

Personalised Integrated Care

Workforce development – theory into practice

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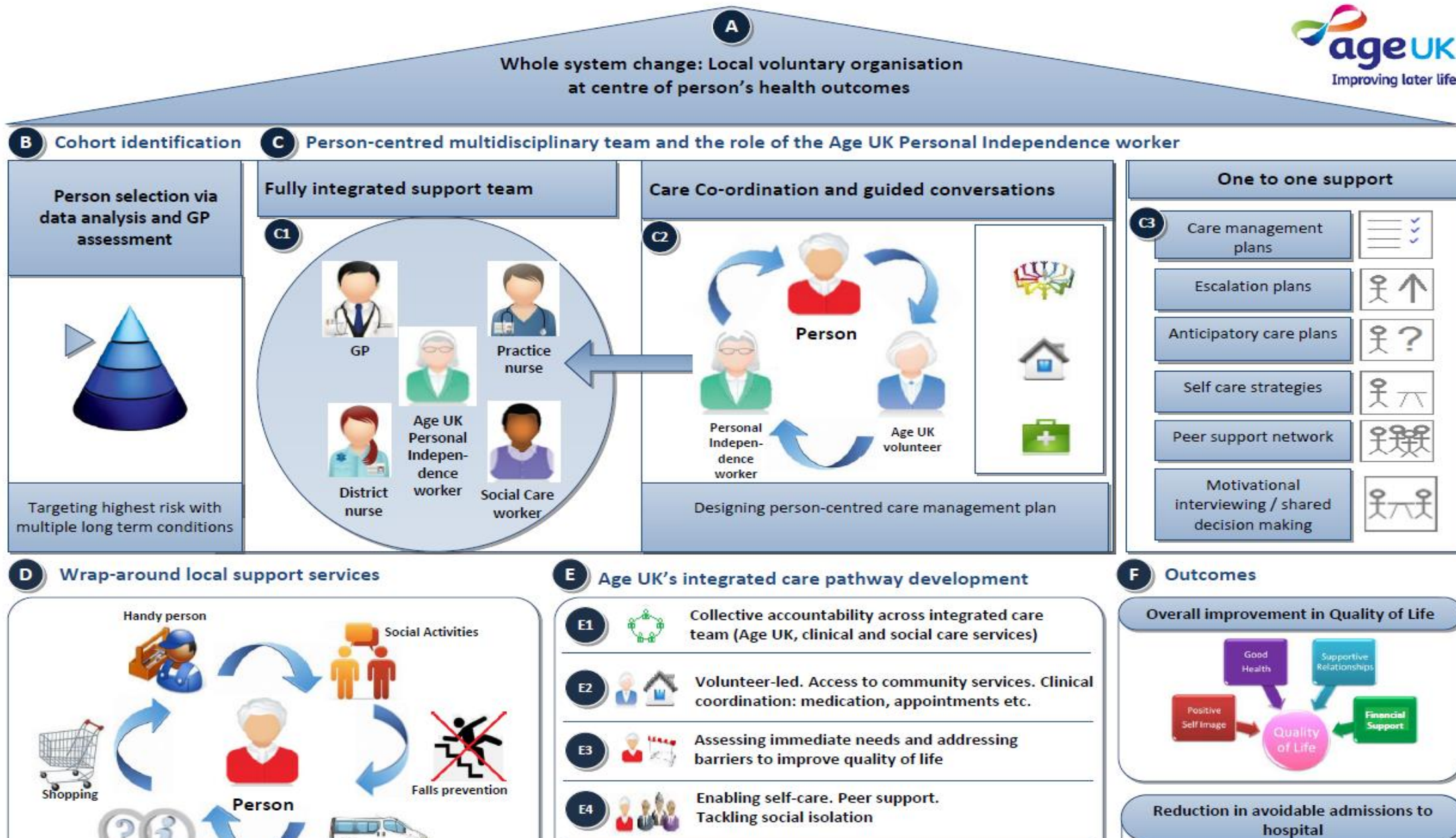
Head of Service Design

Personalised integrated care

Age UK

<https://youtu.be/8vDahAnSfVE>

The key features of the Age UK PICP model



The vision for the Age UK Personalised Integrated Care Programme



The journey

2011

- **Development of Proof of concept** by Improving Care – based on review of international best practice

2012-14

- **Newquay Pathfinder/ Phase 1 Cornwall Pilot** (1000 people showed promising results)
- Recognised need to test in other areas

2014-16

- **Phase 2 pilot sites** – Portsmouth; North Tyneside; Blackburn with Darwen; East Lancashire; Ashford & Canterbury; Redbridge, Barking and Havering, Guildford and Waverley, Sheffield

2016-17

- **Phase 3 - 5 new sites** – S Kent Coast, Northants, S Glos, NW Kent, Croydon,
- Several Phase 2 sites are recommissioned & significant interest across UK and Internationally

2017-18

- **Delivery of Phase 3** including go-live stock-takes
- Evaluation findings – qualitative national findings,



4 Perceived added value: which elements contribute the most to improved outcomes?

Three key elements of the model have proved to be critical in improving the planning and provision of integrated, holistic, person-centred care. While each has been effective in its own right, when combined these elements have delivered real benefits to older people (irrespective of their profile) and added value, especially to primary care.

The guided conversation and continuity of support

- Trusting relationships are built over several home visits, enabling the older person to express their desires and needs freely
- A conversation, not an assessment, that goes beyond asking 'What do you need?' by seeking to discover what the older person can do for themselves, with a little help
- Makes it possible for PICs to understand and address the client's reluctance to accept or seek help (from statutory organisations or elsewhere) and his or her motivation to make changes

Older people are treated as equal partners in a discussion that empowers them to identify their preferences and goals – and their strengths.

Care planning goes beyond a set of actions for health and care professionals to take. Instead, it focuses on how services and support can help ensure that older people's preferences are met and their goals are achieved.

Multi-disciplinary teams involving the PIC

- Provide an effective mechanism to:
 - establish and maintain trusting relationships and understanding of ways of working between various disciplines
 - improve understanding of the value the programme offers
- Shift the discussion and solutions away from a medical model
- Facilitate timely access to coordinated care

MDT working builds a shared understanding of the contribution that different practitioners can make to improving the care and the health and wellbeing of older people.

Older people receive more coordinated care and support that recognise their holistic needs and preferences.

PICs' local knowledge and support that extends beyond 'signposting'

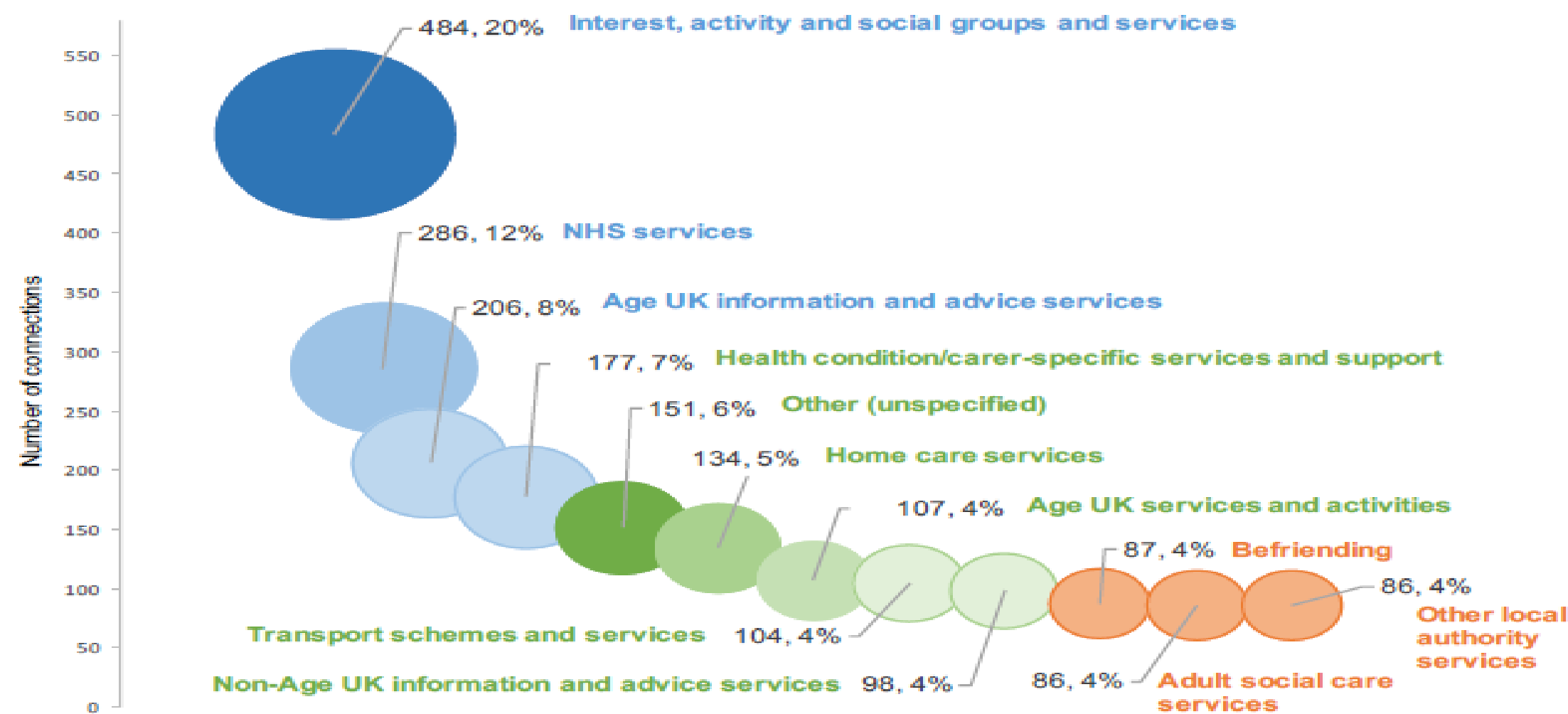
- Tacit knowledge which extends beyond 'what's on paper or a directory'
- Follow-through support helps to address the barriers to accessing care and support:
 - for clients: support consists of 'doing' and enabling connections in a way that signposting alone does not achieve
 - for GPs and healthcare professionals: follow-up support to chase other statutory services and make visible the community offer

PICs are a single and trusted point of contact to access diverse care and support.

Older people are motivated and supported to take action to achieve their goals.

People and services are connected in the community.

Figure 4.2a: The top 12 services, activities and groups clients were connected with to achieve their goals



Improving the quality and experience of care and its delivery

The PICP has improved the quality and experience of care and its delivery by:

Improving care coordination and facilitating timely access to more responsive, and sometimes, opportunistic care and support to meet older people's needs and preferences

Facilitating a more holistic, person-centred approach to care planning and helping to shift the conversation from a purely medical model

Bonus: responding to unmet and unidentified need

The support provided through the PICs has been effective in **answering previously unmet need** by filling a gap in existing statutory primary, community and social services

The programme has also **uncovered and responded to unidentified need**, supporting 'right care, right time, right place'

Supporting People to Live the Lives They Want to- Helping People Change

- Awareness of Living Well and Care Act Principles
- Understanding Well Being
- Understanding the role of the community in relation to a person's well-being.
- Understanding the impact of interdependency and dependency
- Understanding how behaviours can impact on a person
- Ability to use reflective tools and practice
- Confidence to challenge own practice and that of others
- Recognition of paternalistic practice

Straight from the mouth

“The PICs have helped to reframe the discussions in the MDT meetings, it makes the discussions more holistic.

We start to think outside of the box about the things we can do to improve people’s overall health and wellbeing and not just the conditions they are suffering from.

In many cases [the PICs] have been able uncover social issues and the underlying presentations of these patients that weren’t obvious to us beforehand.

The PICs would come back to the MDT meeting and mention it and that would help us to look at how we would care for that individual, informed by that softer knowledge.”

Professional stakeholder (Redbridge, Barking and Havering)

“[The PIC] will often identify a health need in a patient she has been seeing. She has been able to identify cognitive problems that we didn’t realise patients had, and opportunities to improve meds management, and she has been able to help us become involved in things like Power of Attorney decisions.”

Professional stakeholder (Ashford and Canterbury)



The magic ingredients



The guided conversation with older people, and the continuity and duration of the support has been effective in enabling:

- Older people to become equal partners in a discussion that empowers them to identify their preferences and goals
- More personalised, holistic care planning focusing on how services and support can help
- ensure that older people's preferences are met and their goals are achieved

Multi-disciplinary working involving Age UK PICs has been effective in:

- Building a shared understanding of the contribution that different practitioners can make to
- improving the care and the health and wellbeing of older people
- Shifting the conversation from a medical model to more holistic care planning for older people
- Facilitating coordinated care and support that recognise older people's holistic needs



Workforce development in practice

- **Identify roles of each practitioner in the new staff and volunteer teams:** appointment of lead contact for older person based on need
- **Shared training and development** on values, person centred care and process of the Age UK 'Guided Conversation' with each patient
- **Recruitment & selection :** based on values of person centred care
- **Co-location where possible:** to build strong teams which have trust
- **Focused service design:**
 - enable people to have opportunity to influence/shape the service
 - include 'contracts' with patients to adopt a model of self-care to help to maintain independence and manage costs for the cohort
 - include patients education relating to their condition

Care pathways & clinical governance: what does it involve? – **wider than front line delivery**.....

- ✓ **Integrating the voluntary sector with multi-disciplinary teams**
 - ✓ **Aligning the Personal Integrated Care pathway with local service redesign and service improvement strategies and initiatives**
 - ✓ **Establishing clinical governance arrangements** for patients in the cohort GP/Hospital/out of hours care
 - ✓ **Developing a pro-active response if unplanned admission occurs:**
e.g. red flag process if a patient has a crisis at any point in the 12 months
 - ✓ **Community mapping** to identify and establish wrap around services to support older people achieve their goals
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Common challenges associated with delivering the model

The evaluation highlights some common challenges experienced across the pilot sites:

Engaging GPs. Consistently securing genuine GP involvement, crucial as it is, has been challenging for sites delivering the service through individual practices. Further embedding the

PICP within primary care will be critical to its sustainability.

Accessing local health data and active performance management. Problems accessing

HES data have limited sites' ability to track and evidence outcomes and have increased

dependency on GPs to create the risk stratified lists of eligible older people.

Involving volunteers. For all local Age UKs, recruiting volunteers, and having a timely pool of volunteers who match clients' needs has been difficult. Only four sites have used dedicated PICP volunteers. It is essential to invest time and resources in recruiting enough volunteers and in enhancing their effective training, management and support.

Addressing mismatches between existing community offers and clients' interests. Given the pilot's duration, few sites have tried to address gaps in the local community offer. However, stakeholders from several sites recommended exploring the feasibility of establishing new, sustainable community offers to better meet some clients' needs.

