealand, monitoring devices are available for use in clients' homes to measure heart rate, blood pressure, spirometry, pulse oximetry, body temperature, body weight, and blood glucose levels. In this case, technology was primarily used to train patients in self-management, but data are also accessible to clinical staff so that they can pick up early signs of exacerbation[132].

New medical and information technologies create new health care tasks and enable different ways of working[133], including enhanced roles for patients. Technology puts power into the hands of patients and means more care can take place outside the hospital setting. Examples include devices that remotely monitor vital signs, such as blood glucose and heart function, and intelligent devices that control household appliances. While use of these technologies can improve clinical outcomes, and make care more convenient, it is important to note that not everyone feels confident to self-medicate or will want this degree of intrusion in their daily lives.

7.5 PATIENT AND PUBLIC ENGAGEMENT

The focus on the needs and preferences of end users can easily be lost in the challenging task of building the organisational platform for integration and in organising new methods of delivering professional care. Using performance metrics focused on the end user and strengthening the user voice in the platform for integration might avoid this[134].

[130] Telephone discussion on 24 January 2014

131 Developing community resource teams in Pembrokeshire, Wales - Integration of health and social care in progress, Kings Fund, Veronika Thiel, Lara Sonola, Nick Goodwin, Dennis L Kodner, October 2013

[132] Providing integrated care for older people with complex needs: Lessons from seven international case studies, Kings Fund - Nick Goodwin, Anna Dixon, Geoff Anderson, Walter Wodchis, January 2014

[133] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013

[134] National Evaluation of the Department of Health's Integrated Care Pilots, RAND Europe, Ernst & Young LLP, March 2012

In Torbay[135] the involvement of the local community was seen as important. Regular discussion sessions invited patients and the public to share their experience of the health service and asked what they would like to see changed. The community hospital league of friends, schools, residential homes and nursing homes were all involved and kept informed of developments. The aim was to foster a sense of enthusiasm and a desire to get involved and to understand from their point of view what would make their experience better.

Barking & Dagenham[136] Trust set out to change the way it procured care. Listening to patients and their carers was crucial, particularly when it came to working out how the new pathways should look. The Experience-based design (ebd) methodology was used to help staff to understand what it felt like for patients experiencing the services. The principle of ebd is to listen to patients telling their stories and then to involve them in co-designing improved services.

The Northern Health and Social care Trust (NHSCT) has instituted the practice of Telling Patients' Stories. Every fortnight, nurses meet to share case histories. This helps to promote critical thinking, identify the causes of unnecessary hospitalisation and promotes continuous learning and improvement of services.

7.6 CONTRACTING MECHANISMS

There is some international evidence concerning payment approaches that support integrated care and support. This indicates that the design of a currency, or a descriptor of what is being purchased for a given price, should closely reflect what the people who use care and support deem to be value, that is, high quality services which are well coordinated, with minimum duplication, lags, or gaps. This suggests that we need a different concept of what is being paid for: an outcome or series of outcomes. Monitor and NHS England are working together to design the long-term payment system, with each partner contributing particular expertise. To improve the payment system we will develop standardised currencies, identify the appropriate payment approach for different types of care and collect better data on provider costs.[137]

The BGS considered what should a service specification cover: [138] Looking at a range of service specifications, key headings could cover staff roles and core competencies and staff accreditation requirements. The evidence of other parts of the report, around workforce flexibility, new roles upskilling and side skilling, suggest that specifying staff groups may constrain service development, although developing a view of the particular skills and competencies required in order to support patients may be a mutually helpful way of ensuring there is a service/ workforce dialogue.

In keeping with the evidence, it seems sensible for contracts to reflect what the people who use care and support deem to be value, including what they value about the workforce.

The Kings Fund report, ***Making integrated care happen at scale and pace - Lessons from experience***[139] notes the work that is taking place, largely around payment mechanisms and the need

[135] Joined-up care: delivering seamless care, Case Studies, NHS Institute, 2010
[136] Joined-up care: delivering seamless care, Case Studies, NHS Institute, 2010
[137] "Integrated Care and Support: Our Shared Commitment", National Collaboration for Integrated Care and Support, May 2013
[138] Quest for Quality: British Geriatric Society Joint Working Party inquiry into the quality of healthcare support for older people in care home: A call for leadership, partnership and quality improvement, BGS, 2011
[139] Making integrated care happen at scale and pace - Lessons from experience, Kings Fund, Chris Ham, Nicola Walsh, March 2013

to test and evaluate different approaches. Work is under way in Cambridgeshire to explore an outcomes-based contract for frail older people.

RECOMMENDATIONS

Organisational and cultural development is integral to the change management that needs to support and underpin integrating services for older people. The report underlines the close relationship of workforce integration, organisational development and service integration and their importance in effective system design. While organisational and cultural development is not the main focus of the report, it is recommended that the programme should:

- **Consider the findings on organisational development and culture**, especially those that relate to patient voice, clear roles and responsibilities, ICT and contracting mechanisms and their relationship and potential impact on workforce integration

SECTION 8 MAKING CHANGE HAPPEN

This section summarises the change models and key factors for change management.

SUMMARY

- The NHS Change Model and the Principles of Workforce Integration provide a good starting point.
- Co-location of teams and a unified management structure are important, but more important is the need for team members to align goals and work together.
- A key function of teams is to understand the local population and to develop effective relationships with other local networks. Local knowledge can be as important as skills.
- Leaders need to plan over an appropriate timescale (at least five years and often longer) and to base their actions on a coherent strategy that acknowledges the importance of all the lessons.

8.1 CONTEXT

In developing integrating activities there is no one approach that suits all occasions. Local circumstances and path dependencies will be crucial in shaping the pace and direction of change. Integration is not a matter of following pre-given steps or a particular model of delivery, but often involves finding multiple creative ways of reorganising work in new organisational settings to reduce waste and duplication, deliver more preventive care, target resources more effectively or improve the quality of care[140].

In Torbay[141] Thistlethwaite (2011) concluded "*people in Torbay examined evidence from elsewhere, appraised their own performance, built communication and teamwork between stakeholders, made choices, managed risks and reaped rewards: these things are replicable. 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*. "

8.2 THE NHS CHANGE MODEL

The key point is that service redesign and workforce development need to go hand in hand to ensure that the workforce support the work. The NHS has already developed a change model to support the NHS to adopt a shared approach to leading change and transformation which can be found at:

[140] National Evaluation of the Department of Health's Integrated Care Pilots, RAND Europe, Ernst & Young LLP, March 2012
[141] Thistlethwaite, P (2011) Integrating health and social care in Torbay: improving care for Mrs Smith. Kings Fund

http://www.changemodel.nhs.uk/pg/dashboard

This should be the default model for making change.

Workforce redesign cannot be approached in isolation, but is part of the processes for redesigning care, identifying the best site of care, and utilising technologies that facilitate alternative ways of working.[142]

In addition, the National Collaboration for Integrated Care and Support has shared a discussion document, ***Principles of Workforce Integration***[143]. This is a good starting point and when the principles are finalised they might be utilised by organisations in the West Midlands:

THE PRINCIPLES OF WORKFORCE INTEGRATION:

1. Successful workforce integration focuses on better outcomes for people who need care and support.

- Developing a common goal around better outcomes for people who need care and support creates a single vision to underpin transformation.
- It is easy to lose direction or get pulled by competing priorities; continually refocusing on the purpose of the care and support being provided brings everyone back together.
- Integrating the workforce, including the range of different practitioner skills, around the needs of individuals using services will result in better use of resources, and support that is tailored to individual needs.
- People who need care and support and family carers own views and experiences are an integral part of developing new ways of working.
- Creating people centred provision is not just about workforce reconfiguration. It is about how the team operates around the individual, working together to achieve best outcomes.

2. Workforce integration involves the whole system.

- Bringing together front line workers without integrating all of the systems that support and enable those workers is not sustainable. It will create conflict and practical difficulties, and make people feel unsupported.
- Integrating resources, responsibilities and control creates a clear message that each organisation is committed to the transformation.
- Integrating resources will minimise duplication, and ensure that every part of the system is working effectively.
- Bringing in new service arrangements will disrupt some long established informal networks; building new ones should be viewed as a priority.
- The system should be viewed in a non-hierarchical way, each person in the system carries some responsibilities, and all are mutually dependent upon each other for success.

3. To achieve genuine workforce integration, people need to acknowledge and overcome resistance to change and transition. There needs to be an acknowledgement of how integration will affect people's role and professional identity.

- Change and transition can be debilitating if it is perceived to be threatening. Workers need to

[142] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013
[143] The Principles of Workforce Integration, Skills for Care, Think Local, Act Personal, Skills for Health, Local Government Association, NHS Employers, Nov 2013

feel safe, valued and supported. Their anxieties should be freely aired and responded to.

- Where job roles change, workers can feel de-skilled. Identifying and meeting learning needs should be part of any strategy employed.
- Safe environments enable people to innovate, take risks, build new models and ways of working, and share learning to enhance practice.
- A balance needs to be struck so that workers can maintain their sense of professional identity, at the same time as working across boundaries that are increasingly blurred. To achieve this, roles, responsibilities and accountability need to be clearly described.
- Workers who feel their perspectives and skills are recognised and valued by their colleagues and across organisations are likely to feel more confident, motivated and engaged with the changes.
- Professional supervision and the opportunity to manage continuing professional development need to be incorporated into any new arrangements.

4. A confident, engaged, motivated, knowledgeable and properly skilled workforce supporting active communities is at the heart of workforce integration.

- The most valuable resource in any organisation is the workforce. Attending to workforce issues, identifying learning needs, addressing issues of professional identity, recognising infrastructure issues such as employment arrangements, gives a clear message about the value placed upon workers.
- Successful implementation of integration depends upon workforce issues being addressed from the beginning. Workforce issues cannot be added at the end, they need to influence discussion and decision-making, and need to be included in the process of resource allocation.
- An environment in which workers feel safe and confident to raise questions, express concerns, and talk about their experiences, and make suggestions for service improvement based on their experience and relationships with people they support will create trust and help people to feel supported.
- Acknowledging and valuing the expertise that workers bring to their changing workplace environment will make people feel valued and listened to.
- Creating a learning environment that draws on the experiences of workers will maximise innovation, and appropriate risk taking, supporting the development of new models and ways of working.
- People learn in different ways and at different paces, and are affected by change to varying degrees. The design and implementation of integrated strategies needs to reflect this, so that things are paced appropriately, with individual needs identified and met in a range of ways.
- Champions play an important role in the implementation of any transformation. Having champions at every level will help in implementation. Motivated and enthusiastic workers should be identified, nurtured and encouraged to take on this role.

5. Process matters- it gives messages, creates opportunities, and demonstrates the way in which the workforce is valued.

- Give attention to the process, it is by getting this right that ownership, commitment and trust will be developed and the likelihood of sustained success will be increased.
- Good communication, keeping everyone informed and appropriately involved in decision-making is the foundation of an effective strategy.
- Begin by looking for the resources and experiences that are already there, building on these demonstrates the value that individuals' contributions are given. Create opportunities for people to learn from each other.
- The ways in which senior workers behave and act should mirror the co-operative, open and

motivated approaches that will be expected of front-line workers.

6. Successful workforce integration creates new relationships, networks and ways of working. Integrated workforce commissioning strategies give each of these attention, creating the circumstances in which all can thrive.[144]

- Informal networks are critical to individuals, providing them with information, support, ideas and quick responses. Reconfiguring services will interrupt existing networks.
- Opportunities need to be created to ensure that new relationships can thrive.
- The ways in which different professional groups and organisations relate to each other will change with integration. This can feel threatening and create insecurity.
- The needs of each professional group need to be attended to, to enable a continued sense of professional identity and to ensure continuing professional development. At the same time members of newly created teams and services should have the opportunity to share understandings, perspectives, priorities and limitations so that everyone feels comfortable in their role, and with the roles of others.
- The new ways of working that emerge with integration may create specific learning needs to enable individuals to work effectively. These need to be identified and attended to.
- There is richness in the diversity created within integrated teams and organisations; facilitated opportunities should be created to exploit this, so that people can learn together as new approaches evolve.

The Kings Fund report, ***Making integrated care happen at scale and pace***[145], summarised the steps they considered needed to be taken to make integrated care a reality. The steps which are most relevant to workforce are:

7: Build integrated care from the bottom up as well as the top down

The main benefits of integrated care occur when barriers between services and clinicians are broken down, not when organisations are merged. A fundamental building block is the creation of integrated or multidisciplinary teams comprising all the professionals and clinicians involved with the service or user group around which care is being integrated. Experience indicates the importance of a single point of access to this team, a single assessment process, and close alignment between the work of the team and that of other providers of care, such as general practices. In north-west London, multidisciplinary teams in an integrated care pilot have found weekly case review meetings extremely valuable (see Harris et al 2012). Co-location of teams and a unified management structure are important, but critically it is about team members aligning goals and working together. In some instances a new style of working will be needed to support more collaborative behaviours between professionals belonging to different organisations. A key function of teams is to know the population they serve by making use of registries and other data sources, and to stratify the needs of this population in order to target expertise effectively. Teams also need to implement care planning systematically to ensure that people most at risk have a plan developed and agreed with the team responsible for their care. Risk stratification and case finding need to avoid the trap of focusing only on people currently vulnerable and seek opportunities to intervene early to support those who may become vulnerable in future.

[144] The Principles of Workforce Integration, Skills for Care, Think Local, Act Personal, Skills for Health, Local Government Association, NHS Employers, Nov 2013

[145] Making integrated care happen at scale and pace, Kings Fund, Chris Ham, Nicola Walsh, March 2013

13: Use the workforce effectively and be open to innovations in skill mix and staff substitution
High-quality integrated care depends on team working that makes full use of the skills of a range of health and social care professionals. Team-working creates opportunities to vary skill-mix and use staff substitution, eg, nurses and pharmacists taking on roles previously performed by doctors. There are also opportunities to establish new roles, such as the health and social care co-ordinators employed in Torbay's integrated teams. These co-ordinators have no professional training, but are skilled in acting as the point of access in teams and knowing how best to use the skills of other health and social care professionals. Another example is the development of hybrid roles spanning social care and community nursing in jointly commissioned re-ablement services.

8.3 LESSONS FROM THE LITERATURE

Other lessons drawn from the literature are set out below.

EXPECTATIONS

- The scale and complexity of delivering integrated care activities can easily overwhelm even strong leadership and competent project management. While it may seem obvious in theory that integrating activities should be scaled to match local capacity, this was not always the case in practice. In some cases, enthusiastic local leadership produced expectations that were difficult to realise in practice. Changes to practice often took much longer to achieve than anticipated[146].

TIMESCALES

- Leaders need to plan over an appropriate timescale (at least five years and often longer) and to base their actions on a coherent strategy that acknowledges the importance of all the lessons.[147]

- A key message was the significant length of time needed to design and agree change across a range of organisations and the significant impact that contextual factors (such as changes in the management of a local provider trust, the departure of key personnel and wider NHS structural reform) had on implementing the desired changes to local care delivery.[148]

- Recruitment, training and staff preparation is likely to take at least six months and local project managers should be in place to ensure appropriate implementation.[149]

WIDE UNDERSTANDING

- Securing the understanding and commitment of staff to the aims and desired outcomes of new partnerships is crucial to the success of joint working, particularly among health professionals.[150]

[146] National Evaluation of the Department of Health's Integrated Care Pilots, RAND Europe, Ernst & Young LLP, March 2012
[147] Making integrated care happen at scale and pace, Kings Fund, Chris Ham, Nicola Walsh, March 2013
[148] Evaluating integrated and community-based care: How do we know what works? Nuffield Trust - Martin Bardsley, Adam Steventon, Judith Smith and Jennifer Dixon, June 2013
[149] National Evaluation of Partnerships for Older People Projects: Final Report, London School of Economics, University of Kent, University of Southampton - Karen Windle; Richard Wagland; Julien Forder; Francesco D'Armico; Dirk Kanssen; Gerald Wistow, 2010
[150] Factors that promote and hinder joint and integrated working between health and social care services, SCIE, Ailsa Cameron, Rachel Lart, Lisa Bostock and Caroline Coomber, May 2012

- Ensuring that professionals and agencies involved in new initiatives understand the aims and objectives as well as the detail of the eligibility criteria and referral processes is important to the success of any new initiative. One way to develop a common understanding is to involve staff in the development of the policies, procedures and protocols underpinning the service. Additionally, professionals who are not part of the core partnership (e.g. those working in referral services) need to understand the eligibility criteria if the initiative is to succeed. Providing introductory as well as ongoing training was identified as a constructive way to ensure that a common goal is established among partners. [151]

CULTURE

- There is a real risk that the workforce, in particular the medical workforce, will drive the care model not the other way round. To achieve a better alignment between the workforce and the work, workforce and service redesign need to go hand in hand.[152]

SCALING UP

- Lessons from south Devon and Torbay suggest that it is possible to scale up through building a number of locality-based approaches to care under the direction of an umbrella organisation. Yet in each case, the process of relationship-building takes time and, as in Pembrokeshire, is likely to lead to variable approaches to care in local contexts that may or may not be as successful.[153]

[151] Factors that promote and hinder joint and integrated working between health and social care services, SCIE, Ailsa Cameron, Rachel Lart, Lisa Bostock and Caroline Coomber, May 2012
[152] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013
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SECTION 9 SUSTAINABILITY, BARRIERS AND ENABLERS

This section sets out key lessons for sustainability and summarises the barriers and enablers that have been identified.

9.1 SUSTAINABILITY

The key lessons for sustainability are:

SERVICE REDESIGN

Service redesign and workforce development need to go hand in hand to ensure that workforce supports redesign. Knowledge of the local population and local services is also important.

When developing integrating activities there is no one approach that suits all occasions. Local circumstances and path dependencies will be crucial in shaping the pace and direction of change. Integration is not a matter of following pre-given steps or a particular model of delivery, but often involves finding multiple creative ways of reorganising work in new organisational settings to reduce waste and duplication, deliver more preventive care, target resources more effectively or improve the quality of care[154].

ENGAGEMENT

Services must be grounded in local communities[155]. A wide range of local agencies have a part to play in developing holistic services, including voluntary and Third Sector. Successful integrated care must take account of the views and needs of older people themselves.

TEAM WORKING

Multidisciplinary teams need to be built on mutual trust and respect. Staff working with older people and in multidisciplinary teams need the right skills, attitudes and behaviours. These include openness and being receptive to adopting new ways of working. Multidisciplinary teams should be built around models of continuous and continual learning. This should be built into day to day working.

9.2 ENABLERS AND BARRIERS

The workforce barriers and facilitators identified may also be seen as two sides of the same coin.

The key operational factors which affected integrated working[156] fall within a number of themes: relations between partners; organisational culture; change management; enabling staff; professional behaviour; attitudes; outcomes.

[154] National Evaluation of the Department of Health's Integrated Care Pilots, RAND Europe, Ernst & Young LLP, March 2012
[155] The support older people want and the services they need, Joseph Rowntree Foundation - Roger Clough, Jill Manthorpe, OPRSI (Bert Green, David Fox, Gwyn Raymond and Pam Wilson), Vicki Raymond, Keith Sumner, Les Bright and Jinny Hay, 2007
[156] Stewart, A, Petch, A, Curtice, L (2003) Moving towards integrated working in health and social care in Scotland: from maze to matrix. Journal of Interprofessional Care 17 (4), pp 335-350

The top four **barriers** were identified as[157]:	**Enablers** of successful integration included[158]:
• 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

Other barriers identified[159] include concerns about professional status. The medical model of care may dominate in integrated organisations and some medical staff may be reluctant to work in a multi-agency setting. Other barriers centre on organisational boundaries, for example communication/IT systems, funding arrangements and employment issues such as training and career progression.

A fuller description of enablers and barriers is in **Annex D**.

[157] Stewart, A, Petch, A, Curtice, L (2003) Moving towards integrated working in health and social care in Scotland: from maze to matrix. Journal of Interprofessional Care 17 (4), pp 335-350
[158] Robertson, H (2011) Integration of health and social care: A review of literature and models - implications for Scotland. RCN
[159] Robertson, H (2011) Integration of health and social care: A review of literature and models - implications for Scotland. RCN

SECTION 10 SUMMARY OF RECOMMENDATIONS

The following recommendations are intended to support the Older Adults Workforce Programme to take forward the findings of this report within the West Midlands.

Integrated Healthcare and the Workforce: The Context
The programme should work with:

- Representatives of patients, service users and carers, through pilots projects 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. This should include engaging with the proposed patient and public coalition in the West Midlands and the national HEE Patient Advisory Forum.
- Local organisations to **identify the workforce** that provide support to older people in the West Midlands. This should include identifying the **organisations that are already providing integrated care** for older people.

Care Needs of Older People
The programme should:

- Apply the values based recruitment approach and recommendations of the national initiative to ensure the programme takes account of the **values and behaviours** required for working in older people's integrated care teams. This should include ensuring that existing, as well as new, workers are equipped with the appropriate "customer service" skills for caring for older people. This will help to support developing a new culture.
- Establish links through Health Education West Midlands to support implementation work on **the development of pre and post-registration training for the regulated professions** to ensure that clinicians have the competencies to meet the aspirations for older people.
- Work closely with other workforce programmes, including the Innovation Fund programmes for **related areas of work**, 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.

Models of Integrated Care
The programme should work with:

- Pioneers[160] 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 that the workforce implications are understood.

Initiatives to Help Avoid Hospital Admission
The programme should work with:

- Pioneers and pilot sites to test, confirm and validate the **skills and competencies** that are required in order to care for older people in integrated teams.
- Education and training providers and pioneers to further **develop detailed specifications for education and training** based on the findings of this review.
- Pioneers and providers and the independent sector to discuss **how modular and customised training can be delivered most effectively**.

[160] The term "pioneers" is used to include both the nationally funded Integration Pioneers and integration focussed initiatives that are being delivered through the Better Care Fund (see page 11 for more details).

Team Building and Workforce Flexibility
The programme should work with:

- **Mental health organisations** to consider how best to ensure that mental health expertise can be harnessed in integrated care approaches for older people.
- Pioneers and pilot projects 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**.
- Pilot projects to **test the Staffordshire core principles** in practice as a tool for supporting MDTs.

The Wider Workforce
The programme should work with:

- Pioneers and education and training providers to test out the Cavendish recommendations about **training as one workforce**.
- Patients, service user/ carer representatives and voluntary organisations, through pilots projects and pioneers, to **identify the potential contribution of the third sector, the voluntary sector and volunteers, carers and the independent sector** workforce in supporting older people's integrated care.

Organisational Development and Culture
Organisational and cultural development is integral to the change management that needs to support and underpin integrating services for older people. The report underlines the close relationship of workforce integration, organisational development and service integration and their importance in effective system design. While organisational and cultural development is not the main focus of the report, it is recommended that the programme should:

- **Consider the findings on organisational development and culture** (Section 7), especially those that relate to patient voice, clear roles and responsibilities, ICT and contracting mechanisms and their relationship and potential impact on workforce integration

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ANNEX A

CASE STUDIES SUMMARY

TORBAY

Target Client Group
The creation of an integrated health and social care team in Brixham in 2004 worked with a number of general practices to help older people most at risk, with a particular focus on enabling them to remain independent for as long as possible. Later increased investment in intermediate care became a key priority and this improved access to services, thereby helping to reduce avoidable hospital admissions.

Purpose
Discussion of bringing together the functions of the primary care trust and adult social care services emerged out of the establishment of the integrated team in Brixham and the extension of this approach to other localities. The managers overseeing the work of these teams highlighted the complexities of different contractual and other arrangements in place for staff and this led to the suggestion that a care trust should be established.

Point of Entry
Single point of contact in each zone (health and social care co-ordinators)

Assessment
Single assessment process.

Care Coordination/ Case Management
The appointment of health and social care co-ordinators was an important innovation. Co-ordinators became the main point of contact for referrals and liaised with other team members to decide who should handle referrals and how. They also worked closely with nurses, allied health professionals and social care staff to put in place appropriate care packages and support. Co-ordinators do not have formal professional training but know how to harness the contribution of team members.

After all the zones were established, health and social care co-ordinators were appointed to certain key wards at the main hospital in order to improve working links with secondary care. They have access to Torbay Care Trust's IT system and work in conjunction with zone colleagues to co-ordinate or set up care to facilitate safe discharge. A co-ordinator based in a ward is able to exercise more influence than a co-ordinator based in the zone. This gets patients and their families involved early, speeds up the processes, and has reduced the number of professional staff (for example, social workers) involved in discharge planning (Wade 2010b).

In Torbay, formal referral to a separate intermediate care service was eliminated. Co-ordinators could access intermediate care when they felt it was appropriate and effect easy transfers between short-term interventions and longer-term support.

Multidisciplinary Team
Intermediate care was provided through local multidisciplinary teams that managed a small, but rapidly changing, joint caseload. Their focus was on short-term interventions to meet acute needs and restore the confi dence and capability of individuals. The service operated more fl exibly over time – an extended working day was introduced as well as weekends. Response times were very short – within an hour in certain circumstances.

Outcomes
The results of integration include:

- Reduced use of hospital beds.
- Low rates of emergency hospital admissions for those aged over 65.
- Minimal delayed transfers of care.
- Use of residential and nursing homes has fallen and at the same time there has been an increase in the use of home care services.
- There has been increasing uptake of direct payments in social care and favourable ratings from the Care Quality Commission.

Workforce Comments

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Enablers

- For quite some time Torbay has benefitted from strong primary health care services that were innovative and influenced early developments in whole-system thinking.
- The chief executive identified the following local advantages:
- co-terminosity
- quality of staff
- political support
- the foundation of joint work.
- Base strategy on the benefits being sought for service users/patients. Specify the benefits in advance, communicate them constantly, invest in the things that will help achieve them, monitor progress, listen to staff experiences, share results and encourage further improvement.

Barriers

- Cultural differences between professionals.
- Differing terms and conditions in the workforce.
- No basis for information sharing.
- Central/local balance (social services were centralised).
- Governance/accountability would have to be thought through.
- Increasing financial pressures.
- The time needed to make changes in the NHS.
- The role of local leaders in this process, including those in local government who will have an important role in the future of healthcare.
- The importance of organisational stability and continuity of leadership.
- The power of keeping patients and service users at the centre of the vision for improvement.
- Delivering real results depends on working on several fronts simultaneously while remaining faithful to the vision.

PAN GWENT FRAILTY SERVICE

Target Client Group

integrated health and social care and support model for vulnerable elderly people, people with long term conditions and individuals with health and social care or housing need. Patients and carers prefer to be supported at home. Too often “risk” is defined as what is most comfortable for the professional who is taking responsibility, not the patient. Admission to hospital is a highly sensitive issue for a frail person in terms of their prospects for future independence. Frail people can lose independence very rapidly in hospital or institutional settings, so the emphasis has to be on admission avoidance altogether.

Purpose

The Gwent Frailty vision is to support frail people to remain "happily independent". Other health and social care services beyond the scope of Gwent Frailty contribute to frail peoples' well-being and independence, as do a range of services outside health and social care,eg services for housing, transport, benefits, and employment. The emphasis is on preventing unnecessary hospital admissions, discharging patients from hospital at the earliest opportunity and providing care in the community, wherever clinically appropriate.

Elements of the service include:

- Rapid response (within four hours).
- Hospital at Home (for up to 14 days).
- Up to six weeks rehabilitation support free of charge.
- A single point of access for GPs and other professionals to call in the frailty teams, 8.00 am to 8.00pm access, seven days a week.
- A fully integrated falls service.
- A protocol with Wales Ambulance Service, to enable paramedics to refer patients directly to the frailty service as an alternative to A& E.

Point of Entry

The vision for Gwent Frailty includes a single telephone-based point of access (SPA) to frailty services across Gwent. The SPA will determine how best to address a frail person's needs and handle an estimated 18,000 referrals per year. Originally, plans for the SPA included direct access for users and their carers and a fast-track service for professionals, including GPs. SPA function and CRT Portal operation are not yet supporting Gwent Frailty as anticipated. Currently, SPA records that the Gwent Frailty service receives approximately 1,100 referrals per month but this figure is lower than the actual amount received because not all referrals are being made via SPA. Some referrals are coming via e-mail or by direct contact between professionals, without using the SPA.

Assessment

There are no specific eligibility criteria for Gwent Frailty; if users fit within the definition of frailty they will be accepted if they are referred by a professional. There are variations in how Gwent Frailty meets similar needs. Within the franchise, service users should get the same standard of service, although it may be provided in different ways. Currently, Gwent Frailty service users living in different areas but with identical needs do not always receive the same service. There is a commitment to reduce unjustifiable variations over time. However, across Gwent there are variations in levels of investment in services, what services Gwent Frailty delivers, services' hours of operation and in CRT functions and priorities.

Care Coordination/ Case Management and Multidisciplinary teams

- To date, Gwent Frailty has focused on simplifying processes so that professions, services and agencies work together better and deliver services to people in their homes, working with them to preserve independence and dignity; including bringing together health and social care teams in Community Resource Teams (CRTs) where they were not previously co-located. These foundations should begin to deliver better outcomes for service users and their carers in the short-term. o Interactions between hospital-based clinicians and community social workers are increasing, which is starting to improve joint working;
- CRTs are beginning to be able to access medical and social care information to get a fuller picture of needs, allowing CRTs to meet needs more effectively, although more progress in this area is necessary;
- a better focus on providing the right services to meet user‟s need at the first point of contact; and
- referrals to Gwent Frailty are increasing, some hospital beds have closed and hospital-based staff have now moved to community teams.
- Gwent Frailty implementation is highlighting shortcomings in working methods, models of delivery and patterns of services; supporting the need for wider change. Furthermore, the need to continue to deliver services within existing unsustainable structures and processes, whilst simultaneously trying to change them in order to support full implementation, gives rise to some practical problems and tensions, for example:
- difficulties which arise in secondary care as staff are moved from acute hospital to community-based working; and
- issues encountered in primary care during roll-out of the SPA and the CRT information portal which supports it.
- Implementing Gwent Frailty requires staff to work in multi-disciplinary, cross-agency, integrated

teams. Inevitably, this process is encountering some issues around variations in terms and conditions of employment within joint teams and across localities, which the partner agencies are working with the Trade Unions to deal with, and which will take time to address. Integration of Blaenau Gwent CBC and Caerphilly CBC social services will aid this process.

- For Gwent Frailty to successfully refocus services on prevention and shift resources from hospital to community settings, hospital-based clinicians need to accept and adopt changes to the way they work. However, it takes time to change behaviours in secondary care. At present, hospital-based clinicians understand and support what Gwent Frailty is trying to achieve but many have yet to see the direct impact on reducing demand for secondary care, which inevitably raises concerns amongst some clinicians about bed reductions and staffing changes. The Health Board is in the process of remodelling services and as part of this is appointing community-based consultant geriatricians, which will help to change working practices and attitudes.
- Changes to how doctors, nurses, therapists and social workers work raises a number of issues around clinical governance, professional supervision, training and culture as they move from working within individual professional groups to multi-disciplinary teams and from hospital to community settings. These are recognised and are being addressed but are likely to persist for a while.
- Increasing the emphasis on supporting frail people in the community impacts not only on hospital ward staff and services but also on a range of support services which need to change in order to avoid hospital admissions, speed up discharges and smooth referral patterns to Gwent Frailty. For example, hospital pharmacy and physiotherapy services, which are outside Gwent Frailty but contribute to its objectives, do not currently operate at weekends or out of hours. Across health and social care, wider changes, such as seven day working, are necessary in order to better match capacity to demand.
- Aneurin Bevan Health Board: The current model is a medical/professional one and there are benefits in moving the current arrangements to include patient/carer self-referral, which some services had prior to Gwent Frailty being introduced.

Outcomes

Patient

- User and carer feedback on the services has been overwhelmingly positive, due to a focus on enabling frail people to remain independent in their own homes and considering their needs on a holistic, rather than condition led basis.
- More weekend discharges and reduced length of stay across elderly beds.
- Earlier diagnosis and timely interventions when they are needed.

Overall system

- Improved pathway for paramedics managing falls, freeing up time and availability to respond to other calls.
- Since implementation of the model, readmission for chronic conditions in the Aneurin Bevan Health Board area has fallen from 15% to 13% whilst it has remained at 15% in the rest of Wales.
- The impact of the programme has raised awareness of the potential for integration. The Welsh Government intends to roll the programme out across other Welsh Health Boards, which has already commenced in Cardiff and the Vale.

Workforce Comments

There were initially challenges in recruiting staff, which impacted on operational progress and the ability to optimise weekend capacity. These are now largely addressed. Offering secondment opportunities for A&E nurses also helped to tackle perceptions around the role and value of community nurses, and concerns about potentially being de-skilled.

Enablers

- Building integrated teams in the community from the outset is important
- Partnership working is effective; it will take time and effort to find the right metrics to demonstrate

this and a short term approach may give an incorrect picture of impact

- Where new ground is being broken an entirely new way of looking at the situation may be needed to determine what success looks like
- With the right leadership mindset, executive and political, at a local and national level, any barriers can be overcome over time
- Solve problems quickly and effectively, ensuring you consider patients' health and social care needs as a whole rather than individually

Barriers

Challenges and solutions:

- The Frailty Programme was introduced on a franchise basis, allowing different operating models to be tested in the five localities across Gwent, within overall core standards. This has recently been subject to review and actions are now being put in place to achieve a consistent operating model across the area. Issues that still need to be addressed are:

- The balance of admission prevention versus pull is still not right.
- Seven day cover from clinicians for rapid response is not yet available across the whole area.
- More consistent use of nursing skills across all five teams.
- Some GPs are still reluctant to refer.
- Take up from ambulance crews needs to be improved.
- Technology still needs refining to produce accurate and timely data.

- Demand has grown more rapidly than anticipated, meaning that the situation is contained rather than reduced. Work is being scoped to assess whether financial expectations should be revised from original ambitions given current demand patterns.

MIDHURST MACMILLAN COMMUNITY SPECIALIST PALLIATIVE CARE SERVICE

Target Client Group

The Midhurst service caters for approximately one-quarter of all patients needing end-of-life care in the area. The majority of patients supported by the service have a diagnosis of cancer, but the service supports a growing number of patients with other conditions including dementia, heart failure and neurological disorders. In 2010/11, 409 patients benefited from the service.

Purpose

The service seeks to prevent avoidable admissions into hospital, to enable patients with complex needs to be cared for at home, and to allow them to die in the place of their choosing. As a flagship end-of-life care model supported by Macmillan Cancer Support, the service acts as an exemplar for
successful home-based specialist palliative care services and an innovative model of co-operation between the NHS, the voluntary sector and the local community.

Point of Entry

Typically from a GP - Rather than rely on referrals from specific health care professionals, such as GPs, the service has encouraged referrals from all partners in care (including family and friends). This direct access to the service goes through a single point of entry, supporting effective decision-making and care co-ordination. . Referral criteria for the service are based on World Health Organization (WHO) and National Institute for Health and Care Excellence (NICE) guidelines for palliative patients. The NICE guidelines are statutory for specialist palliative services in the United Kingdom. Referrals often come from GPs and hospitals, but also from specialist nurses and community hospitals. Referral criteria are:

- severe, intractable complex symptoms that have persisted after palliative care by generalist
- patients and their carers having difficulties in adjusting to/coping with their disease, psychologically, spiritually or emotionally
- information and explanation is required relating to the illness, treatment, care options and allied support services
- patients and carers experiencing difficulties in bereavement, who would benefit from specialist

support/further psychological intervention
- to assess the need for further specialist unit services, ie, day care or inpatient carehealth care professionals require specialist advice and support with case management.

(Source: Midhurst Macmillan Service Referral and Discharge leaflet)

Referral is made to one of the clinical nurse specialists who act as the single point of contact for the patient and families. The CNS then assesses patients at their home, taking their wishes and needs on board.

Assessment

A CNS will carry out the assessment at the patient's home. If the patient is in a crisis, the CNS will see the patient on the same day and do what is necessary to alleviate the crisis before carrying out a full assessment, including an assessment of the carers. The patient is then assigned a status of zero, green, amber or red. Zero indicates no admittance to the service at this stage. Green indicates that there is a need for some low-level input that can be provided over the telephone. The CNS will visit occasionally to check on the patient's status. Amber indicates higher-level problems needing more complex interventions. A CNS will visit weekly and the clinical support team will be involved in providing care. A red status prompts several visits a week from the CNS and strong involvement of the clinical support team.

Care Coordination/ Case Management

Once a patient is admitted to the Service, care coordination proceeds according to the care plan. Continuity of care is delivered through the relationship between the allocated Clinical Nurse specialist (CNS) and the patient. The CNS holds overall responsibility for organising and co-ordinating care, while other team members retain responsibility for their aspect of the service and can arrange additional services without initial sign-off from the CNS. For example, the volunteer co-ordinator can arrange for help independently of the CNS. Information is shared face-to-face or by telephone, and all team members update their actions on the internal IT system, Crosscare. Following assessment and treatment, patients can be discharged and readmitted at a later stage if they need further specialist intervention; however, most patients are very near the end of their lives and die within a few weeks of being admitted. The flexibility of the service derived from its structure facilitates decision-making, enabling professionals to act quickly to fill gaps in care and adapt the care plan when circumstances change without going through the CNS. It relies on mutual respect and trust between staff within the Midhurst team.

Multidisciplinary Team

There are three types of staff in the Midhurst team: medical, clinical support, and non-clinical. The medical professionals focus on care management and care co-ordination, liaising with GPs, district and community nurses, specialists and other relevant medical staff to arrange or change treatment for patients. This role largely falls to the consultants, who take on the formal case manager role with patients, other team members and external providers. Consultants visit about 30 per cent of patients cared for by the service; of these patients, one-third require a single visit; the rest are reviewed more frequently. Outside the visits consultants are updated through weekly multidisciplinary team meetings and occasionally provide specialist medical procedures, such as paracentesis. A full list of procedures administered by the team in a patient's home is listed in the box below.

There are seven clinical nurse specialists (CNS) on the team who hold a caseload based on allocated GP practices. One CNS does not carry a caseload, but covers the cases of the other nurses if they are overstretched, ill or on leave. The clinical support staff consists of trained nurses and health care support workers who carry out the majority of the hands-on clinical care, with consultants and CNSs conducting more specialist procedures or providing care in emergencies. Although the CNSs do not usually provide hands-on care, they maintain their clinical skills to ensure that they are able to respond when urgent care is needed. The service also employs a physiotherapist and an occupational therapist, roles that are not typically involved in community-based palliative care. The two members of staff work interchangeably, conducting an assessment for both disciplines that often takes place during joint visits with the allocated CNS or a consultant. A counsellor works with patients and families pre- and post-bereavement.

Outcomes
Evaluation in progress

Workforce Comments
A key lesson of the Midhurst model of care co-ordination arises from the team structure and skill mix, with a fully integrated mix of consultants, senior nurses, health care support workers, allied health professionals and volunteers. Clinical staff are allocated to specific patients, enhancing continuity, and the floating CNS is able to pick up cases and respond quickly to urgent situations. Professionals have the time and freedom to conduct joint visits assessing medical, social and holistic needs at the same time, reducing the need for multiple visits. Volunteers are integrated into the service, supporting patients and carers as and when needed. Finally, knowledge about the patient and their circumstances is shared within the team through meetings and logged on the internal IT system.

In addition to the care process, other markers for success in the service include a passion and dedication among staff manifest in a positive team culture and a commitment to improving the patient's experience of care. This has been underpinned by a readiness to learn and reflect on quality of care and outcomes in a team structure with a flat hierarchy supporting devolved responsibility.

Enablers

- Awareness-raising and relationship-building :The service has built relationships with a wide range of key partners in care (GPs, community staff, social services, hospital consultants, volunteers and local people) that have ensured legitimacy and trust in the service, so ensuring its ability to 'capture' people nearing the end of life before, or very soon after, a hospital admission.
- Multiple referrals to a single-entry point :Rather than rely on referrals from specific health care professionals, such as GPs, the service has encouraged referrals from all partners in care (including family and friends). This direct access to the service goes through a single point of entry, supporting effective decision-making and care co-ordination.
- Holistic care assessment and personalised care plan : A single assessment process examines both the health and social care needs of the patient and their family and also takes into account their life situation and choices about future care and treatment options, and a personal care plan that uses clear criteria on patient need to initiate appropriate packages of care.
- Dedicated care co-ordination: The care co-ordinator (usually a clinical nurse specialist) plays a crucial part of the care process by acting in a number of roles: being the principal point of contact with the patient and their family and effectively coordinating care from the multidisciplinary team and the wider network of care providers.
- Rapid access to care from a multidisciplinary team: The rapid deployment of care professionals working flexibly and with the appropriate skill mix (including volunteers and non-clinical care) allows care and support to be initiated to meet the needs of people at home.
- Assigned accountability: Decision-making at the team level is made with clear role demarcation and an understanding of professional boundaries.
- Responsive provider network: Partnership working with GPs and community services outside of the core team is promoted to ensure services are co-ordinated and provided effectively. Significant effort is placed on effective communication of patient and family-sensitive information in the absence of linked care records.

What appears most important to the success of the approach, however, has been its ability to detect and provide a personalised and rapid response to meet people's needs at an earlier phase than other models as well as to have a community-based team with the mix of skills to maintain most people effectively at home.

OXLEAS ADVANCED DEMENTIA SERVICE

Target Client Group
The Oxleas service caters for people with a diagnosis of moderate to severe advanced dementia, complicated by complex mental and physical comorbidities requiring social care input, who are being supported to live at home (by family or paid carers). These patients tend to be in the last year of their lives with an average age of 75. The service has capacity to support up to 25 patients, as staff co-ordinate care in addition to their substantive roles.

Purpose
This model seeks to help patients with advanced dementia to live at home for as long as possible in the last year of life with support from family and/ or carers. The core team works with GPs, secondary care and social services to support carers in providing ongoing and palliative care. Staff respond to crises at home to prevent unnecessary hospital admissions where possible and reducing the likelihood that patients are placed in residential care: "The main aim is acting as a focal point for that carer in what can be an incredibly complex pathway… Liaising with other services and getting the support and equipment that someone needs to look after someone with quite advanced dementia at home.

Point of Entry
Referrals are accepted from a wide range of health care professionals and a standardised referral form is used to capture information which flows into a single system for assessing and allocating cases to care co-ordinators. Referral criteria for the service are based on the presence of a diagnosis of moderately severe or severe dementia as classified on the Global Deterioration Scale stage 6 or stage 7 plus at least one of the following criteria:

- the patient needs a more palliative approach to their care and the clinician would not be surprised if the patient were to die in the next 6–12 months
  OR there are
- recurrent infections, significant weight loss and poor nutrition level, recurrent fevers, pains, falls, severe pressure ulcers that are not easily amenable to treatment, severe physical frailty
  OR the patient has
- severe, persistent distress (mental or physical) that is not easily amenable to treatment OR another condition (eg, co-morbid cancer) whose co-existence with dementia means that more intrusive treatments would be less appropriate.

Staff in the Oxleas service use a mixture of case finding and referrals to locate appropriate patients. Community matrons identify relevant patients from their caseload; the consultant psychiatrist and APN see patients through their work with the community mental health team and can bring these cases to the dementia service. Referrals are made by email, telephone or face-to-face contact and are accepted from APNs, CPNs, psychiatrists, GPs, district nurses, continuing care nurses, hospices and mental health wards.

Assessment
There is no standard care package for patients with advanced dementia and other complex needs. Care is tailored to each person based on their primary need and the range of services available locally. As the disease progresses needs are re-assessed and care is adjusted accordingly

On identification the psychiatrist and a specialist nurse jointly visit the patient's home to conduct an initial care assessment led by the psychiatrist. The care assessment identifies the mental, physical and social needs of the person. It covers a wide range of topics including a full medical and psychiatric history, personal and social background, current medications, existing care package, equipment needs and end-of-life/spiritual wishes. A quality of life assessment ascertains their mental state and ability to carry out daily activities such as washing and dressing. This is followed by a needs assessment drawing out medical, psychiatric, sleep, nutrition and hydration, swallowing, mobility, continence and pain requirements. The carer undergoes an assessment to determine their financial situation, health status, mental state and quality of life, with levels of stress measured.

Care Coordination/ Case Management
The care co-ordinator takes on the role of primary contact with the patient and family. This role is filled by a specialist nurse with physical or mental health skills, eg, a CPN, APN or community matron. They do not receive any formal training, but are all experienced case managers.

In Greenwich care co-ordination is led by a consultant old-age psychiatrist based in the local mental health trust, working alongside community matrons. The rest of the team comprises a community matron (based in Greenwich), two specialist nurses (based in Bexley) and a dementia social worker. The service has capacity to support a maximum of 25 patients, as the staff have full-time roles and work in the service in addition to those responsibilities. From the start, the team conducted home visits as part of their existing workload, co-ordinating care with other care providers to ensure that patients' specialist palliative needs at home were met.

Staff liaise with community mental health services and general practitioners (GPs) to provide care in patients' own homes, focusing on supporting the carer and/ or family to provide palliative care for the patient.

- The patient is discussed at a weekly multidisciplinary team meeting, and a named care co-ordinator is nominated based on the patient's prevailing needs – physical, mental or social care.
- Following the meeting, a personalised care plan is produced with detailed action points. This is sent to the patient's GP and copied to the patient/ carer.
- The care co-ordinator oversees delivery of the care plan, conducting ongoing assessments and setting up a schedule of home visits with the family, liaising with relevant services and attending case conferences. Any changes to medication or the status of the patient prompts a follow-up letter to inform the GP.
- Once the patient's and carer's immediate needs have been met, the care co-ordinator visits the patient regularly as arranged with the carer. If a crisis occurs, they will try to visit on the same day. Although the service is available Monday to Friday, 9am to 5pm, staff are flexible and can usually be contacted by phone outside those hours. If the care co-ordinator is not available, carers are advised to contact the district nurses or failing that to seek help from the emergency services. In the event of a hospital admission, the care co-ordinator liaises with hospital staff to input into discharge assessment and planning.
- Patients on the service are rarely discharged, remaining on the caseload until they die or are admitted to residential care. In their last days and hours of life the district nursing service provide direct care. Following the patient's death, the care co-ordinator can provide bereavement support to the family.

As care co-ordination takes place at home, a patient should have a primary carer (normally a family member).

Multidisciplinary Team
Liaising with services in primary care and in the community is integral to the model. Staff have developed strong links with other professional groups including district nurses, social workers, occupational therapists, physiotherapists and relevant specialist services such as the speech and
language team. However, engagement with local GPs is variable and generating referrals has been problematic. This may be due to a lack of understanding or awareness of the service. The service has attempted to actively engage GPs, presenting to GPs at the launch of the new memory service in 2011 and visiting GPs; however, levels of engagement have not improved.

Although the service is integrated, the approach to co-ordinating social care differs between the boroughs. In Greenwich, patients known to the social services department in the local authority have a care manager in that service with responsibility for organising care packages, respite care and equipment. If the patient is not known to social services, a care co-ordinator from the advanced dementia service can carry out these tasks directly. In Bexley, a social worker with a special interest in dementia organises all the care packages.

Outcomes
Savings to local health and social care commissioners from these patients can be estimated at between £200 and £350 per week, saving upwards of £177,200 to £310,100 for these patients.

it was clear that carers and relatives valued the co-ordinator's role as the person responsible for organising care, and as problem-solvers

Workforce Comments
There is a clear, shared aim among staff in the service to help people in the latter stages of advanced dementia to live well and die at home, with a focus on bringing together physical and mental health. Staff are strongly rooted in their local communities and feel supported by managers to work in an integrated way.

Another interesting aspect is the importance placed on the role of the carer as an essential element of the team. Without the presence of an engaged, willing carer, none of the patients in the service would be able to stay at home. This aspect has wider implications for other care co-ordination programmes; an over-reliance on family support or informal networks can become problematic, placing them under undue stress.

Enablers

- The absorption of community services into Oxleas NHS Foundation Trust has instilled a sense of common purpose and joint working in staff.
- The team culture has created a strong yet flexible framework around its staff, supporting them to deliver high-quality, personalised care to patients at home and co-operate with professionals across traditional silos.
- Staff in the Oxleas service are motivated and possess detailed knowledge of services and professionals in the local health economy.

Barriers

- Providing an integrated service across two local authorities initially proved difficult as the health and the social care geographies do not correspond. Cross-borough working has now been implemented between the mental health and community teams and the Oxleas service is managed by a single person based in the Older People's Mental Health Directorate to facilitate integrated working.
- Size is a major challenge to the viability of this model. Commissioners may not take an interest unless the model is scaled up.
- Engagement from and with external providers has proved highly dependent on the local context and history. Links with specialist services such as speech and language therapy and existing relationships with other district nurses and community matrons work well.
- Wider GP engagement remains a challenge and is limited to contact on an ad hoc basis for individual patients. The lack of GP engagement could be linked to concerns that they do not want to refer patients to a service without the capacity to accept referrals, and the staffing to provide round the clock support to carers.
- Despite working for the same organisation electronic patient information is not easily shared between team members in the service. Community teams (district nurses, physiotherapists, occupational therapists) use a different version of the electronic patient record system, RiO, from the mental health team. Various mechanisms have been developed to overcome this barrier including copying case notes between systems, and information is shared at regular team meetings. Outside the service, communication with other care professionals such as GPs is conducted face to face, by phone or letter.
- Occasionally patients and their families have been unwilling to accept outside help such as care packages and it has taken time for team members in the Oxleas service to build trust with families struggling to navigate through the system. They have overcome this obstacle by visiting regularly to build trust and providing referrals to educational programmes and wider carer networks.

THE SANDWELL INTEGRATED PRIMARY CARE MENTAL HEALTH AND WELLBEING SERVICE

Target Client Group
The team targets people on the SMI register and receives referrals from secondary, primary and community care organisations as well as social care and probation services. Patients can also self-refer. The service is open to anyone over the age of 16 who is registered with a Sandwell GP. In 2012, the Esteem Team had a caseload of 168 patients.

Purpose
The key aim of the Esteem Team is to help people with mild to moderate mental health problems and complex social needs at an early stage to prevent deterioration and admission to secondary care services. It aims to empower patients to take control over their own lives by offering guided therapies and tools for self-help.

Point of Entry
The Esteem Team accepts referrals from multiple sources who have identified complex cases and actively targets people on the SMI register. The team will contact patients on the register proactively, phoning to inform them about the help they can offer and what steps they could take (eg, initial assessment). Patients come from all ethnicities and socio-demographic backgrounds, although the majority of patients come from deprived circumstances, reflecting the poor economic profile of the borough. In 2012, the Esteem Team had a caseload of 168 people. Patients suffer from depression and anxiety, with additional complex social and/or medical problems exacerbating their condition and preventing recovery. Issues include unemployment, debt, substance abuse, relationship breakdowns, domestic violence, poor housing and living circumstances, long-term illnesses or chronic diseases.

Assessment
Initially, the team employed two 'gateway' workers to carry out the first assessment of the patient and to decide if the Esteem Team was suitable for them. However, their role was not sufficiently defined and differentiated from that of the link worker, leading to duplication and confusion in responsibilities. Initially, there were no formalised referral criteria for the Esteem Team. This led to some inappropriate referrals, for example, sending people in acute crisis to the team rather than to emergency services. These inappropriate referrals stretched the team's capacity and led to the change of governance and management. Patients now receive a whole person assessment using an emotional needs audit tool, as well as an assessment of their physiological and social needs. Physical needs are assessed by the GP. If a patient's needs are not complex, they are referred to the services or to counselling.

Once a patient is referred to the Esteem Team, a link worker carries out an initial assessment as soon as possible (within three days of referral or immediately if the crisis appears to be acute), usually at the patient's home. The link worker uses tools such as Core 10 and WEMWBS (see Impact section), and takes a case history, listing all issues (clinical or not) that the patient may have. If the link worker identifies an urgent need, they will initiate interventions as required directly after the assessment, for example, contacting social services if there is a housing issue such as overcrowding. The link worker also identifies carers and informs them about services available to them through the Sandwell Wellbeing Hub such as respite, information and peer group support. They ensure they are put on the carers' register, which triggers an assessment and support process by the local authority and entitles carers to benefit payments. The Esteem Team meets weekly to discuss new and existing cases. Cases are assigned a colour code of red, amber or green depending on their complexity. They are allocated to a link worker based on expertise and availability. In some cases link workers will take on patients with whom they have had a previous relationship.

Care Coordination/ Case Management
The Esteem Team delivers only low-level interventions such as introducing the patient to relaxation techniques and self-help tools. Their main role is to act as care co-ordinators and navigators. They build strong relationships with the patient, their families and caregivers, gaining their trust and meeting them regularly at their homes or in the community to listen to any issues they may have and to actively work with

patients to jointly find solutions. The team employs six link workers who provide care co-ordination for complex patients. They act as patients' navigators through the health and social care system. They typically have a social worker background and/or personal experience with mental health problems. The Esteem Team can refer patients to a wide variety of statutory and voluntary sector services such as social services, debt advice agencies, substance abuse counselling, therapeutic services and peer support groups. Link workers form close relationships with their patients, building their confidence and self-esteem. They will visit patients at home and accompany them to appointments if required. Link workers will also show patients simple wellbeing interventions such as relaxation techniques, but the main focus of their work is care co-ordination. The Esteem Team's work is not time-limited: patients will be discharged from the service only if the link worker and the clinical co-ordinator agree on discharge using guidelines developed by the service.

Following assessment, the link worker visits the patient, creates an action plan and discusses suitable therapies. The action plan also includes steps to address a patient's social problems. The link worker arranges for referrals to services.

If needed, they will accompany patients to appointments, for example, when agoraphobic patients are too afraid to leave the house on their own. Throughout their relationship, the link worker seeks to bolster the patient's confidence and self-esteem by offering them step-by-step actions that the patients can implement at their own pace, creating a sense of achievement. The link worker will also invite the patient to use self-assessment tools to measure their wellbeing and to chart progress. If no progress is made, the action plan is revisited to discuss alternative therapies and services. The emphasis throughout is on empowerment to give patients control over their own lives and to make them more resilient for future crises.

Multidisciplinary Team
The Esteem Team consists of five link workers who co-ordinate care. A sixth link worker with sign language specialisation for deaf and hearing impaired people provides input as and when required. Link workers have a clinical or social worker background, and most will have either experienced mental health problems themselves or cared for a family member or friend with mental health issues. As part of the team review (see timeline above), the gateway worker role has been abolished. The link workers are managed by a clinical co-ordinator and support manager, who split the role between clinical work and managerial oversight. A clinical supervisor is also based in the administration centre, which receives and co-ordinates referrals to support the process and prioritise cases. The team have input from a dedicated local GP who provides medical oversight. A Maternal Mental Health Team is part of the Esteem Team and employs a further three link workers and two counsellors who provide dedicated specialist services to parents with mental health issues as a result of impending or recent childbirth, and additional social and/or health problems. Two South Asian workers funded by the voluntary sector also work on the team to support rollout among the South Asian Community. The two teams are co-located and cooperate on a case-by-case basis, but they do not hold joint team meetings.

Outcomes
Statistical analysis carried out by the commissioner shows significant levels of improvement on a clinical and a wellbeing scoring tool (the Core 10 and Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)). There was also a reduction in the percentage of patients with a diagnosis of clinical depression.

Workforce Comments
All members (including the GP) have experience of working with complex patients, either through professional or personal experience. This can be seen in team meetings, where staff express sympathy and encouragement and provide constructive input in the form of practical suggestions and offers of support, although the team administrator will intervene if she believes that team members add too many tasks to their workload. The positive team climate, the fostering of team and service user participation in the shaping of the service and the high levels of independence are all key to the success of the service. Recruitment practices also contribute – personal or professional experience with mental health problems is valued highly.

Enablers

- The IAPT programme has helped to unlock funding for primary care-based services. The flexibility and collaboration of the local IAPT team was integral to the team's success.
- The dedication and vision of the commissioner and of the local mental health lead GP were mentioned as indispensable to the service and its creation.
- The involvement of former service users and patients from day one in listening exercises that helped to shape the Sandwell Wellbeing Hub is another key feature. It helped to identify the failings of the previous system such as the lack of handover, discharge from services without follow-up, long waiting times and few community-based facilities and services, and enabled the commissioners and service users to co-produce the service that now exists.

Barriers

- Professional silo thinking hindered development, as the suggested approach of service delivery in the community and of user involvement in service design went against the grain of established practice.
- As well as convincing health managers, the commissioners also needed to convince the local authority that it was in their interest to co-operate and help with funding for certain posts. Commissioners describe feeling that many local staff had written off Sandwell, meaning there was no faith in the local community's willingness to improve wellbeing.
- In the absence of formal referral criteria many services (probation, social services, alcohol and substance abuse counselling services) would refer inappropriate cases to the team. The Esteem Team also received referrals of people with acute suicide risks, instead of them being sent to acute services.

COMMUNITY RESOURCE TEAMS IN PEMBROKESHIRE, WALES

Target Client Group

The CRT services are available to everyone with multiple health and social care needs at risk of hospitalisation (depending on team capacity). The majority of clients are frail older people, typically with dementia and multiple co-morbidities, such as cancer, respiratory illnesses and chronic heart disease (in 2012, the average age of people supported through CRTs was 74). Younger people under the age of 65 tend to have neurological conditions, such as multiple sclerosis (MS), motor neurone disease (MND) or Huntington's disease. Since the inception of CRTs, 1,469 people have had a relationship with the teams, of which 120 patients are currently actively case-managed by the four teams (July 2013).

Purpose

The main goals of the programme are to improve or restore the quality of life and confidence for people with complex health and social care needs, and to reduce avoidable admissions to hospital. The four community-based teams bring together professionals from health, social care and the third sector to provide care for patients at home.

Point of Entry

Referrals come from several sources: team members can introduce patients they are already caring for if they think they would benefit from a care coordinated approach. GPs also refer patients to the team, as do the hospital based teams, consultants and specialists.

Referrals come through a contact centre run by the local authority and staffed by social care assistants. The contact centre is advertised in the community as a calling point for people who feel they or their relatives may need help in their everyday lives. People can phone the contact centre directly and social care staff also use it to make referrals. The social care assistants take case histories using a holistic health and wellbeing template that also records economic and living circumstances. Once a referral is accepted, a professional help desk staffed by medical and social care workers assesses cases to determine the level of care needed. If a case requires face-to-face assessment, it is referred to the relevant CRT

Assessment
Patients referred to the service are assigned to a care co-ordinator based on the initial assessment provided by the referrer, the patient's location, team members' workloads, and whether they are already known to a team member.

Assessment of a patient's needs and acceptance as a CRT case is based solely on clinical knowledge and judgement of the health team and the expertise of the social workers.

The care co-ordinator visits the patient at home, tailors an individual care package in co-operation with the patients and their carers, and assigns tasks to CRT members and specialist staff. Care co-ordinators strongly encourage patients and their carers to create an emergency and contingency care plan in case a patient is admitted to hospital or if a carer falls ill. They also offer carers an assessment of carers' needs. Patients are given a risk-based code of red, amber or green, resulting in higher or lower frequency of visits and discussion at the team meeting. If a patient remains stable (code green) for several weeks, they are discharged from the service to lower level services. If their health deteriorates, patients can be admitted to short-term intermediate, residential or hospital care until their condition improves. If the deterioration is permanent, the patient may qualify for continuing health care and the CRT's involvement in care provision is reduced or stops. In future, predictive risk modelling will help both the triage process and case identification.

Care Coordination/ Case Management
Care co-ordinators act as the main point of contact for patients and work with the team and patients and carers to tailor individual care packages to enable people to stay at home.

Multidisciplinary Team
CRTs meet weekly to discuss cases. Meetings are chaired by a team co-ordinator who is responsible for disseminating information among team members and exchanging information with GP practices. Team co-ordinators also assign tasks to team members and follow up on implementation and outcomes. The team co-ordinator also has a caseload.

The four teams comprise social workers, occupational therapists, physiotherapists, district nurses, voluntary sector service brokers and specialist nurses. The two voluntary sector service brokers can arrange for additional services from local charities, such as befriending, dog walking or gardening. The team can also call on the services of dieticians, speech and language therapists, and other health and social care professionals. One team member acts as team co-ordinator. The teams meet weekly to discuss cases. The CRTs also work with three specialist teams in the acute sector to facilitate early discharge of patients with complex needs and to prevent unnecessary hospital admissions.

The teams each consist of community health care, social care and third sector staff. The weekly meetings are typically attended by district nurses, clinical nurse specialists, social workers, physiotherapists and occupational therapists from both health and social care, and volunteer brokers. Specialist staff, such as speech and language therapists, chronic condition nurse practitioners, community pharmacists, dieticians, and community psychiatric nurses attend on an ad hoc basis, depending on availability. Teams discuss patients, which interventions have been implemented by whom, and with what results. The team co-ordinator also checks that all interventions that were agreed for the person have been carried out and, if they have not, asks for reasons and solutions.

CRTs also co-operate with community teams based in secondary care and acute care teams.

Three community teams are based in the emergency department of the DGH. They co-operate with the CRTs to avoid unnecessary emergency admissions and facilitate discharge of patients with complex needs.

The Hywel Dda Health Board funds two part-time volunteer organisers who each attend two CRT meetings. Their role is to match patients to volunteer services available in the region to help them to stay in their home. There is a broad range of services on offer, from organisations arranging social outings for older people to

befrienders and day-sitters who offer respite care. Specialist charities, such as the Alzheimer's Society, provide information and peer support. Team members describe the involvement of the voluntary sector as a key feature of the service as it provides the low-level support that is frequently needed to enable people to stay at home.

Outcomes
Client satisfaction data collected in 2012 from 392 patients demonstrated that 55 per cent of people reported 'improved' or 'restored' confidence following CRT involvement with 38 per cent stating that they felt more independent. Data available for 2012/13 shows a decline in emergency admissions for patients with chronic heart disease (953 to 704). Length of stay for patients with diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease (CHD) is also below the mean of 5.5 days for the Hywel Dda Health Board, and emergency admissions for people with CHD dropped from 953 to 704 in the year 2012/13.

Workforce Comments
A key point to emerge was the importance of understanding and appreciating the roles of others and their potential for improving care co-ordination. Such relationships require time to develop: interviewees indicated that after 18 months of working in CRTs, much progress had been made, but that it still had some way to go.

Enablers
- Management interviewees clearly identified the early integration of health, social and third sector representatives in the project management board as a key facilitator.
- A history of co-operation between social and health care in both formal and informal ways.
- Improved care co-ordination for patients resulting from the collaborative approach ensures continued buy-in from staff.

Barriers
Systematic challenges
- The geography of Pembrokeshire leads to time consuming journeys for staff and the amount of informal care and support available from family and neighbours.
- Recruitment can be difficult. This has resulted in delays recruiting directors in both services after retirement left the positions vacant. This affected the pace of integration.

Organisational challenges
- Lack of clarity of roles within teams, for example, the exact accountability and responsibility of the team co-ordinators.
- Silo thinking between community and secondary care staff: CRTs mentioned a lack of understanding in the secondary sector of the time it takes to put a care package in place and discharge a patient safely.
- While GP engagement is a slow process requiring great effort from the project team.

The lessons from Pembrokeshire suggest that a 'maturity model' to integrated care exists, a finding suggested by other studies of integrated care in the UK (eg, Rand Europe and Ernst and Young 2012).

POOLE INTERMEDIATE CARE SERVICES (PICS)

Target Client Group
To improve the health and well-being of adults and older people by reducing inappropriate hospital admissions and facilitating early discharge to community settings.

Purpose
Designed to address the needs of the 28,000 over-65's in the area and its work began in December 2007.

Point of Entry
- A patient is offered "admission" to a virtual ward if a risk prediction tool identifies him or her as

being at high risk of a future emergency hospital admission.

- Patients remain in the community during their time on a virtual ward, and receive multidisciplinary care intended to maintain or improve their health status and reduce their risk of unplanned hospital admission. Care is delivered in person at the patient's home, by telephone and/or at a local clinic.

Assessment

Medical assessment is provided 9-5 throughout the week by four consultant geriatricians, working in a variety of settings. These include daily rapid assessment clinics (with access to the full range of hospital diagnostics), the Emergency department (screening all referrals for potential discharges, supported or otherwise), the medical assessment unit (screening these inpatients the day after admission) and in the homes of patients referred by GPs and community matrons. Similar case-finding efforts are made across all hospital wards by social workers within the teams, and in GP practices by our senior nursing staff.

Workforce Comments

There is an active and continuous programme of training for our care assistants, enhancing their role beyond the provision of personal care to patients at home by teaching such skills as nursing observation and phlebotomy. Our service accommodates attachments for trainee social workers and students from the school of nursing, and training in intermediate care is provided for our specialist registrars in geriatric medicine.

ANNEX B

SUMMARY OF IDENTIFIED FUNCTIONS FOR INTEGRATED ROLES

PURPOSE

This annex summarises the functions for integrated roles identified in the main report.

Most of the functions which have been identified are already being delivered through education and training within the wider system. However, integrated/ multidisciplinary working means that skills they may now be needed by new staff groups who would not traditionally be trained to do them.

The annex can be used to:

- Test and validate the specific requirements with stakeholders to establish the functions which will be carried out in multidisciplinary teams and the training required to support them. The outcomes of validation could be used as the basis for developing detailed specifications.
- Consider how the various requirements are most effectively delivered to support the development of integrated care.

• COORDINATOR ROLES

While the type of person acting care co-ordinator varied greatly, the functions of care co-ordinators have been reported consistently. Roles will need to be defined locally depending on local circumstances and the nature of the needs being addressed.

• Area	• Functions
Co-ordination	• Brokerage and advocacy skills[161]. • Liaising with other health professionals and coordinating the support required[162]. • Networking skills[163]. • Being the patient's advocate in navigating across multiple services and settings[164]. • Providing care directly in the home environment (by case managers with advanced skills)[165].

[161] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[162] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[163] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[164] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner
[165] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner

	• Ensuring that professionals within the multidisciplinary team are kept informed of the patient/carer's situation[166]. • Taking accountability for the provision of care and ensuring that care packages are put in place and delivered[167]. • Communicating with the wider network of providers (outside of the core multidisciplinary team) so that information about the patient/carer is shared and any actions required are followed up[168]. • Good communications and interpersonal skills[169]. • Good understanding of the local health or social care system[170]. • Building effective working relationships between care co-ordinators, multidisciplinary teams and wider service providers[171]. • Good 'people skills[172]. • Problem-solving skills[173]. • Negotiation and brokerage skills[174]. • Prescribing qualifications[175].

- **MULTIDISCIPLINARY FUNCTIONS**

The functions described below are drawn from different parts of the main report. How they are deployed in practice will vary depending on local circumstances and the nature of the needs being addressed.

• Area	• Functions
Interpersonal	• Communication skills, including under challenging conditions e.g. to take a detailed history from the person, ability to explain things in more than one way, give encouragement[176]. • Listening skills[177]. • Time/patience and the ability to build a rapport/relationship quickly[178]. • Empathy, listening and relationship building[179]. • Relationship styles of working that support co-production with the older person[180].
Values	• Compassion, empathy and respect[181]. • Respect for preferences and belongings[182]. • Timeliness, completing actions as promised, perceived expertise in tasks

[166] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner
[167] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner
[168] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner
[169] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner
[170] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner
[171] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner
[172] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner
[173] Case management: What it is and how it can best be implemented, Kings Fund, Shilpa Ross, Natasha Curry, Nick Goodwin, Nov 2011
[174] Case management: What it is and how it can best be implemented, Kings Fund, Shilpa Ross, Natasha Curry, Nick Goodwin, Nov 2011
[175] Case management: What it is and how it can best be implemented, Kings Fund, Shilpa Ross, Natasha Curry, Nick Goodwin, Nov 2011
[176] QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS ("Silver Book"), June 2012
[177] QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS ("Silver Book"), June 2012
[178] QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS ("Silver Book"), June 2012
[179] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010
[180] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010
[181] QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS ("Silver Book"), June 2012
[182] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010

	and the quality of relationships[183]. • Understand the need for individualised services including, e.g. for interpretation, sharing experiences in community centres or information[184] and disabilities such as deafness or visual impairment[185].
Knowledge of older people	• The likely needs and experience of older people[186]. • Treating older people with multiple needs in an holistic manner[187]. • Managing multiple conditions and co-morbidities understanding the other conditions that may affect the service user (esp AHPs)[188]. • The effects of ageing on the body, and what this means for various medical procedures such as taking blood (esp for nurses)[189]. • Additional specialist training in geriatrics and working jointly with acute consultants to enhance clinical skills relevant to older people for GPs and community medical staff[190]. • Specialist nursing skills in geriatrics, dementia, COPD and falls[191]. • Moving and handling skills[192].
Clinical	• Advanced skills to provide acute care in the community[193]. • Additional skills to allow them to carry out complex procedures and provide a fuller service to their patients' e.g. intravenous therapies, blood transfusion and inserting cannulas[194]. • Specialist skills such as advanced prescribing, intravenous therapies and practitioner skills to perform higher acuity interventions in the community setting for nurses[195].
Mental health	• Awareness of the early signs of dementia[196]. • Understanding the effects of mental health problems on the cognition of service users[197]. • Issues assessing "capacity" and the mental awareness of a service user and their ability to make decisions (esp GPs)[198]. • Mental health engagement with the community teams[199]. • Psycho-social support[200].

[183] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010
[184] The support older people want and the services they need, "Joseph Rowntree Foundation - Roger Clough, Jill Manthorpe, OPRSI (Bert Green, David Fox, Gwyn Raymond and Pam Wilson), Vicki Raymond, Keith Sumner, Les Bright and Jinny Hay, 2007
[185] The support older people want and the services they need, "Joseph Rowntree Foundation - Roger Clough, Jill Manthorpe, OPRSI (Bert Green, David Fox, Gwyn Raymond and Pam Wilson), Vicki Raymond, Keith Sumner, Les Bright and Jinny Hay, 2007
[186] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010
[187] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010
[188] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010
[189] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010
[190] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[191] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[192] QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS ("Silver Book"), June 2012
[193] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[194] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[195] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[196] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010
[197] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010
[198] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010
[199] Health Education England, Briefing in a minute – Integrated Care Pioneers Support programme, 02 December 2013
[200] The nursing contribution to chronic disease management: a whole systems approach. National Institute for Health Research Service Delivery and Organisation programme. Kendall S, Wilson P, Procter S, Brooks F, Bunn F, Gage H ,McNeilly E. 2010

Medicines	• Poly-pharmacy and helping older people manage multiple medications (clinicians, including GPs and nurses)[201].
Multidisciplinary team skills	• Multidisciplinary team working skills[202]. • Personal care training skills[203]. • Basic life support skills[204]. • Supporting patient transitions and providing patients with clear communication about their treatment and care pathways (and doing so in a timely way and in a way that recognises patients' own preferences[205]). • Mental health engagement with the community teams[206]. • Continuity of care through a recognised or named key person from health or social care[207]. • Ongoing shared review[208]. • Functioning ties or links across a wider primary care service network[209]. • Act as intermediary with multiple services[210]. • Ability to manage multi-disciplinary teams[211]. • Support for carers[212]. • Enable different staff members to perform simple interventions for each other (e.g. physiotherapists performing certain nursing assessments and interventions) to maximise each patient visit[213]. • Able to facilitate support for a variety of patient needs from physical exercise to psychological support of the dying and grieving[214]. • Networking skills[215]. • Dementia training for all workers[216]. • Improving clinical confidence to conduct better risk assessment and management across every element of the integrated and whole systems model[217]. • Single joint-assessment across different disciplines to minimise duplication and reduce the need for multiple staff to visit the patient[218].

[201] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010
[202] QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS ("Silver Book"), June 2012
[203] QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS ("Silver Book"), June 2012
[204] QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS ("Silver Book"), June 2012
[205] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010
[206] Health Education England, Briefing in a minute – Integrated Care Pioneers Support programme, 02 December 2013
[207] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010
[208] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010
[209] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010
[210] The nursing contribution to chronic disease management: a whole systems approach. National Institute for Health Research Service Delivery and Organisation programme. Kendall S, Wilson P, Procter S, Brooks F, Bunn F, Gage H ,McNeilly E. 2010
[211] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[212] The nursing contribution to chronic disease management: a whole systems approach. National Institute for Health Research Service Delivery and Organisation programme. Kendall S, Wilson P, Procter S, Brooks F, Bunn F, Gage H ,McNeilly E. 2010
[213] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[214] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[215] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[216] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[217] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011

	• Case management training across all disciplines[219]. • Training in health and social care to be able to provide service users with one person providing multiple services[220]. • Awareness of the importance of early intervention[221].
Case management	• Increased user confidence in managing their conditions, passing on self-management techniques, addressing patient and carer priorities[222]. • Case management skills[223].
Judgement	• Clinical reasoning and assessment skills[224]. • Ability to balance contrasting needs of a complex individual[225]. • Skills/ experience to make decisions on higher acuity patients[226]. • Enhanced decision making and risk assessment skills[227]. • Decision-making to identify and triage patients[228].
Local knowledge	• Services grounded in local communities[229]. • In depth knowledge of wider community services including pathways and criteria[230].
Experience	• - of older people and from a wide-range of settings[231]. • Both secondary and community sectors so that the team as a whole has knowledge of the resources and services available and has networks of contacts[232].
Pre and post registration training	• General concern that pre and post-registration training for the regulated professions did not providing clinicians with the competencies to meet the aspirations for older people[233].
New roles	• Additional skills so that they can administer care plans and free up the time of more qualified staff[234]. • Specialist liaison roles[235].

[218] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[219] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[220] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[221] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[222] The nursing contribution to chronic disease management: a whole systems approach. National Institute for Health Research Service Delivery and Organisation programme. Kendall S, Wilson P, Procter S, Brooks F, Bunn F, Gage H ,McNeilly E. 2010
[223] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[224] QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS ("Silver Book"), June 2012
[225] QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS ("Silver Book"), June 2012
[226] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[227] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[228] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[229] The support older people want and the services they need, "Joseph Rowntree Foundation - Roger Clough, Jill Manthorpe, OPRSI (Bert Green, David Fox, Gwyn Raymond and Pam Wilson), Vicki Raymond, Keith Sumner, Les Bright and Jinny Hay, 2007
[230] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[231] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[232] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[233] Healthcare Workforce Skills and Competencies for an Ageing Society, Age UK, 2010
[234] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011

	• Skills in re-ablement and care of the dying and grieving family[236]. • For extra care housing: care management, housing management, health symptoms recognition, building communities, managing staff, funding and finance, marketing and promotional skills[237].

[235] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[236] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011
[237] INTEGRATED CARE FOR OLDER PEOPLE EXAMINING WORKFORCE AND IMPLEMENTATION CHALLENGES, Centre for Workforce Intelligence, June 2011

ANNEX C

THE STAFFORDSHIRE CORE PRINCIPLES

See separate document.

ANNEX D

WORKFORCE BARRIERS AND ENABLERS

The enablers and barriers described below are derived from the documents reviewed during the evaluation.

WORKFORCE ENABLERS

Leadership and engagement

Local leadership and commitment have been essential[238] as has been the development of a clear joint vision[239] that actively encouraged the development of person-centred care co-ordination[240]. Shared values, a collective communicated vision, and efforts to achieve widespread staff engagement have been cited as strong facilitating factors[241]. Similarly, the importance of having an integrated management structure has been identified as a factor[242].

In Northern Ireland a 'parity of esteem' model afforded to each profession gives everyone involved the opportunity to take the lead in management. It enables and encourages health care professionals to move across to management roles, and widens the pool of potential managerial talent[243].

Existing good relationships

In Torbay, the existence of longstanding positive relationships between organisations was a significant factor[244]. Long-term association with the programmes was seen as essential in providing the 'leadership continuity' required to drive through innovation and change. Existing personal relationships between individuals has helped pilots to make rapid progress[245].

In South Devon and Torbay CCG[246], for some time Torbay has benefitted from strong primary health care services that were innovative and influenced early developments in whole-system thinking. This has benefitted local developments. The virtual wards have also benefited from existing good working relationships between care professionals across health, social care and voluntary sector and their knowledge of locally available services

Multidisciplinary/ interprofessional approaches

Coordinated leadership between different professional groups within a multi-disciplinary team is reported to improve understanding of the aims of initiatives. Ensuring staff feel supported in their

[238] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner, Oct 2013
[239] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner, Oct 2013
[240] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner, Oct 2013
[241] National Evaluation of the Department of Health's Integrated Care Pilots, RAND Europe, Ernst & Young LLP, March 2012
[242] Factors that promote and hinder joint and integrated working between health and social care services, SCIE, Ailsa Cameron, Rachel Lart, Lisa Bostock and Caroline Coomber, May 2012
[243] Integrated care in Northern Ireland, Scotland and Wales: Lessons for England, Kings Fund, Chris Ham, Deirdre Heenan, Marcus Longley, David R Steel, July 2013
[244] Thistlethwaite, P (2011) Integrating health and social care in Torbay: improving care for Mrs Smith. Kings Fund
[245] National Evaluation of the Department of Health's Integrated Care Pilots, RAND Europe, Ernst & Young LLP, March 2012
[246] South Devon and Torbay: Proactive case management using the community virtual ward and the Devon Predictive Model, Kings Fund, Veronika Thiel, Lara Sonola, Nick Goodwin, Dennis L Kodner, October 2013

professional roles was seen to be an important part of effective multi-disciplinary working[247]. Building integrated teams in the community from the outset is important[248].

Staff empowerment and commitment

Programmes have used a range of strategies to promote a strong ethos among staff to 'do the right thing' – for example: promoting the needs of patients before themselves; supporting knowledge-sharing; and enabling role substitution and subsidiarity through staff empowerment. Allowing professionals to use common sense (specifically for non-clinical care) meant that many had undertaken tasks that may not be strictly related to their professional roles, but have resulted in faster and appropriate intervention for the patient[249]. Another factor has been the dedication and energy of key staff.

Training

The provision of training was identified as a way to ensure that policies and processes are widely understood and that staff are competent to complete them[250]. Education and training specific to the changed staff roles has been seen to increase the chance of success[251].

Co-location

Co-location has been reported as an important element in the success of joint working. E.g. leading to greater levels of informal contact which in turn increases mutual understanding. It is reported to lead to quicker and easier communication and to facilitate learning across professional boundaries[252]. 'Virtual co-location' can also be an option, especially in rural areas. There are good examples virtually integrated teams in Wales. They require investment in setting them up and maintaining them[253].

Information and communication systems

Effective mechanisms to share information, including shared documentation and shared or compatible information technology systems have been factors identified as improving joint working, leading to speedier and timelier assessments of need. Effective communication was also reported to lead to cases being prioritised more efficiently[254].

Links with primary care and local communities

There was more likely to be effective interprofessional working when there was a functioning link with wider primary care services, as well as system's which allow for input from the older person and family carers and a recognised and named person in a key worker type role[255]. Similarly, services

[247] Factors that promote and hinder joint and integrated working between health and social care services, SCIE, Ailsa Cameron, Rachel Lart, Lisa Bostock and Caroline Coomber, May 2012
[248] Integrating health and social care in Torbay: Improving care for Mrs Smith Kings Fund - Peter Thistlethwaite, March 2011
[249] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner, Oct 2013
[250] Factors that promote and hinder joint and integrated working between health and social care services, SCIE, Ailsa Cameron, Rachel Lart, Lisa Bostock and Caroline Coomber, May 2012
[251] National Evaluation of the Department of Health's Integrated Care Pilots, RAND Europe, Ernst & Young LLP, March 2012
[252] Factors that promote and hinder joint and integrated working between health and social care services, SCIE, Ailsa Cameron, Rachel Lart, Lisa Bostock and Caroline Coomber, May 2012
[253] Integrated care in Northern Ireland, Scotland and Wales: Lessons for England, Kings Fund, Chris Ham, Deirdre Heenan, Marcus Longley, David R Steel, July 2013
[254] Factors that promote and hinder joint and integrated working between health and social care services, SCIE, Ailsa Cameron, Rachel Lart, Lisa Bostock and Caroline Coomber, May 2012
[255] A study of the effectiveness of interprofessional working for community-dwelling older people, NIHR - Professor Claire Goodman, Professor Vari Drennan (St Georges, University of London), Professor Heather Gage (University of Surrey), Professor Stephen Iliffe (University College London), Professor Jill Manthorpe (King's College London), December 2012

must be grounded in local communities[256]. Implementing systems of risk stratification can be important in engaging GPs and their staff.

Care co-ordination

The care coordination role appears has been crucial in enabling programmes to deliver their objectives effectively[257]. In one of the projects the appointment of health and social care co-ordinators was an important innovation in harnessing the contribution of all team members in improving care[258].

New roles

There is good evidence that the creation of new roles working across professional boundaries is considered an effective facilitator of integrated working. New appointments made to the partnership could help to change staff attitudes at other levels in the partner organisations[259] and help to overcome professional resistance to integration, acting as a shared resource[260].

WORKFORCE BARRIERS:

Organisational

The key barriers are the divide between primary and secondary care in the NHS and between health and social care. Differences in staff contracts, employment arrangements, funding approaches, and approaches to service provision build allegiances to the needs of specific organisations[261]. These can lead to operational and cultural barriers.

Managerial

Lack of clarity about authority for decision making and lines of responsibility can be a barrier[262], as can be the presence of separate management structures[263]. Lack of strong and appropriate managerial support was thought to undermine attempts to work across agencies and professional boundaries, leaving practitioners feeling unsupported[264].

Professional boundaries

Rigid and inflexible professional roles and concern about maintaining role boundaries in multi-agency teams undermine joint working[265]. Professional attitudes towards record sharing[266], concepts such as 'risk'[267] and mistrust in assessments made by other professionals[268] are also undermining.

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[256] The support older people want and the services they need, "Joseph Rowntree Foundation - Roger Clough, Jill Manthorpe, OPRSI (Bert Green, David Fox, Gwyn Raymond and Pam Wilson), Vicki Raymond, Keith Sumner, Les Bright and Jinny Hay, 2007

[257] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner

[258] Integrating health and social care in Torbay: Improving care for Mrs Smith Kings Fund, Peter Thistlethwaite, March 2011

[259] Glendinning, C (2003) Breaking down barriers: integrating health and care services for older people in England. Health Policy 65 (2), pp 139-151

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[261] Integrated care in Northern Ireland, Scotland and Wales: Lessons for England, Kings Fund, Chris Ham, Deirdre Heenan, Marcus Longley, David R Steel, July 2013

[262] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013

[263] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013

[264] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013

[265] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013

[266] Integrated care in Northern Ireland, Scotland and Wales: Lessons for England, Kings Fund, Chris Ham, Deirdre Heenan, Marcus Longley, David R Steel, July 2013

[267] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013

[268] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013

Electronic records

Lack of access to shared electronic health records can be a common issue as can incompatibility between health and social care IT systems. The consequential time burden related to communication is perceived to be heavy[269].

Communication

Poor communication between case managers and hospital staff is often reported as a barrier to co-ordinating patient care[270] as is communicating across professional or agency boundaries, particularly when staff are not located on the same site[271].

Engagement

Lack of involvement in the initial planning of services by some professionals (specifically health staff) is thought to have contributed to a perceived lack of understanding and appreciation of services and might lead to unwillingness to refer patients into the service[272]. Other issues cited in case studies included perceived lack of support and involvement on the part of the medical profession[273] and acute sector clinicians feeling excluded from the development and provision of intermediate care[274].

Lack of GP engagement has led to slower progress in developing effective care co-ordination and to ensuring referrals into programmes. A variety of strategies to improve GP engagement have been used e.g., financial incentives, information sessions and attending regular GP meetings. In many cases they have still not achieved the desired engagement with GPs (other than in south Devon, where virtual wards were hosted by GP practices)[275].

Cultural

Silo-based thinking and existing medical paradigms have been real challenges at the clinical and service level in some projects. Midhurst and Oxleas both needed to convince other care professionals, particularly specialists, that palliative care could be provided in people's own homes[276]. There has been reluctance to refer patients to programmes that were seen as outside existing professional norms and values[277]. In Wales, integration within health care remains difficult because of persistent cultural differences between the care sectors, lack of mutual understanding and the dominance of performance measures that are thought to relate exclusively to one sector or another[278].

Other cultural issues have included perceived imbalance of power between community and acute sectors and concern that new services might become dominated by the interests of acute services at

[269] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner, Oct 2013
[270] Case management: What it is and how it can best be implemented, Kings Fund, Shilpa Ross, Natasha Curry, Nick Goodwin, Nov 2011
[271] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013
[272] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013
[273] Challenges, benefits and weaknesses of intermediate care: results from five UK case study sites, Emma Regan, Graham Martin, Jon Glasby, Graham Hewitt, Susan Nancarrow, Dec 2008
Hilda Parker, University of Nottingham
[274] Challenges, benefits and weaknesses of intermediate care: results from five UK case study sites, Emma Regan, Graham Martin, Jon Glasby, Graham Hewitt, Susan Nancarrow, Dec 2008
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[275] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner, Oct 2013
[276] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner, Oct 2013
[277] Co-ordinated care for people with complex chronic conditions, Kings Fund, Nick Goodwin, Lara Sonola, Veronika Thiel, Dennis Kodner, Oct 2013
[278] Integrated care in Northern Ireland, Scotland and Wales: Lessons for England, Kings Fund, Chris Ham, Deirdre Heenan, Marcus Longley, David R Steel, July 2013

the expense of their partners[279]; perceptions that social work values, and in particular the social model, are not respected by health professionals and that the contribution of social workers is under appreciated within multi-professional teams[280]. Differences in professional culture were also believed to undermine the introduction of integrated systems, with some professional groups appearing not to appreciate or value the aims of integration[281]. There is also concern that there are language and wider cultural issues, such as understanding of user priorities (timeliness) as between health and social care.

Recruitment

There have been some difficulties relating to the recruitment and retention of both qualified and nonqualified staff[282]. For support staff, low wages and long, unsociable hours were perceived as particular barriers to recruitment[283].

Rurality

There has been particular difficulty in recruiting care workers and rehabilitation assistants to work in intermediate care services in rural areas[284]. Potential for professional isolation within small community-based teams and a lack of awareness of intermediate care were identified as deterrents by professional staff[285].

Demonstrating effectiveness

It takes time and effort to find the right metrics to demonstrate this and a short term approach may give an incorrect picture of impact Where new ground is being broken an entirely new way of looking at the situation may be needed to determine what success looks like[286].

[279] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013
[280] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013
[281] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013
[282] Challenges, benefits and weaknesses of intermediate care: results from five UK case study sites, Emma Regan, Graham Martin, Jon Glasby, Graham Hewitt, Susan Nancarrow, Dec 2008
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[284] NHS and social care workforce: meeting our needs now and in the future? Kings Fund, Candace Imison, Richard Bohmer, July 2013
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[286] Integrating health and social care in Torbay: Improving care for Mrs Smith Kings Fund - Peter Thistlethwaite, March 2011