Health and Wellbeing Board 10 March 2015	Tower Hamlets **Health and Wellbeing Board**
Report of: Healthwatch Tower Hamlets	**Classification:** Unrestricted
Qualitative Evaluation Tower Hamlets Co-ordinated Care Network Incentive Scheme	

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Executive Summary

Healthwatch Tower Hamlets was commissioned by THCGG to carry out an evaluation the new Co-ordinated Care Programme during 2014. Its main purpose was to understand the experiences of and feedback from both the providers and the users of the new service over a period of time so that the programme could be both improved and tailored to their needs.

This report provides a summary of the key findings.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Note the report.

Qualitative Evaluation
Tower Hamlets Co-ordinated Care NIS

The following summary of key findings <u>should only be read in conjunction with the full report</u>[1] so that the context is fully understood and that justice is done to the richness of the data collected. The detailed methodology is also outlined in the report.

Summary of provider findings
Research carried out between April and June 2014.

- Concerns about 'integrated care' focused not on whether it should be implemented but, instead, on how and in what way.

- Although providers tended to have a vision of 'integrated care', it was not a shared vision across providers and provider teams either conceptually or practically in terms of what it was and how it should be implemented.

- There were some examples cited of where 'integrated care' was seen to be working but not only were some services seen as being more 'separate' than others but there were additional organisational and governance protocols that hindered greater integration. This was seen to be compounded by differing levels of commitment particularly within the GP community and a perceived lack of understanding of the roles of different professionals with respect to the implementation of 'integrated care'. Some also considered that it remained based on a 'medical model'.

- There were general confusion at all professional levels between the Tower Hamlets 'Integrated Care Package' and the Co-ordinated Care NIS particularly in terms of understanding the distinctive features of each initiative and where they overlapped. This was important not so much for the patients' care which most felt would be the same but because of the protocols, pathways and governance involved. It was also felt that, with the new DES, this confusion would only get worse.

- There was equally a lack of clarity of the purpose of the NIS which again influenced how providers, especially GPs, approached its implementation. At one end of the spectrum were those who believed that the NIS was merely the next evolutionary phase following the Virtual Ward and that 'change' should be given time to settle. At the other end, was the argument that its real purpose and benefit would be in identifying patients that might have previously 'slipped through the net' as well as providing an opportunity to catch problems early. Some also felt that the NIS would act as a point of reference giving GPs a chance to reflect upon their patients.

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[1] **A copy of the report can be downloaded by clicking this link** Healthwatch Reports or at http://www.healthwatchtowerhamlets.co.uk/our-work/documents/.

- Many perceived the NIS to have been set-up in a rush with constant reiterations and poor communication. Further there was no uniform way in which it was being approached by surgeries.

- Concerns were raised about the level of resources available in terms of finance, staffing and training GPs but the most common concern focused on the staff shortages within Community Health Services. Many within these services predicted a greater workload within rapidly changing services which was being constantly transformed without any apparent and concurrent organisational development which in turn fed into the difficulties of implementing co-ordinated care.

- The majority of providers agreed that the NIS was capturing the appropriate cohort of patients but it was also argued that they were generally the patients they would be seeing anyway on a regular basis. Thus although the new package would offer an opportunity to interact with patients differently, they may well not spend any longer with them than previously.

- Although the NIS might pick up patients and crises early providing a faster service, there were also patients who might deteriorate fast and it would not necessarily be possible to avoid hospital admission.

- Many thought that it would be unlikely that there would be a great change in patient experience and if there were it would probably go unnoticed. Further some GPs argued that care would be no different for their patients since they already provided 'holistic' care. It was also argued that there was a potential danger the NIS would become another tick-box exercise.

- The majority believed that the appropriate professions were in the multi-disciplinary Teams and including social workers and a geriatrician was seen as a huge bonus. There was more debate about the role of the Care Navigators but the concept was applauded and seen as integral to the concept of the NIS.

- Some difficulties were reported in the development of the multi-disciplinary meetings across practices in terms of both how they were being conducted and attendance. Members of the CHS also reported they felt 'superfluous' at meetings emphasising the lack of integrated working and difficulties within their relationships with practice staff. They also pointed out that they held their own meetings every day to discuss patients.

- Most acknowledged that the Care Plan was a useful document but there was confusion as to whether it was a 'plan', a 'referral' or an 'assessment'. It was considered that all professionals should be involved in its compilation and it should not be the responsibility of one professional group. A number of professional groups argued that they would still need to do their own specialist care plan for their patients but the most common concern was that it should be a 'live' document and would need to be constantly updated. There was also criticism of the length of the form and the nature of the questions particularly those about 'end of life' care and 'wellbeing' and a

general feeling that the form was running the risk of becoming another 'tick box' activity. It was additionally queried whether the Care Plan was needed at all if there were regular multi-disciplinary meetings held and if the Orion system was working effectively.

● Although 'consent' was seen as being both appropriate and necessary, a number from all professional groups argued that there was a lack of clarity about how the information would be used and by whom and this led to a sense of uneasiness not least since many patients would sign 'anything' if asked to. Potentially, it was thought by some, that it could undermine the trust that existed between patients and GPs.

● The vast majority felt that the Single Point of Access was working well and effectively but for a minority there was a lack of clarity particularly about who was able to telephone the service, whether it was patients as well as providers.

● The majority considered that Orion would be a huge bonus if it worked. There was nonetheless a level of scepticism as to whether it would meet all expectations.

● The Mental Capacity Assessment raised no particular issues or concerns and the new training was generally welcomed.

● Finally, most felt it was too early for an evaluation of the NIS but there was greater concern as to how the CCG would evaluate it and whether or not there would be outcome measurements. There was a general consensus that hospital admissions could not or should not be the only indicator and that 'better health' should be the key issue as seen from the perspective of patients.

Summary of patient findings
Research carried out between September and November 2014.

● There was evidence that the patients interviewed, who were suffering from a range of co-morbidities, felt a loss of control of their lives, exacerbated by their medical condition and by a element of fatalism, particularly with regard to the provision of their care. There was a belief among the older respondents that old age was not respected and, across the cohort, was a level of general anxiety and depression which cut across those living alone and those living with families.

● Interviewees focussed particularly on their day-to-day needs, not simply in terms of health but more frequently in terms of concerns such as the fear of a loss of a 'partner/carer', the need to keep their homes clean, malfunctioning of home gadgets, burglaries and so on.

● There was a call for greater 'support' but the nature and level of support was rarely clarified. Partly this was because the deterioration of the medical condition could not be predicted but it was also hard for

respondents to think beyond their immediate concerns which were more pressing. What appeared to be critical was the need for support to enable patients to articulate and communicate what they needed and at what point.

- GPs were generally perceived to be only able to deal with purely 'health' and medical issues. Many respondents were reluctant to ask the GP for support or help, some even for 'health' issues.

- Other sources of support were discussed such as a specific individual who might provide a co-ordinating role or simply be a 'befriender'. A free telephone service was suggested as was a directory of key telephone numbers listing all the centres of care, including social care.

- The support of families was seen as pivotal and there was a stark contrast with those interviewees who did not have a family around them in terms of support needed rather than in terms of the nature of the problems raised by illness.

- Specific individuals (such as a District Nurse, a GP, a social worker, the local librarian), often played a critical role in patients' lives and the removal of this support, through job changes for example, could have negative consequences for the individuals concerned.

- Many respondents believed that socialising benefitted them and their health and the lack of social contact was difficult for those on their own as well as for those living with families. Accessing social provision could also be beset with difficulties for this group and there was a call for more volunteers to help visit the elderly and infirm.

- Anxieties about their own health fed into perceptions about provision which again was more acute for those living on their own. However, expectations and perceptions of medical provision also appeared to be dependent on previous experiences either of others or their own but the extent to which negative experiences was treated with equanimity was notable. Many, too, acknowledged they found complaining difficult.

- Many were unaware of services to which they were entitled but there was an overriding concern as to how to obtain care when it was needed. Others complained of poor administration but more importantly about how professionals who did not do what they had said they were going to do such as visit or make contact. Almost all commented upon the long waits for provision and appointments. Other issues mentioned were discharge difficulties, poor transport and language issues.

- GPs tended to be perceived as the gateway to provision and often the most 'trusted' professional. They were, though, criticised for the difficulties in obtaining appointments, their rushed nature and only being able to bring up one problem at each visit. Others called for GPs to carry out more home visits, sometimes to simply 'check' on patients

- An explanation of the Co-ordinated Care NIS was generally well received with particular support for the idea of a Care Co-Ordinator.

- The majority of patients had little recollection of either the Care Plan or the Consent Form. In terms of the latter there was confusion as to what precisely had been signed and there was a request for more information to be given. Experiences of the Care Plan varied widely and, in contrast, more patients could recall the recent letter they had received from their GP surgery regarding having a 'named' GP - a move that was favourably met.

- Few patients had noticed any change in their care over the two interviews during the evaluation.

- Patients tended to see care in 'silos' and, as a result, found it hard to envisage holistic provision.

- Sharing notes was seen to be a good idea. Most believed that GPs and hospitals shared notes but would be surprised if this were the case for other branches of provision.

- Whether or not respondents felt 'involved in' their care or 'listened to' by health professionals appeared to depend partly on their understanding of the terms and partly on the extent to which they were focused on their daily existence and able to think beyond their immediate concerns. In addition, patients would argue they were 'involved in' their care and 'listened to' but their experiences contradicted this. There were, though, also those who did not feel 'involved' or 'listened to' as well as those who did not want 'involvement' in their care.

- Respondents varied as to whether they were more concerned about co-ordination of their care or administrative co-ordination. Whereas some believed that it was essential the GP should 'know' them others felt as long as a GP had their notes it did not matter.

- The cohort sampled in this study was not homogenous. Three broad sub-groups were detected based on the evidence. The sub-groups, which were fluid and not static, were determined on the basis of perceived service and support needs in particular as well as on expectations of service provision. It was notable that the difference in service and support needs between those living on their own and those living with families appeared to be one of emphasis rather than a requirement for different services.

Research carried out by Kate Melvin