Blended Roles Trailblazer

Integrated Care and Wellbeing Scrutiny Panel

12 March 2020

Tameside Metropolitan Borough

NHS Tameside and Glossop Clinical Commissioning Group

Blended Roles Trailblazer

Better care for older people and better jobs for care staff - messages from a trailblazer blending health and care worker roles in the community

- The Greater Manchester Adult Social Care Transformation Programme has recently reconfirmed its priorities - one of which is Living Well at Home - with associated work programmes underpinned by cross cutting initiatives such as workforce
- The Adult Social Care Transformation Programme aims to encourage ‘bottom-up’ development and spread of innovative ways of working through rapid testing and roll-out by those that deliver services locally
- A series of small projects were implemented across Greater Manchester, with multiple ‘trailblazer’ teams engaged simultaneously. Combined, these individual projects provide an opportunity to re-cast the operating model

Blended Roles Trailblazer

This trailblazer aimed to explore how we might work in a more integrated way across health and social care at a neighbourhood level. This was informed by feedback that:

- People often reported a disjointed experience with different services delivering separate components of care in isolation
- A lack of coproduction and person-centred conversation with only limited community connecting
- A focus on task and time rather than a strengths-based approach to care and support
- Providers experiencing on-going problems recruiting and retaining staff
- Communication between health and care professionals was often poor

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- Aims:
  - Further facilitate a more person centred approach
  - Joined-up support and improved continuity of care - fewer knocks on the door
  - Address issues around recruitment and retention of staff in homecare
  - Improve job satisfaction and the image of homecare role
  - Improve career progression
  - Better integrate neighbourhood services
  - Free up district nurse capacity
- Piloted in West neighbourhood over spring/summer 2019

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- What we decided to do:

- Find a way for homecare staff and district nurses to work more closely together
- Focus on low level health tasks that district nurses do but which you don't need to be a district nurse to do – tasks that individuals and family members are routinely shown how to do
- Set up a pilot in our West neighbourhood focussing on pressure area care/basic wound care/body map and skin observations
- Two zoned homecare providers and the district nurse service

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- **Approach of pilot**

- **Improved integration between providers and district nurses** – better communication and contact through named team members/named nurses, shared contact details and provider attendance at weekly safety huddles

- **Development of a joint care plan – the 'care bundle' - and competency document –** suite of care planning documentation for use by LWAH providers and district nurses including competency sign-off

- **Trained and competent homecare workers -** homecare workers receive refresher awareness training re pressure area care and care bundle paperwork

- **40 High intensity users (HIU) of pressure area care support identified –** named team members are trained in the delivery of low level/low risk healthcare tasks appropriate to only that individual's care needs, have access to district nurse support, appropriate clinical governance, joint assessments and competency sign off

- **Co-location and attendance at MDT meetings –** where possible providers spending more time in neighbourhood office and attending team huddles/team meetings

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- Impact of pilot
- All 12 staff surveyed report that the new way of working has made a positive difference to the care they have been able to provide
- 92% of that staff group surveyed reported that the new way of working has made a positive difference to their job satisfaction

“Things have really changed since the project began for myself and my clients as now we have the knowledge of what to look for and how to deal with it. Myself and my colleague have managed to keep all pressure areas under control without the need for a dressing or contacting the district nurses. We have a weekly meeting with district nurse at the client’s homes in which we share any concerns we may have had within that week, district nurses also do their weekly pressure checks”

Niamh at Comfortcall

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- User care is now more joined up with joint team meetings, joint care planning and a nominated single point of contact
- Reduced risk associated with poor communication across organisational boundaries (e.g. escalation of physical or mental health and care issues that isn't noticed or communicated)
- Improved communication between providers and district nurses means less need for users to repeat conversations or to negotiate with multiple organisations/individual and more continuity of care
- Reduction in users waiting for interventions (e.g. being bed bound awaiting a district nurse to change a wound dressing).

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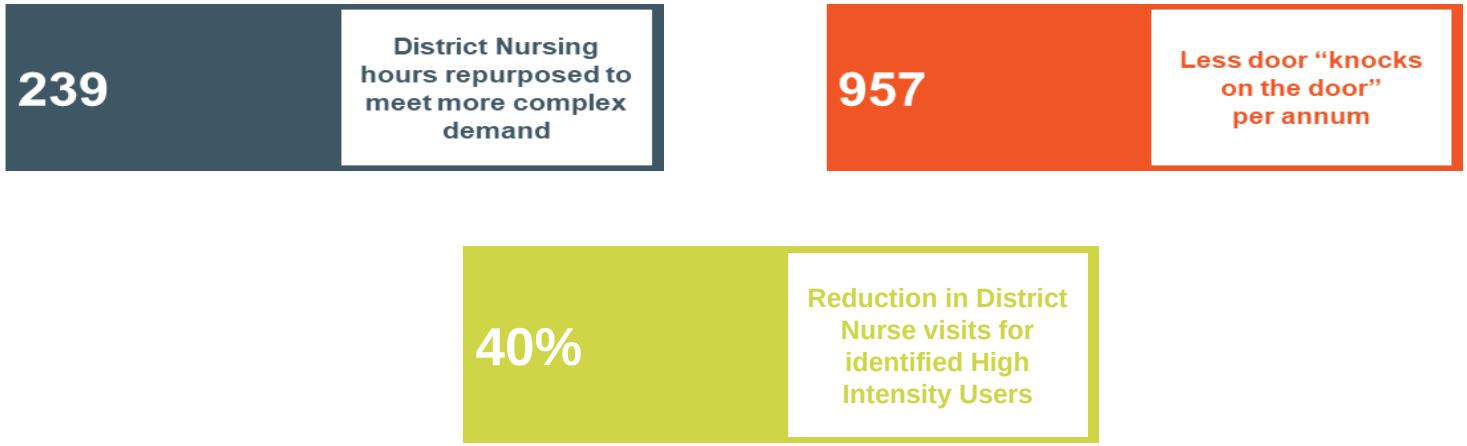
- Based on the 40 people requiring a high level of pressure area care support (HIU's), it is estimated that over a full year this would result in 205 fewer district nurse visits, a 21.4% reduction. 51 hours of "patient facing" time (15 minute slots) can therefore be repurposed to meet demand

- If the approach was rolled out completely across West neighbourhood to the remaining HIU's, 957 fewer district nurse visits would be required. This would free up 239 district nursing hours to complete more complex nursing tasks



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- What next?

- Roll out across West permanently and the three other neighbourhoods
- Insulin (via dial-up pen) being piloted in South
- All six providers ready to go with the full range of tasks identified
- Other tasks for the future:
  - Tracheostomy care
  - Gastrostomy care
  - Blood glucose monitoring
  - Bladder washouts
  - Nutritional assessments
  - Eye drops, non-post op
  - Catheter care/hydration/UTI management and prevention