Good Governance Institute

CARE ENGLAND
Representing independent care providers

Innovations in Care

A collaborative white paper produced by
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Innovations in Care:
a white paper from the Good Governance Institute

Editors: Professor Martin Green, Andrew Corbett-Nolan, Donal Sutton, and Dorothea Baltruks

The Good Governance Institute (GGI) is an independent organisation working to improve governance through both direct work with the leaderships of individual organisations, and by promoting better practice through broader national programmes and studies. We run board development programmes, undertake governance reviews, and support organisations to develop and improve. We also facilitate and publish debates on issues pertinent to those leading our health and social care organisations.

The growing series of reports developed by GGI considers issues contributing to the better governance of healthcare and social care organisations and wider strategic issues. The GGI portfolio of original work now covers both technical aspects of governance and board working, as well as policy commentary and thought-pieces around aspects that we feel need to be discussed in the boardroom.

Other recent GGI reports and board development tools have considered the integration agenda, patient safety, clinical audit, the strategic context of the NHS, risk management, quality and safety of telehealth services, services for people with long-term conditions, diabetes services, better practice in treatment decision-making, productive diversity, the board assurance framework, integrated governance, governance between organisations and of course, good governance.

You can find out more about the work of GGI from our website:

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The Good Governance Institute is committed to develop and promote the Good Governance Body of Knowledge. This report and the work that enabled it has been made possible by an educational grant from Tunstall Healthcare (UK) Limited, an organisation that provides telecare and telehealth services throughout the UK and internationally. GGI also thanks those who contributed to the working group that helped develop the ideas in the report, as well as the many others who subsequently contributed to our consultation programme around integrated care.

Developing this white paper

This white paper came from a discussion facilitated at GGI's Clinical Advisory Group (CAG). This group has been meeting regularly over several years to develop thinking about how the health and social care systems in the UK are going to be able to rise to the challenge posed by the demographic changes the country is now experiencing, and the changing pattern of morbidity in the population evidenced by the increasing numbers of people living with often multiple long-term conditions. The group has been considering the role of technology, particularly telehealthcare, in the future delivery of health and social care. The CAG is currently funded by an educational grant from Tunstall Healthcare and colleagues from Tunstall regularly join the group to provide insight and technical input.

The membership of the CAG is:

Andrew Corbett-Nolan, Chief Executive, Good Governance Institute (Chair of the CAG)
Dr. Zoe Wyrko, Consultant Geriatrician, University Hospitals Birmingham NHS Foundation Trust
Dr. Amanda Thompsell, Consultant Old Age Psychiatrist, South London and the Maudsley NHS Foundation Trust
Dr. Adrian Heald, Consultant Physician in Diabetes and Endocrinology, Mid-Cheshire Hospitals NHS Foundation Trust
Alison Rogan, External Affairs Director, Tunstall Healthcare Group
Liz Butler, Chair, Lewisham Healthcare NHS Trust
Professor Martin Green OBE, Chief Executive, Care England
Tom Mytton, Research Analyst, Good Governance Institute

For this discussion paper the Group benefited from a number of invited guests who joined the CAG for a specific session:

Kevin Alderson, Sales and Marketing Director, Tunstall Healthcare (UK) Limited
Simon Arnold, Chief Customer Officer, Tunstall Healthcare Group
Kristoffer Axelsson, CEO of Northern Europe, Tunstall Healthcare Group
Syd Coombes, Chief Executive, Active Pathways
Debra Mehta, Journalist, Care Talk
Deborah Sturdy, Independent Healthcare Consultant

Introduction and purpose of this white paper

While innovation is expected within many sectors, care provision is an area which has historically avoided much of the modernisation evident across the broader health and social care space. We will investigate in this paper why some health and social care services have been more receptive to innovations than others.

Technology is at the forefront of innovation. It permeates every facet of our lives, from how we interact socially, to enabling the delivery of complicated surgical procedures. As Sir Arthur C Clarke asserts:

Any sufficiently advanced technology is indistinguishable from magic[1]

Imagine a travel company that did not let you book tickets online, or a car factory that did not use advanced technology to produce quality materials.

In the context of social care, we need to understand the reservations and concerns of those governing bodies that have been reluctant towards introducing technological innovations, alternative commissioning models and strategies, sustainable workforce empowerment, and professionalisation of careers in care. These factors must be considered in order to ensure the adoption of innovative services and delivery models that contribute to increased patient safety and independence.

The Burstow Commission's 'Key to Care' report[2] encapsulates concerns that have been debated throughout the sector for years, and that are described specifically for the residential care sector in the Commission on Residential Care's recent report "A vision for care fit for the twenty-first century"[3]. Care England was directly involved in the commission that produced the report. The sector faces enormous challenges that we can only meet effectively if we rethink homecare delivery systematically.

This paper will explore innovations in care home concerning:

(1) accommodation and facilities;
(2) the care that is actually delivered; and
(3) the commissioning and strategic organisation of homecare.

(1) Clarke, Arthur C., (1973) Hazards of Prophecy: "The Failure of Imagination"
(2) www.lgiu.org.uk/wp-content/uploads/2014/12/KeyToCare.pdf
(3) http://www.demos.co.uk/files/Demos_CORC_report.pdf?1409673172

1. Accommodation and facilities

Technological innovations have an important role to play in increasing patient safety and giving service users as well as their carers more confidence in managing certain conditions, as GGI and Tunstall Healthcare describe in their report on the delivery of telehealthcare solutions; *Keeping the NHS great*[4]. The range of Technology Enabled Care Services (TECS) is constantly growing, and some care homes in the UK exemplify the potential of their contribution to better care.

St Cecilia's[5], a 21 bed care home in Scarborough, is such an example. Almost all of the residents there have telecare solutions in place to reduce the risks from falls, incontinence, and safety incidents at night. There are enuresis sensors which detect instances of enuresis during the night, obviating the need to make habitual, intrusive checks. Bed and door sensors alert when a resident leaves their bed or room for more than a certain length of time, for instance, can help to target night support more effectively by replacing routine time-consuming night checks. Thereby, TECS can help to increase patient safety, increase independence, dignity and choice for residents and use staff resources more effectively by responding to incidents immediately, enabling carers to take action as soon as the incident occurs. This is particularly important when staff shortages occur due to sickness or absence, for instance.

There are certain signs of innovative ways of working being embraced across the care sector. For instance, both telehealth and telecare solutions have been integrated into residential care in 25 care homes in Calderdale with around 500 residents as part of the commissioning strategy focussed on improving patient care and safety. The programme is jointly run by local Clinical Commissioning Groups (CCGs), the local authority, Calderdale & Huddersfield NHS Foundation Trust and community services. Through the Quest for Quality in Care model, TECS support self-management of conditions as well as anticipatory care planning by local multi-disciplinary teams and this approach is already significantly reducing hospital admissions to A&E[6].

It is crucial to recognise the need for forward planning in this context, as the widespread implementation of technological improvements will rely on facilities being built for and equipped with the necessary infrastructure to support innovations. As Professor Martin Green, Chief Executive of Care England emphasises:

"When you build a care home, try and build it in a way that might mean you can still use it when the notion of a care home has been completely reconfigured in 20 years."[7]

A more long-sighted and flexible conceptualisation of care homes is, in many ways, the underlying requirement for greater innovation to be embraced and secured.

(4) Elsy, S. and Rogan A., 2014, "Keeping the NHS great – Delivering technology enabled care services"
(5) http://www.tunstall.co.uk/Uploads/Documents/St%20Cecilias_Layout%201.pdf
(6) http://www.tunstall.co.uk/news/356/nhs-calderdale-clinical-commissioning-group-launches-quest-for-quality-in-care-homes-initiative
(7) GGI & Care England round table discussion, September 2015

2. Care & carers

Among the most pressing concerns in the adult care sector is the need for substantial workforce development. Foremost within this is the need to work toward establishing care work as a valued career path, and to shift away from the current environment of substantially high turnover rates (almost 20% a year in residential care[8]), and a lack of investment into staff.

The current situation where, according to a new report by the Joseph Rowntree Foundation[9], "78% of frontline care staff earn an average of £6.45 per hour" is unsustainable. This profession is not only physically, emotionally and psychologically demanding, it is also one of the most indispensible in our society. Yet, low wages, lack of training and professional development opportunities, unsocial working hours, and high productivity pressures make the profession outright unattractive.

The Kingsmill Review[10] highlighted that the introduction of 'zero hours contracts', under which about 20% of adult social care professionals are employed, has contributed to the precarious nature of the work and made it more difficult to enforce minimum wage laws effectively. In fact, average wages in health and social care have fallen continuously since 2008[11] – a trend that needs to be reversed.

Moreover, the lack of on-going and specialist training around specific medical conditions inevitably compromises the quality of care provided and poses a real risk to patient safety. High-quality apprenticeships could be a key part of a more sustainable, appreciative, and dynamic approach to workforce planning. Too many apprentices now receive too little training, too little money and too few prospects of a progressive career path.

This underinvestment in the workforce is unsustainable, increases risks to patient safety and the quality of care, and increases costs in the long-term. Paying lip service to the recognition and status that care professionals undoubtedly deserve, is not good enough so long as this is not translated into the proper enforcement of appropriate remuneration (at least Living Wage as the Burstow Commission suggests) and improved working conditions.

The latter should entail replacing rigid formulaic care plans with more individually responsive plans that allow care professionals to fully focus on the needs of service users. Within home care commissioning in particular, the proliferation of 'time and task' care plans can effectively disincentivise compassionate care. Care workers are often paid according to contract time, which can differ greatly to actual working hours due to the nature of care work. Moreover, the needs of service users are not placed at the centre of care when workers are responding to rigid plans with little flexibility around actual care needs. The financial restraints informing this context cannot be ignored, with risk and financial shortfalls being passed onto frontline workers and the people they care for.

We support Atul Gawande's call[12] for a different mind-set that conceptualises residential care not in a narrow medical sense, but recognises the importance of residents' social and emotional life. Research has shown that the impact of social relationships on mortality can be as strong as for other major risk factors such as smoking or obesity[13]. Therefore, facilitating social interaction, community activities, and relationships, should be a key focus of every care home and an integral part of commissioning strategies, risk management, and resource allocation planning. Crucially, creative approaches to facilitating the social dimension of care homes should always involve service users and their families as well as other formal and informal organisations in the community. From local authorities to book clubs, bringing people together on the basis of common interests and hobbies can be at least as important to a resident's well-being as their diet or their blood pressure. It is time for the entire health and social care system to recognise this. The potential for care homes to act as community well-being hubs in this regard is a key resource that should be supported in the broader reconceptualisation of health and social care.

(8) Baroness Kingmill, 2014, "The Kingsmill Review: Taking Care"
(9) Joseph Rowntree Foundation, 2015, "John Kennedy's Care Home Inquiry"
(10) Baroness Kingmill, 2014, "The Kingsmill Review: Taking Care"
(11) Franklin B., 2014, "The Future Care Workforce"
(12) Gawande, A., 2014, Being Mortal, Metropolitan Books
(13) Holt-Lunstad, J., Smith, T. B. and Layton, J. B., 2010, "Social Relationships and Mortality Risk: A Meta-analytic Review"

3. Commissioning and organisation of care

Innovative commissioning strategies that are outcome-based rather than focused on time and tasks, can contribute to improving the quality of care and the integration of different services. We would agree with the Burstow Commission's support for greater outcomes-based commissioning, and an examination in particular of the longer-term financial benefits to be garnered from such an approach.

Instead of the current commissioning system, where commissioning organisations can often operate in silos with responsibilities separated for primary, secondary, or tertiary care, commissioning could be more holistically responsible for the effectiveness of the care delivery, and for the assurance that outcomes are delivered within given parameters and guidelines within a wholly patient-centred system.

One way to reorganise social care more systemically could be to make care homes the centre of the management of certain conditions such as dementia within the wider community, supporting not only the residents of the care home but opening this support up to the entire community. The Burstow Commission and others[14] advocate the positioning of care homes in a broader understanding of health and social care within the community. This would see greater organisation of care around the patient pathway in order to ease transitions from primary to secondary to tertiary care, with a more flexible approach to integrating various services to better meet the needs of service users.

The social care sector in the Netherlands provides an inspiring example as it has embraced innovation in various forms and implemented new models of organising social care. The Buurtzorg model, which GGI has described as an innovative example of health and social care integration in a recent report[15], is a nurse-led community care model, where small interdisciplinary care teams provide patient-centred care.

Another example is that of Dutch and German kindergartens which are based in care services, bringing together the care for children and the elderly, and facilitating relationships which benefits both the older residents with their experiences and stories to tell, and the children who learn from them. Depression and other mental health issues are widespread in care homes, and models like these which explore new ways of facilitating social interaction and relationships with others, can contribute considerably to the mental and emotional well-being of elderly people.

There are encouraging examples in the UK also, where many care homes seek to involve the community through open days or public coffee mornings on their premises, but the untapped potential in this area is huge, particularly around implementing innovative concepts to meet the emotional and social needs of older people.

The role of technology in this area should not be underestimated, with communication tools such as video calls, group messaging, and 'community club' apps now widespread and relatively easy to implement. As well as boosting social interaction with care home residents and service users, such technology can be an invaluable resource for care staff. As outlined in the Burstow Commission's 'Key to Care' report[1], technological innovation can be as simple as shifting to the use of electronic care notes, rather than traditional paper-based information sharing. This can facilitate rapid and accessible communication between carers in relation to client needs, with obvious impacts on the quality and continuity of care.

Such innovations can only be enacted on a large scale if system-wide change is embraced. There is cause for optimism with the growing drive for the integration of health and social care across the UK.

(14) "Martin Green: Care homes should become community hubs", Guardian UK
[http://www.theguardian.com/society/2013/jun/18/martin-green-care-homes-community-hubs]
(15) Goldberg, D. and Baltruks, D., 2014, "Goldberg III: Can the NHS deliver integration? Lessons from around the world"
(16) www.lgiu.org.uk/wp-content/uploads/2014/12/KeyToCare.pdf

Barriers to innovation

Many innovations in the care home sector that we regard as essential, such as the earlier described changes to workforce planning and empowerment, or the roll out of telehealthcare solutions, require dedicated financial resources – at least for an initial time period. National and local policy-makers need to realise the importance of these investments. The substantial cuts to the social care budgets under the current administration have been a shift backwards in this regard. The lack of investment into long-term improvements to the quality and efficiency with which care is delivered, driven by short-sighted budget concerns, is therefore a major barrier to innovations in the social care sector, as Syd Coombes, Chief Executive of Active Pathways told us.

In addition to this, investment into the 'infrastructure' needed to enable innovations, is just as important. The transmission of patient data for instance needs to be carried out within a secure network and site-wide Wi-Fi enables additional services such as Skype – yet this is still far from the norm in many health and social care organisations. Simple technological solutions from electronic door openers to bed sensors need to become more widespread, so that care professionals' time and resources are effectively applied to serve in the best interest of service users.

Many care homes, carers, and service users are risk averse when it comes to introducing new methods or tools, such as TECS. Commissioners, health and social care providers, and providers of TECS need to provide assurance to those using and working with these new tools regarding their safety and impact on service users' quality of life. We need to ensure that service users do not perceive the use of telehealthcare solutions as a 'robotification of care' merely intended to save costs. Communicating how technological innovations can support and complement compassionate care – not replace it – is key to ensuring acceptance of service users and care professionals.

Conclusion

Some branches of healthcare are agile at adopting new technologies. For example, the field of surgery is one that has greedily adapted to new technologies and innovations as fast as they have developed. The delivery of care itself, though, is still very much in a place where the potential for technology to help lags behind. This is particularly so in care delivered in the home and in many care homes.

If we ask ourselves the question 'If we wind the world on five years, do we believe that technology will play a greater part in the delivery of care services?' the answer is of course 'yes'. The only matter of debate is around how quickly and at what scale.

GGI has consistently encouraged the leaderships of health and social care organisations to think about how technology can help, and indeed this year we are planning a study tour to India to take NHS and social care leaders to meet those at the forefront of developing tomorrow's world. Over the years, we have built up a body of work to help boards and governing bodies better understand telehealthcare in particular, and are on the verge of yet more publications around quality standards and patient safety issues in telehealthcare.

2015 is a crucial year, with the funding issues in health and social care becoming ever more pressing. It is not a year to be lost to lethargy around ensuring that millions of vulnerable NHS and social care service users are able to have better lives by virtue of the simple technology that is telehealthcare. We encourage commissioners and providers to work together over the next 12 months and to work through the issues raised in this paper, creating partnerships with care homes, home care organisations and technology providers to quickly ensure that the benefits available are realised quickly.

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