PC

Ymchwiliad i ofal sylfaenol

Inquiry into primary care

Ymateb gan: Cyngor Gofal Cymru

Response from: Care Council for Wales

Primary care inquiry by the Health, Social Care and Sport Committee -

Care Council for Wales response

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Introduction

1. The Care Council for Wales is responsible for regulating, promoting and developing the social care workforce. We are a Welsh government sponsored body. In April 2017 our remit will expand to include research and improvement and we will have a new name – Social Care Wales.

2. In line with our remit, our response mainly deals with the second item on which you are seeking views, namely **the emerging multi-disciplinary team** in primary care GP clusters, in particular the role of the social work service and domiciliary care.

3. The Social Services and Well-Being (Wales) Act, 2016 emphasises the need to deliver integrated services which have been designed around the needs of the individual. We will be supporting the social care workforce to adapt to this change by providing training and support.

Care and support at home draft strategy

4. We have recently produced a draft strategy on care and support at home for the care sector, written in partnership with the sector. We have sent the strategy to the Minister for Social Services and Public Health and we expect to receive her endorsement in the coming weeks before the strategy is formally launched.

5. There are a number of key messages from the draft strategy which we believe will support the committee's inquiry into multi-disciplinary teams in GP clusters. Once the strategy is published we would be pleased to share a copy with you.

6. One of the strategy's key messages is that care and support workers do not have parity of esteem, when working in multi-professional teams, despite usually having most contact with individuals and a good understanding of their needs and aspirations.

7. The draft strategy reflects the growing importance of providing care and support at home, rather than in hospitals or residential care home. In this context it will be important to establish effective co-operation between GP clusters and domiciliary care services. It will be important for the committee to consider models of how this effective partnership can be achieved.

8. Similarly the relationship between the social work service and GP clusters is a matter of key importance. The social work service plays a central role in providing care, support and protection for vulnerable people in our communities. Therefore it is vital they have a strong relationship with GP clusters. Again, it will be important for the committee to consider this area.

Evidence on the benefits of working in multi-disciplinary teams

9. In preparing our draft strategy for care and support at home, we commissioned a literature review by Social Care Institute for Excellence. The evidence suggests that joint working can improve the standard of care, promote more holistic service provision, and encourage collaborative learning.

10. In particular there is evidence about the benefits of co-operation between GPs, social care staff and others to support people dying at home. The evidence suggests that 'that encouraging practitioners to share past experiences and foster common goals for palliative care are important elements of team building in interprofessional palliative care. Also, establishing a team leader who emphasises sharing power among team members and addressing the need for mutual emotional support may help to maximise interprofessional teamwork in palliative home care[1]'.

11. Similarly, the Commission on Improving Urgent Care for Older People (2015), setting out the principles for redesigning services that better meet the needs of older people, supports greater use of multidisciplinary and multi-agency teams, both hospital and community based, suggesting that for frail patients 'there is evidence that comprehensive geriatric assessment – underpinned by a multidisciplinary approach – leads to better outcomes.' For instance, examining the impact of the Westminster Falls Service, which provides a multidisciplinary falls risk assessment and targeted intervention for people referred following a fall, or who are at risk of falling, the Commission on Improving Urgent Care for Older People reports that people followed up a year post-discharge reported 60 per cent reduction falls, 55 per cent fewer fractures, 92 per cent fewer A&E admissions, and an 80 per cent reduction in GP appointments compared to the year prior to intervention. There are examples of similar integrated teams across Wales, e.g. the Gwent Frailty service and you may find the evidence from schemes funded via the Intermediate Care Fund useful to your enquiry.

12. The use of an integrated multidisciplinary approach is supported by the literature, as a way to meet the multifactorial needs of complex dementia-related conditions. The evidence

[1] SHAW, J. & ET, A. 2016. Interprofessional team building in the palliative home care setting: use of a conceptual framework to inform a pilot evaluation. Journal of Interprofessional Care, 30, 262-264.

suggests that joint working can improve the standard of care, promote more holistic service provision, and encourage collaborative learning. Some papers however caution that multidisciplinary services may require specific, appropriate commissioning and that integrated may increase demand for services but not necessarily clinical outcomes[2].

13. Research suggests that the most successful multi-disciplinary teams are those which are designed around the needs of the individual using services. A King's Fund study about the most effective approaches to integration found that "the central plank of success … in shaping service around the individual receiving services.[3]"

14. This approach is supported by National Voices, a coalition of individuals who use services. They describe integrated care as 'person-centred coordinated care'. For an individual using care and support, this means: "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[4].

15. This emphasis on the individual's needs underpins the approach to integrated services in the Social Services and Well-being (Wales) Act, 2014, which sets out the strategic approach to the regional design and delivery of the health and social care services.

16. Whilst such strategic frameworks are important, the evidence is clear that the most effective integrated services are those which have developed from the bottom up. In its report on integration, one of the King's Fund's main points of learning was that those planning multi-disciplinary teams should "start from the bottom up by bringing together frontline teams and align these teams with general practices and their registered populations".

[2] DAWSON, A., BOWES, A., KELLY, F., VELZKE, K. & WARD, R. 2015. Evidence of what works to support and sustain care at home for people with dementia: a literature review with a systematic approach. BMC geriatrics, 15, 1.

[3] 'Integrating health and social care in Torbay Improving care for Mrs Smith Implications for people who use services and carers', Kings Fund, 2011, Peter Thistlethwaite (PDF)

[4] 'A Narrative for Person-Centred Co-ordinated Care', National Voices