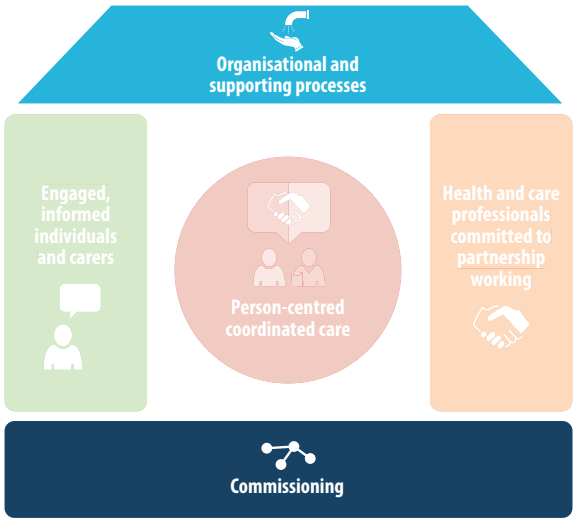
NHS
Improving Quality

LONG TERM CONDITIONS CASE STUDY

Volunteer-led support within the MDT helps older people to achieve their aspirations, improving quality of life and reducing costs across the system



Summary

- Trained volunteers work within multi-disciplinary locality teams to coordinate personalised support for 'at risk' older people
- Support is developed from a 'guided conversation' with the individual that aims to understand and support their personal aspirations and to develop confidence and resilience
- Shared care management plans define the potential interventions available from health and social care and the support and services available across the wider community
- Delivered significant benefits including increased wellbeing and reduced costs across the health and care system

Background

Age UK in Cornwall and the Isles of Scilly was commissioned by NHS Kernow CCG to set up a new model to provide targeted practical support to 'at risk' older people. It aimed to build these people's self-confidence and self-reliance and to help them achieve their aspirations. It was anticipated that this would lead to improvements in quality of life and reduced dependency on health and social care and fewer hospital admissions.

Trained Age UK volunteers were introduced as Promoting Independence in People (PIP) key workers into the multidisciplinary locality team (MDT) in Newquay. The volunteers would work with older people and their carers to understand their needs and aspirations and to work with the MDT and others to deliver a personal, coordinated and flexible response.

Action

Patient cohort

People were selected using a primary care risk stratification tool. They were included if they had a high risk of hospital admission and at least two long term conditons that had the potential to be managed in the community. The team felt that the approach would not improve care for patients with a terminal diagnosis or clinical need for regular hospital admissions, so they were not included in the cohort.

The final pilot cohort consisted of 106 people, mostly female and mostly aged over 85. Only 27% of the cohort had on-going social care packages.

Locality MDT and shared care management plans

The MDT integrates district nurses, community matrons, GPs, voluntary sector staff, therapists, social workers and case coordinators. It was essential that organisations involved in the pilot understood their respective roles and responsibilities. This was achieved through discussion and engagement, and practically demonstrated in their successful approach to development of shared management plans.

An overarching frailty management plan is accompanied by specific plans for each of the long term conditions identified and every plan includes a protocol for clinical escalation.

By using the approach of the volunteer within the MDT, the shared care plans are much more holistic and richer in content because they are bespoke to each individual. In addition, the people with whom the MDT can engage to deliver the plan is much wider; the MDT is able to bring in a variety of organisations in the local communities that have not been included in this way before such as community police support workers, clergy, British Legion, dog walkers, and befriending schemes.

Volunteer role

The volunteers were managed by Age UK and underwent a specific tailored training programme including motivational coaching techniques. To work effectively within the team the volunteers needed to be able to access patient information and contribute to the records. Work was undertaken by Age UK, supported by the CCG, directly with each MDT and the GPs to secure agreement with this process.

The volunteers receive continued support and mentoring through Age UK and the clinical team once they are established in post and many have progressed on subsequently to lead the training of new volunteers within Newquay, and other areas in Cornwall as the programme has spread.

The process is initiated through a ‘guided conversation’ between the individual and a volunteer. This includes elements of motivational coaching, supportive questioning and active listening in an unhurried manner to find out from the individual what their aspirations are. The approach was designed to build self-confidence and personal resilience, avoiding the creation of a new type of dependency on any specific individual or service.

This information is then shared with the wider MDT back at the practice and the process of creating the shared care plan begins, pulling in specialists, local clinicians, social care, the voluntary sector, and local community organisations to work with the individual collaboratively.

Crucially, the ability to draw in a wider range of support services from beyond the health and care system has significant advantages. It helps individuals to re-engage with their community, stops them becoming dependent on the MDT or specific volunteers within that MDT, fosters self-care and independence and helps build resilience to combat loneliness and isolation.

Performance management

Health and social care partners have agreed a joint performance framework which has been developed using a social impact bond model (see 'further information' below for further details) with Age UK as the central data processor.

Challenges

One of the key success factors was the engagement between Age UK, GPs and the traditional MDT. It required considerable time and patience from all stakeholders to build the relationships and trust necessary for this to work. Without this, traditional fears and reluctance around sharing data, access to patient information, and crossing perceived role boundaries would have prevented any real progress or change. This took many hours of preparation, numerous discussions and negotiations. Success with one practice was not assumed to guarantee immediate and identical success with another and each set of people was listened to and worked with individually.

Impact

The initiative has demonstrated significant improvements in wellbeing and a reduction in costs across the system:

- 23% improvement in people's self-reported wellbeing
- 87% of practitioners say integration is working very well and their work is meaningful
- 30% reduction in non-elective admission cost
- 40% drop in acute admissions for long term conditions
- 5% cost reduction for adult social care and a drop in demand for social care services.

In addition, there have been other benefits from the approach. At the start, none of the people in the cohort were providing any community or peer support to others. Twelve months after the pilot, 10% were involved in providing this kind of support, building wider social capital. This has positive messages for sustainability and giving back something to local communities who are supporting the work. It also shows how other large organisations beyond health and care can build engagement and grow communities without large investments of money.

The finding that 87% of practitioners say integration is working very well and their work is meaningful is important when looking at scaling up this work. It provides powerful data to share with new MDTs, people engaged in workforce redesign more widely across Cornwall and those involved in health and social care education and training for the future.

TOP TIPS

- **Trust is essential to an integrated team:** Trust is needed to discuss sensitive issues and work together to find a solution. It was important that volunteers were regarded as full members of the team. They are recruited, trained and work to a specification in the same way as paid staff, the difference being they give their time freely.
- **Empower people on the frontline and find the pioneers:** People on the frontline are best placed to redesign services around individuals, and those who are interested and passionate can often achieve more than those who are 'in charge'.
- **Think about language to overcome organisational and cultural boundaries:** The terms 'people and practitioners' were used rather than 'patients and professionals'.

Further information

More information on social impact bond model
www.gov.uk/social-impact-bonds

Newquay pathfinder pilot report
www.icase.org.uk/pg/cv_content/content/view/127504

'Living Well in Cornwall' video
www.icase.org.uk/pg/cv_content/content/view/121597/network?cview=83816&cindex=1

Newquay pathfinder case study on NHS England learning environment website
https://learnenv.england.nhs.uk/pinboard/view/43

Contact

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