



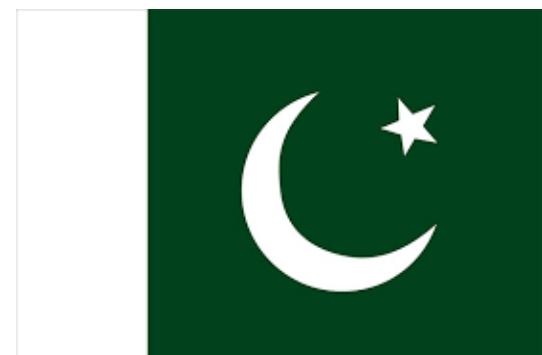
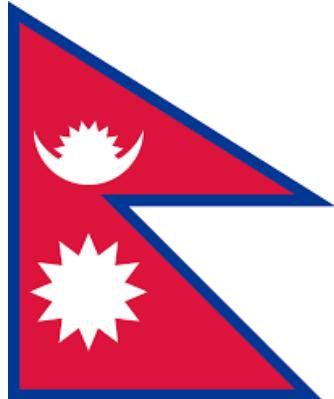
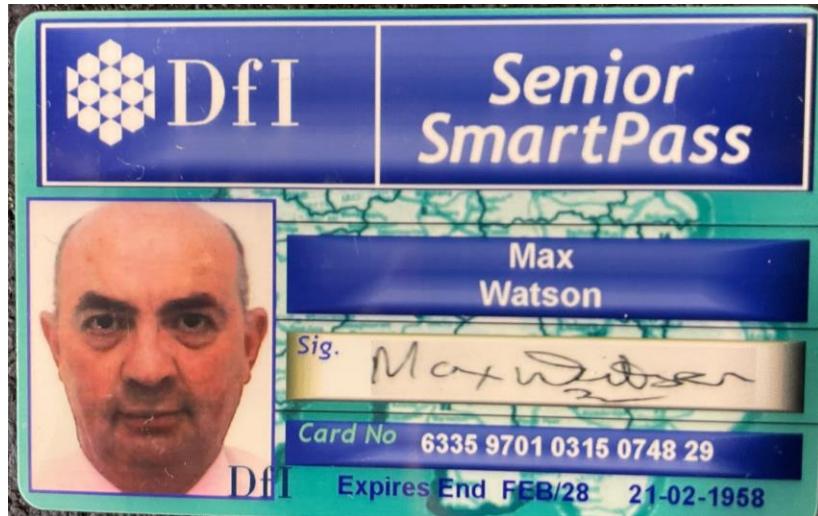
Workforce Education, Support and Retention

Professor Max Watson, Director Project ECHO, Hospice UK

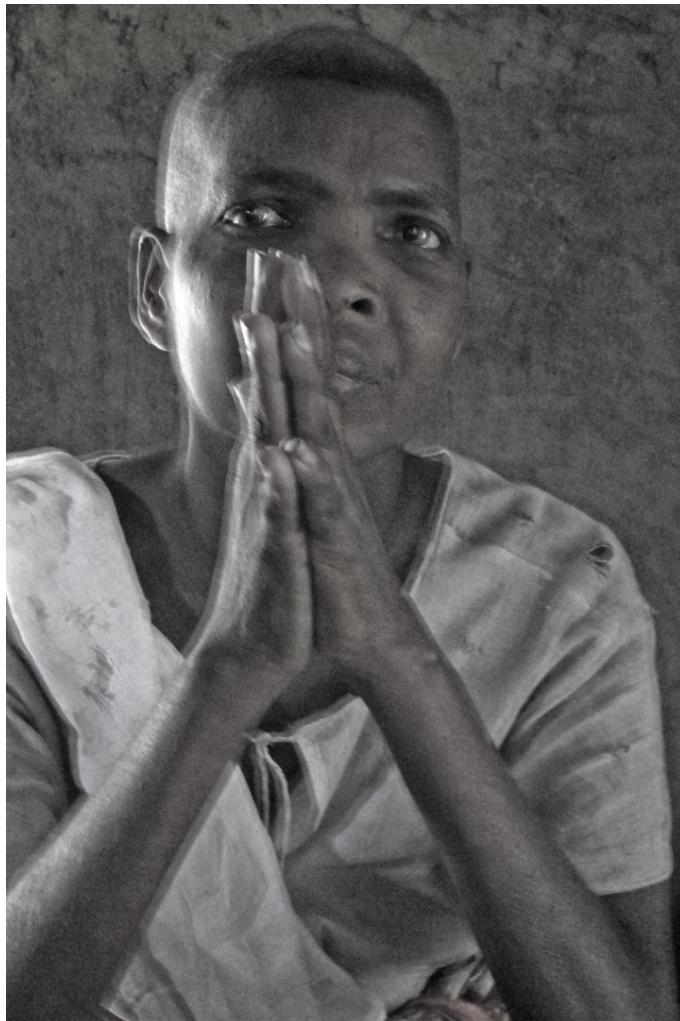
Consultant Palliative Medicine Western Trust, N.Ireland

Associate Professor St. John's Bangalore and St. Margaret's Taunton

Declarations



USE OUR ASSETS WELL



Overview

Workforce is not just about the Workforce

Workforce about today AND tomorrow

Need for change, but how?

A specific workforce gap

Integrated workforce for a growing frail rural population

A New way of growing our own clinicians?

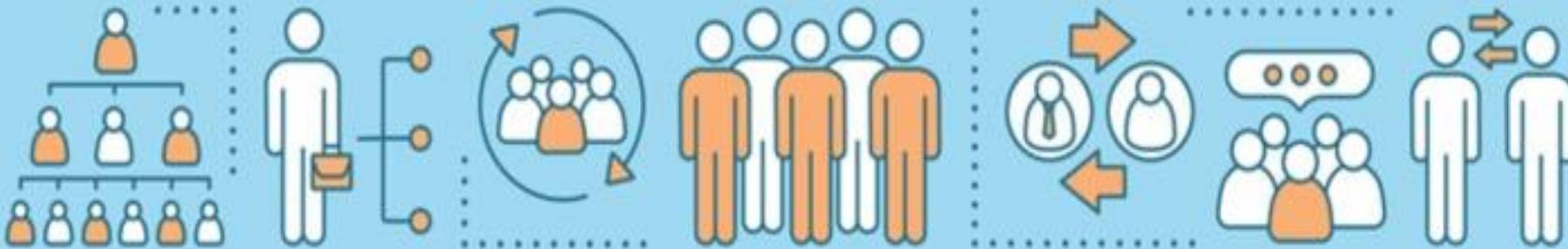
Workforce is not just about the Workforce

KEEP
CALM

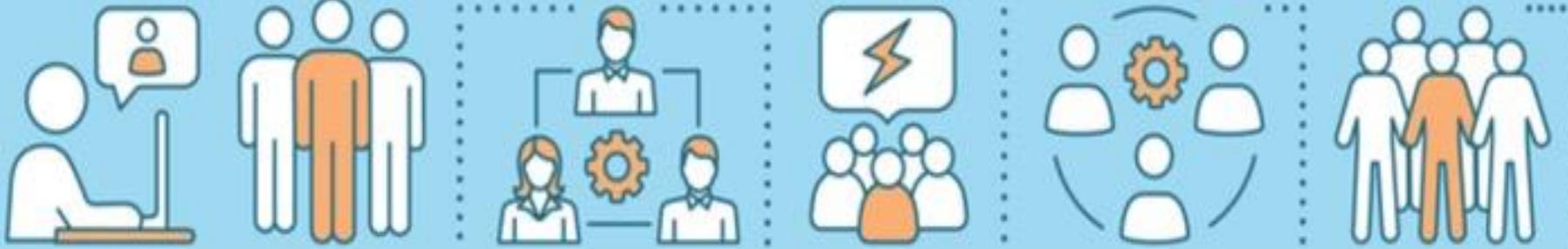
and tell me what you want
what you really,
really want

Workforce is not just about the Workforce

What is it that YOU want to do?



WORKFORCE



“Keep our Hospice open”

“Provide 2023 appropriate Hospice/Palliative Care”

“Deliver our good standards of care within budget”

“Maintain our beds and services”

“Fill our current staff gaps in our services”

“Fulfill our contracts”

“Deliver Hospice Palliative Care to/with our community”

WORKFORCE

QUALITY OF VISION

QUALITY OF LEADERSHIP

QUALITY OF INCLUSION

THE PRACTICE MATCHES THE VISION IN ALL ASPECTS OF DELIVERY

PATIENT & STAFF CENTRED CARE DELIVERY

NON-HIERARCHICAL

The NHS Long Term Workforce Plan

- Growing the workforce
- Retaining existing talent
- Working and training differently
- Building flexible teams



Workforce about today AND tomorrow -ve

Growing population of people living with frailty and palliative care need while our services face huge challenges to even keep going

High rates of localised poverty and social deprivation and communities who have never benefitted from our services

Workforce gaps extending in frailling Services

Financial threat WAGES

Morale and sense of being undervalued

Ongoing impact on society of COVID, Brexit, and Political limbo



Workforce about today AND tomorrow +ve

Inspiring young staff joining sector

Growing population of people living with opportunity and time to help others

High rates of social capital and sense of community

Must do a master of innovation and new ways

New solutions being co-created

Less reliant on centralised "routine" ways of doing things

Ongoing impact on society of COVID, Brexit, and Political limbo



Workforce about today AND tomorrow



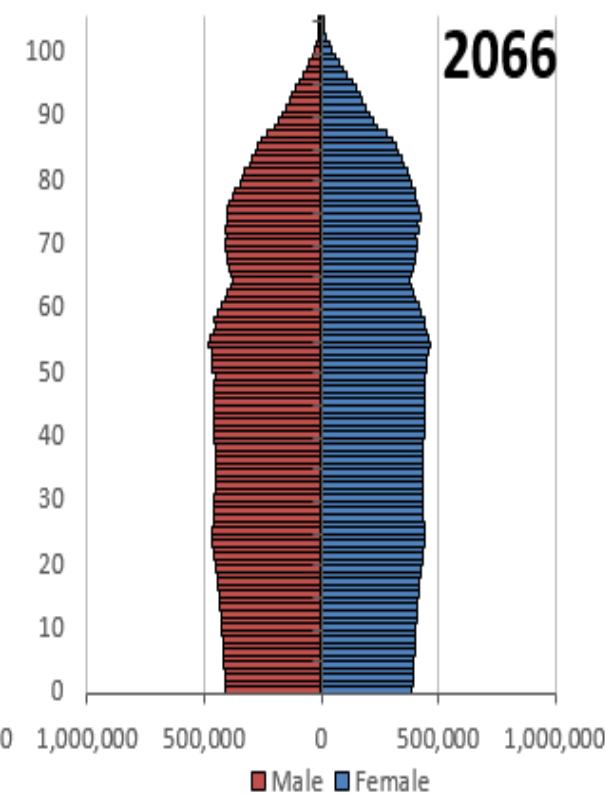
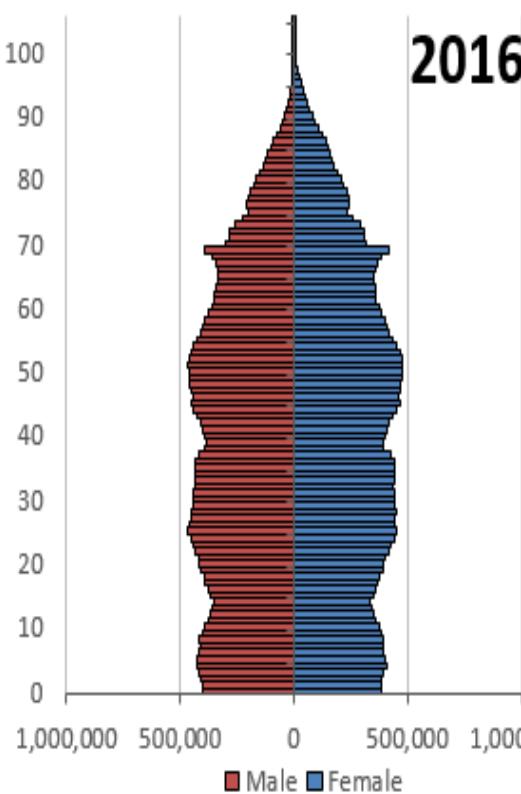
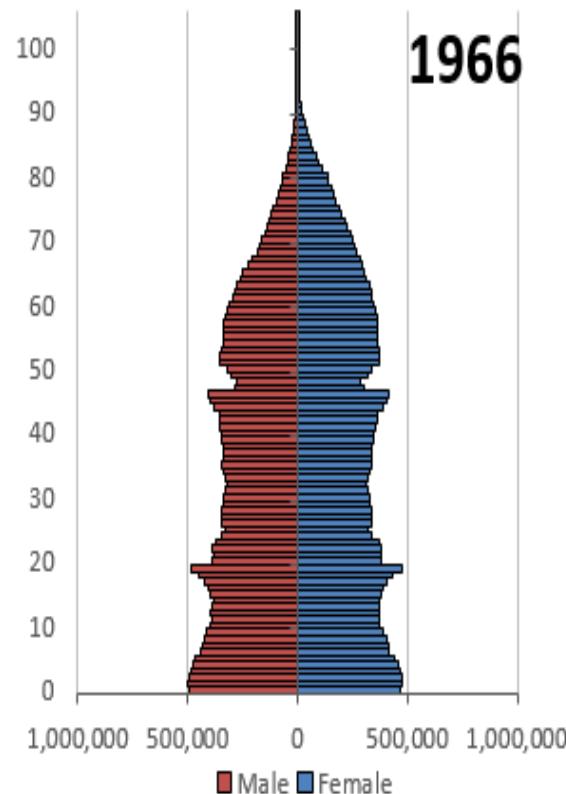
The British Academy
COVID-19 and Society

Nine areas of long-term societal impact

- 1. Increased importance of local communities**
- 2. Low and unstable levels of trust in governance**
- 3. Widening geographic inequalities**
- 4. Exacerbated structural inequalities**
- 5. Worsened health outcomes and growing health inequalities**
- 6. Greater awareness of the importance of mental health**
- 7. Rising unemployment and changing labour markets**
- 8. Renewed awareness of education and skills**



Workforce about today AND tomorrow



Workforce about today AND tomorrow

Demographic Imperative

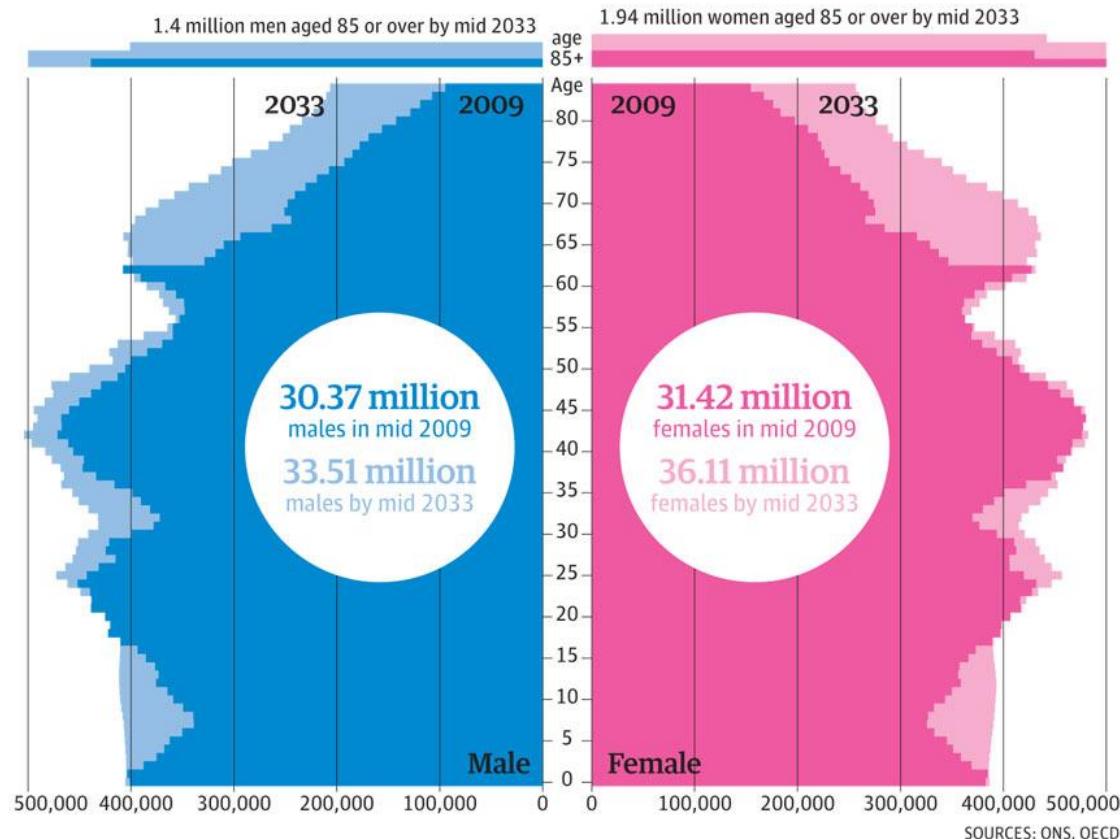
Population ageing means that 160,000 more people are expected to need palliative care by 2040, up to a 43% increase compared to 2020.

Population based estimates suggest 69-82% of dying people in England and Wales will need access to palliative care services

The changing shape of the UK

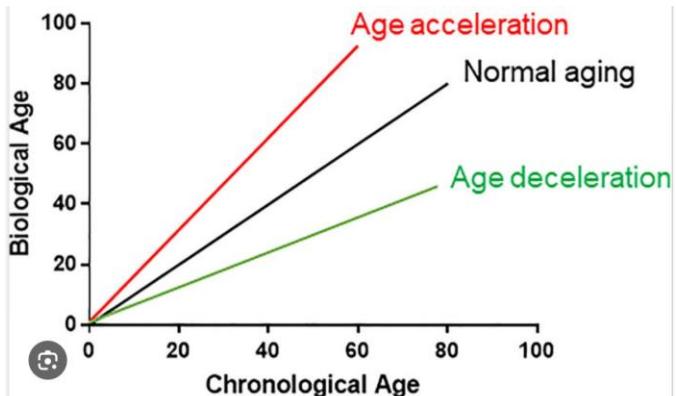
Age structure of the UK population

Males 2009 Males 2033 Females 2009 Females 2033



Dangers of Ageism

Young and old



Burden or Treasure?





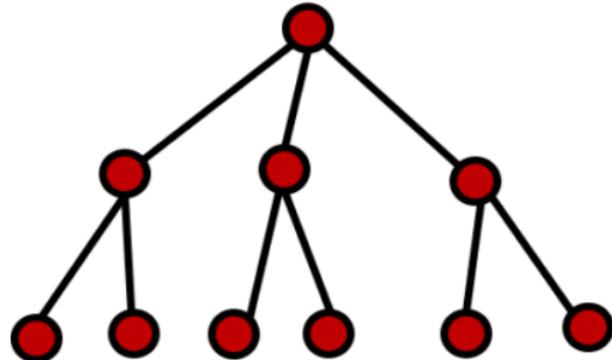
Who wants change?

Who wants to change?

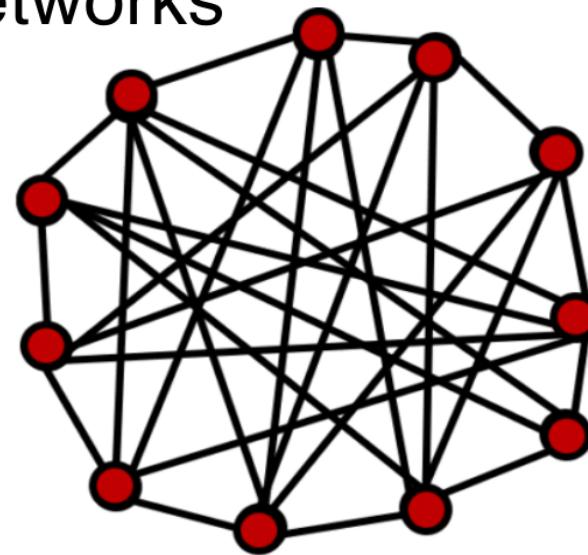
Who wants to *lead the* change?

Need to co-produce and co-design new models of care delivery and integration to maximise our workforce.

Hierarchies to Networks



“Top-down”



“Community of Practice”

Building Trust and Understanding



WHAT?

An Enabler of Vision

EXTENSION OF C
OMMUNITY H
EALTHCARE O
UTCOMES

Not for profit movement to improve care by gathering a community of practice together on line, for learning and support, with the goal of improving decision-making by collaborative problem solving

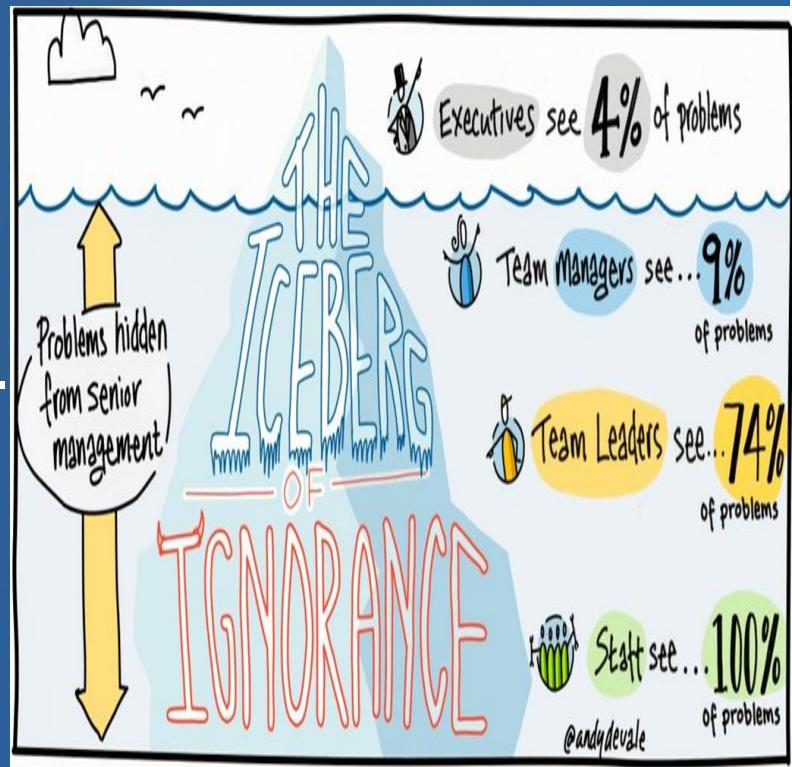




The Fundamentals of ECHO Ethos & Methodology

Enabling Workforce *FAST*

1. All Teach, All Learn, All Evaluate.
2. Community of Practice
3. Trained Facilitation
4. Adult learning-loops.
5. A safe space to learn and share
6. Dedicated IT support
7. Dedicated Administration support





Workforce

ECHO Stories across the world



India – TB elimination across India by 2026 -
USA – Autism diagnosis in a timely manner

Canada – Indigenous palliative care support

Ethiopia – Village Midwife support

Ukraine – Teaching and supporting trauma management
to all health care professionals



Three workforce examples arising from what ECHO Networks have co- created...



Palliative care MDM's now involving SPCN, Hospital Team, DNS, GPs, AHPs



Glaucoma follow up by optometrists with virtual support provided

HFVC000150 VS 65 yo female Dr Elliott

Presenting complaint

- IP December 22 with headache, BP high, BNP raised. Troponin 57, 57 and 50 (thought due to CKD and HTN). Commenced furosemide and fluid restricted.
- ED review Jan 23: AKI - eGFR 15 from a baseline of mid-20's. Furosemide held.

O/E

BP - @200 systolic December 2022
HR 83 NSR
BMI 21

Background

- Type 1 DM
- HTN
- Hypothyroidism
- CKD
- COPD
- Fibromyalgia
- Recurrent left arytenoid neuroendocrine tumour

10 Minute GP Appointment Service with
Cardiologists



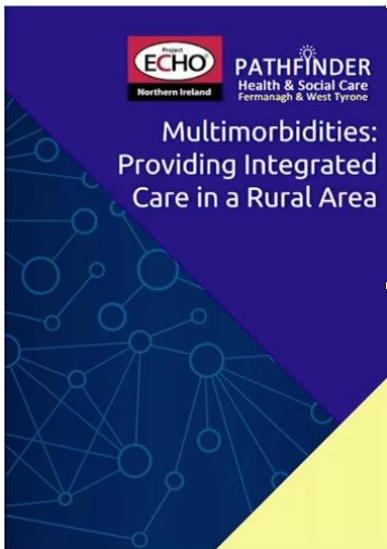


A Specific Workforce Gap



- *The needs of the rapidly increasing population of elderly, frail, socially deprived and dying within the Southern Sector of the Western Trust.*
- *“Our older population is growing with a 27% increase predicted in those aged 65-84 years and a 39% increase in the 85+ age groups by 2028.”*
- *Five of the top 10 most deprived areas*
- *10 of the top 20 areas with poorest access to services*
- *This population places a significant service burden on acute services despite often doing badly within the acute sector due to problems such as rapid deconditioning, delayed discharges, and susceptibility to hospital acquired infections.*
- ***Growing workforce gaps in both Palliative Care and Care of the Elderly
Palliative Consultant sessions down from 19 to 7 in past three months***

What should we do?



domestic
improvement signposting
undertaking assessing
time councils multidisciplinary
management promote dementia prescribing
practices treated cross planning accessible
navigators people connectedness gp access work clinics deserve
appropriately invest multimorbidity communication
improved appointments multimorbidity contact hubs voluntary paid
deprived services basic central primary connected mobile
plans coordination person stop shop better eg address
multiple early one shop digital rural navigator
professionals eye leading teams domiciliary
pathways foot one support facilitate
sector border shops ltc hospital live patients social
multimorbidities hospitals
border shops ltc treatment settings carers valued areas bring
signal communities introduced diagnosis
treating mobilities based secondary visit point
collaboration based secondary visit point
transport statutory
mileage



01

Carers and Care in the Community

QUESTIONS AND FEEDBACK

1. What actions could we take to support patients with multimorbidities to be cared for in their own homes?

Q1 themes (24 responses):

- Communication
- Pay/working conditions
- Training/technology
- Planning
- Recognition

2. How do we make it safer for patients being discharged from Hospital to be cared for at home?

Q2 themes (22 responses):

- Communication
- Assessment
- Build support networks (CVS, family, friends)

3. How could all those involved in providing supportive care in the community work more closely together? (Inc. Primary care teams/ Community & Voluntary Agencies/ Carers Networks etc.)

Q3 themes (27 responses):

- Communication
- Teaching/Training
- Build support networks
- Ownership/responsibility/accountability

4. What actions do we need to take to support and value Carers and Community Carers?

Q4 themes (27 responses):

- Time/flexibility
- Terms and conditions
- Recruitment
- Recognition (esp. informal care givers- respite at home rather than traditional respite)

WHEN: 08th October 2021

WHO:

Total Number of Attendees:	23
WHSCT	9
CVS	6
Service User/Carer	3
NIHE	1
GP	1
FODC	2
NIAS	1

02

Communication including a central point of access

WHEN: 22nd October 2021

WHO:

Total Number of Attendees:	25
WHSCT	15
CVS	6
Service User/Carer	1
PHA	1
GP	1
HSE	1

QUESTIONS AND FEEDBACK

1. What is the added service value that a single point of access could bring to people with multiple conditions known to you?

Q1 themes (23 responses):

- Integration
- Better Access (Communication)
- Efficiency (removal of steps)
- Early support/intervention/better management

2. Who should, and how could a single point of access be staffed?

Q2 themes (30 responses):

- Technology (virtual platform)
- MDT approach
- Combine existing teams
- Robust Pathways
- Role for Multimorbidity Clinics (incorporating CVS)

3. What do we need to do now to make a single point of access happen in our area?

Q3 themes (25 responses):

- Define what it is and the scope of it (workshop)
- Coproduce and consult/involve frontline staff
- Create clear pathways

WHEN: 05th November 2021

03

Multimorbidity Hubs in SWAH and OHPCC

WHEN: 05th November 2021

WHO:

Total Number of Attendees:	24
WHSCT	14
CVS	4
Service User/Carer	1
GP	2
NIAS	1
FODC	2

QUESTIONS AND FEEDBACK

1. What would a satellite hub in Omagh Hospital look like?

Q1 themes (23 responses):

- Connected/links with Primary Care
- Technology/virtual element
- Access
- Multidisciplinary
- Co-produced

2. How do we make this happen now?

Q2 themes (21 responses):

- Co-produce
- Engagement
- Commitment
- Courage

3. How do we get people on board and engaged?

Q3 themes (23 responses):

- Clear communication
- Shared lived experience
- Coproduction
- Inclusion of all groups inc. Section 75 groups



04

Community based one stop for early intervention and prevention

WHEN: 19th November 2021

WHO:

Total Number of Attendees:	27
WHSCT	11
CVS	6
Service User/Carer	3
PHA	1
GP	1
FODC	1
NIAS	1
HSE	3

QUESTIONS AND FEEDBACK

1. What would be included in a Community Multimorbidity Hub?

Q1 themes (32 responses):

- Patient Education
- Intervention
- Multidisciplinary
- Systems
- Multi agency
- Diagnostics
- Prevention
- Access

2. How do we ensure that a Community Hub integrates with the Multimorbidity Hub in Secondary Care (SWAH and OHPCC Hub) and Primary Care provision?

Q2 themes (24 responses):

- Testing
- Scale and Spread
- Involvement
- Staff rotation
- Technology
- Clear communication and accountability with established Pathways

3. What do we need to do now to engage people and make this happen?

Q3 themes (33 responses):

- Involvement
- Patient centred
- Redesign and realignment of existing services
- Map existing resources to support understanding of need and provision
- Scale and spread
- Agree clear implementation plans and outcome measures
- Quality improvement approach and sharing the learning

05

Out of Hours Services

WHEN: 03rd December 2021

WHO:

Total Number of Attendees:	29
WHSCT	14
CVS	7
Service User/Carer	3
NIAS	1
HSCB	1
FODC	1
GP	1
HSE	1

QUESTIONS AND FEEDBACK

1. What assets do we have across our community that can support people with multimorbidities in Out of Hours care?

Q1 themes (31 responses):

- Communication
- Partnership working
- Community and Voluntary Services
- Community infrastructure
- Technology

2. What planning and support could be put in place for people with multimorbidities to reduce the burden on GP Out of Hours and hospital Emergency Departments?

Q2 themes (33 responses):

- Information, education and training
- Connecting all care givers
- Virtual Technology
- Communication
- Community development and ownership approach.
- Care delivery in the appropriate setting (R's approach)

3. What can we do now to improve Out of Hours care?

Q3 themes (30 responses):

- Improve access
- Provide multimorbidity training to first responders (usually carers)
- Co-ordinate Out of Hours response
- Connect services

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Multimorbidity Hubs in SWAH and OHPCC

WHEN: 05th November 2021

WHO:

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- Engagement
- Commitment
- Courage

3. How

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HSE	1

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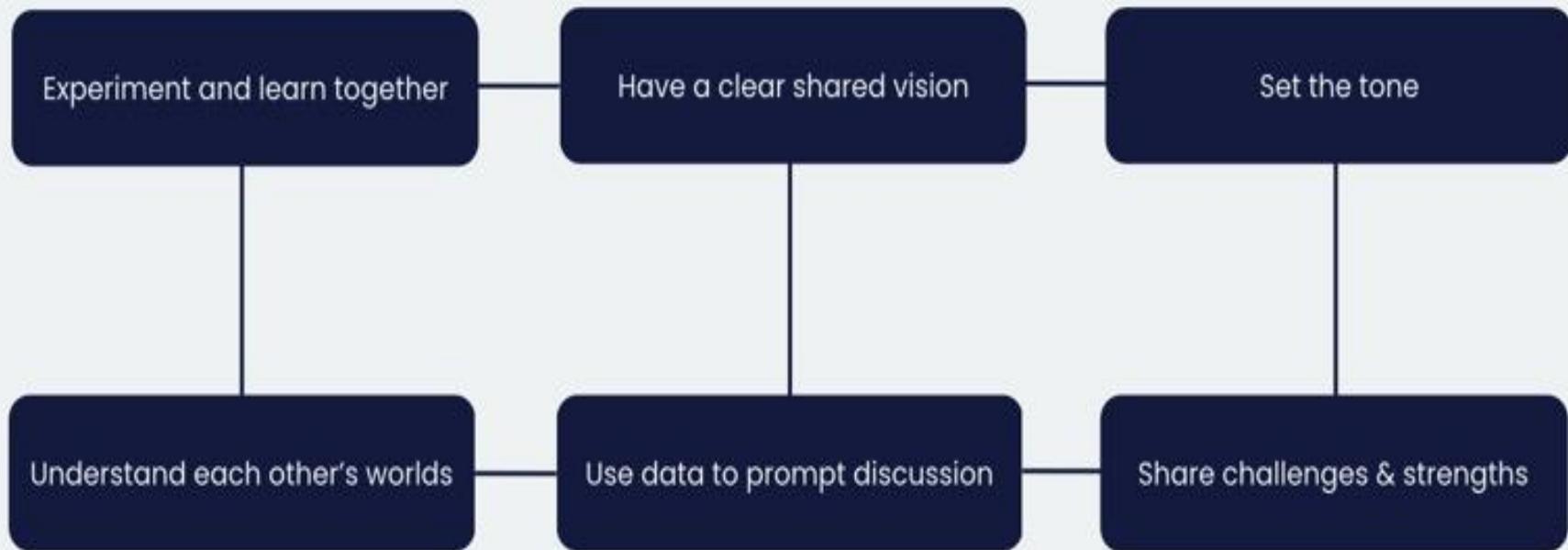
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More integrated service



Six ways to create a culture for integration



Workforce Integration Opportunity



Increasingly frail, ageing population with multiple long term conditions



Rurality
Socioeconomic
deprivation



Recruitment and
Retention Issues
**Retirements pending
(Palliative & GP
workforce)**



The Medical Workforce Gap

Palliative Care and Care of the Elderly recruitment repeatedly failed to attract applicants

Shape of training changes, COVID, industrial action and changing workforce contributing to acute risk of service collapse

Meanwhile patient population is growing....

Integration?



How best can palliative care services contribute to supporting people living with frailty and geriatricians support people at the end of life?

Integrated Care Fellowship Programme.

Four year Consultant Level Training programme combining Palliative Care and Community Care of the Elderly Curricula but excluding acute care so cannot be subsumed onto acute rotas.

Allows for a medical team who can cross cover and sustain and develop new integrated services, with the skills to engage with the community and build on community assets

Integrated Care Fellowship Programme

Two years to develop in consultation with colleges

Recognition that Foundation Trusts can appoint people with proven appropriate experience to consultant roles

Local Training for local need, with access to additional learning needs virtually and with placements

Masters, Specialty Exit Exam(Either Pal. Or CoE) and Four Annual Appraisals

26 Applicants for initial three posts.

Job Title - Clinical Fellow in Integrated Care

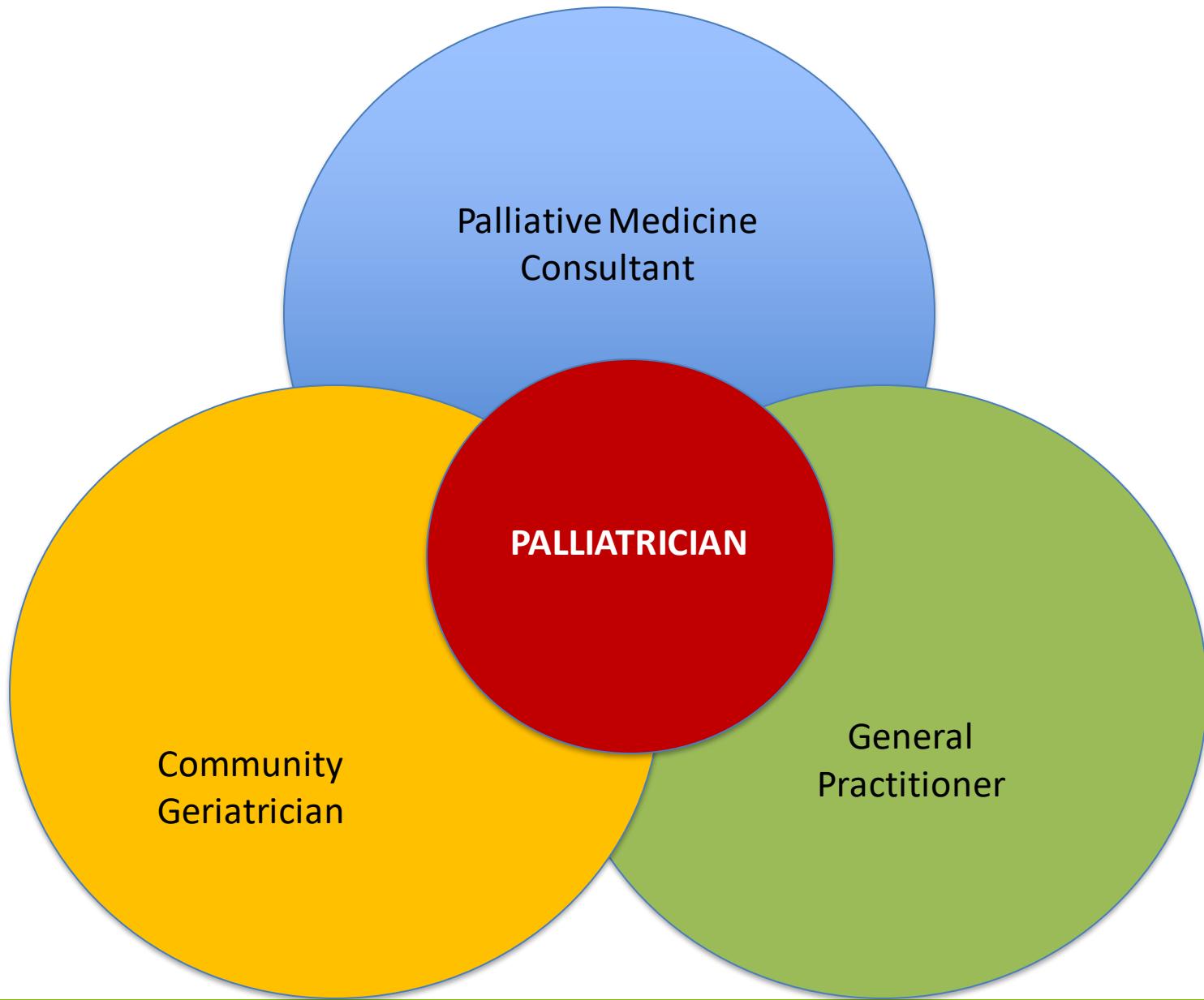




Western Health
and Social Care Trust

**Job Title - Clinical Fellow in Integrated
Care**

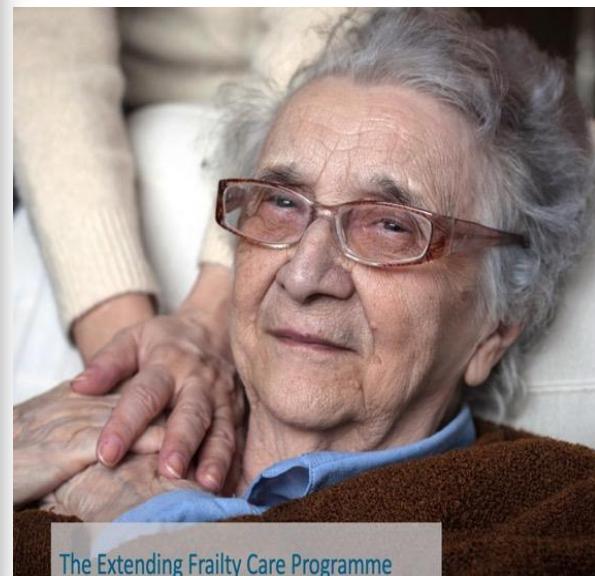
Job Description



Hospice UK: Extending Frailty Care Programme (April 22-April 25)



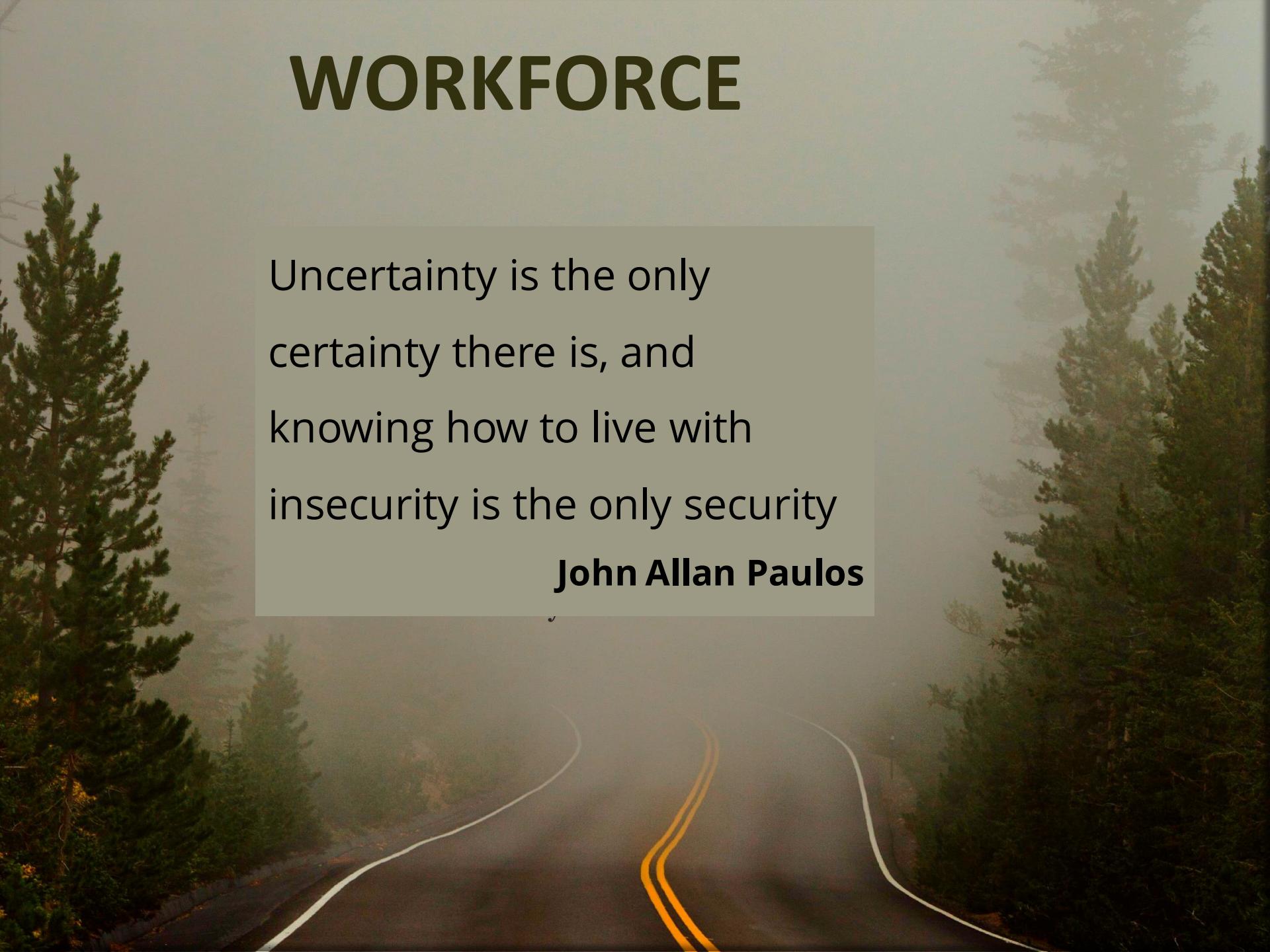
- Aims to improve quality of life for older people with advancing frailty who have palliative care needs, and who also experience lack of care coordination due to fragmented community services
- Bring together UK opinion and research leaders in frailty and palliative care to determine high impact opportunities for improvement
- Emerging evidence-based frailty care models will be planned, tested using a Quality Improvement approach, and evaluated
- 11 sites:
 - St Catherines, Crawley: Outreach, Education
 - Strathcarron: Care for people in prisons
 - Highlands: Helpline and education in care homes
 - St Clare's, East Sussex: Domiciliary care – new frailty care lead role
 - Trinity, Blackpool: Community Pathway – Partnership
 - Isabel, WGC: Compassionate communities
 - ellinor, Gravesend: Care home rehabilitation
 - St Michaels, Harrogate: Pathway streamlining/care co-ordination
 - St Christopher's, London: Care Home, education and family support
 - Prospect House, Swindon: Virtual Ward support, Education
 - St Barnabas, Worthing: Patient journey and equity of access
- Using QI methodology
- Peer support (ECHO Network)



The Extending Frailty Care Programme



WORKFORCE

A photograph of a winding asphalt road with yellow double lines, curving through a dense forest of tall evergreen trees. The scene is shrouded in a thick, hazy fog, creating a sense of uncertainty and depth. The road starts in the foreground and disappears into the misty distance.

Uncertainty is the only
certainty there is, and
knowing how to live with
insecurity is the only security

John Allan Paulos

Overview

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Workforce about today AND tomorrow

Need for change, but how?

A specific workforce gap

Integrated workforce for a growing frail rural population

A New way of growing our own clinicians?