Sustainable tailored integrated care for older people in Europe (SUSTAIN-project)

Lessons learned from improving integrated care in the United Kingdom

Colophon

Acknowledgements

Key points

- Whilst there is currently a strong policy emphasis on improving integrated care in the UK, significant barriers to integration remain.

- Improvements to established integrated care initiatives can be made using an implementation science approach, in which local stakeholders and research partners co-design and implement improvement plans; this approach also identifies useful learning for other health and social care systems.

- Experience in the UK case study sites suggests that local innovations at community level should be better supported by the new area-based partnership forums currently being developed in the UK, by ensuring there are investments in primary and community care, and by ensuring strong system leadership.

- Improvements to integrated care rely heavily on frontline staff capable of embracing and driving change, and committed to working with all relevant stakeholders; but also they require support from senior leaders and action from policy makers to minimise barriers.

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1. INTRODUCTION

1.1 Integrated care in the United Kingdom

The existing systems of health and social care provision are no longer suited to meeting the needs and expectations of the increasing number of people living into old age in the UK. In recognition of this, the Parliaments of the UK, Scotland, Wales, and Northern Ireland have all made explicit efforts over the last two decades to facilitate integration in health and social care through joint working, partnerships, pooled budgets and structural changes. Each of the four countries in the UK have different structures, and each have progressed different approaches in facilitating integration and improving outcomes (Ham et al., 2013).

This report describes integrated care in England. Here, there is a strong policy emphasis on moving toward integrated care through new care models, sustainability and transformation plans, and emerging integrated care systems. However, significant barriers to integration remain, and integration is the exception rather than the norm.

A key point for the English system is that the National Health Service (NHS) provides health care free at the point of need and is funded directly by taxation, whilst social care services, on the other hand, are means tested. Local authorities carry out needs assessments in order to assess whether residents qualify for social care services like help maintaining independence at home. The amount individuals pay towards their social care depends on the value of their assets. For older people living at home, in particular, the distinction between what is a health and what is a social care need is not always clear.

The organisational separation of health and social care services contributes to the fragmentation of care in England (Shaw et al., 2011). There is a lack of service

coordination for individual service users and carers and a structural (and cultural) separation of generalist from specialist medicine, health care from social care services, and physical health from mental health care. Evidence has shown that such separation has caused service users to experience a lack of seamless care (Shaw et al., 2011). There is also historical under-investment in community and primary care services, compared with hospital care.

Over the years, different approaches have been taken to reducing fragmentation, including multidisciplinary care in the 1960s, partnership working in the 1970s, and shared care and disease management in the 1980s and 1990s. During the 2000s the focus shifted towards 'whole system' working, for example with integrated delivery networks and integrated care pathways. The most recent policies are building on the whole system working approach by aiming to reduce the barriers between providers and commissioners through policies such as primary care co-commissioning (NHS England, 2018).

1.2 The SUSTAIN project

SUSTAIN, which stands for 'Sustainable Tailored Integrated Care for Older People in Europe' (www.sustain-eu.org), is a four-year (2015-2019) cross-European research project initiated to take a step forward in the development of integrated care. SUSTAIN's objectives were twofold: 1. to support and monitor improvements to established integrated care initiatives for older people living at home with multiple health and social care needs, and in so doing move towards more person-centred, prevention-oriented,

safe and efficient care; and 2. to contribute to the adoption and application of these improvements to other health and social care systems, and regions in Europe.

The SUSTAIN-project is carried out by thirteen partners from eight European countries: Austria, Belgium, Estonia, Germany, Norway, Spain, the Netherlands, and the United Kingdom. With the exception of Belgium, in all other countries two integrated care initiatives per country were invited to participate in the SUSTAIN-project. The initiatives were already operating within their local health and social care systems. Criteria for including these initiatives, also referred to as 'sites', were defined by SUSTAIN research partners and drawn from the principles of the Chronic Care Model and related models (Epping-Jordan et al., 2004; Minkman, 2012; Wagner et al., 2005). Accordingly, initiatives should:

- Be willing and committed to improve their current practice by working towards more person-centred, prevention-oriented, safe and efficient care, which, in line with the European Commission's stipulations, are SUSTAIN's four key domains.
- Focus on people aged 65 years and older, who live in their own homes and who have multiple health and social care needs.
- Support people to stay in their own homes (or local environments) for as long as possible.
- Address older people's multiple needs, in other words, they should not be single disease oriented.
- Involve professionals from multiple health and social care disciplines working in multidisciplinary teams (e.g. nurses, social workers, pharmacists, dieticians, general practitioners).
- Be established, i.e. preferably operational for at least two years.
- Cover one geographical area or local site.
- Be mandated by one organisation that represents the initiative and that facilitates collaboration with SUSTAIN research partners.

The fourteen initiatives selected according to these criteria showed great diversity in the type of care services provided (Arrue et al., 2016; De Bruin et al., 2018). Their focus ranged from proactive primary care for frail older people and care for older people being discharged from hospital, to nursing care for frail older people, care for people with dementia, and palliative care.

In the SUSTAIN-project, we adopted an implementation science approach using the Evidence Integrated Triangle (Glasgow et al., 2012), in which local stakeholders and research partners co-design and implement improvement plans. In the first phase of the project (starting autumn 2015), SUSTAIN-partners established working relationships with the different sites, and identified relevant local stakeholders related to the initiative (i.e. managers, health and social care professionals, representatives of older people and informal carers, local policy officers). Furthermore, they carried out baseline assessments of each initiative's principal characteristics and also worked with local stakeholders to identify areas of current practice in

the initiative, which might be subject to improvement (e.g. collaboration between formal and informal care providers, involvement of older people in care processes). Findings from the baseline assessments were used as inputs for workshops with key stakeholders related to the initiative at each site. The purpose of the workshops was to discuss outcomes of the baseline assessments and enable sites to determine local improvement priorities.

In the second phase of the project (starting spring 2016), local steering groups were set up. Steering groups consisted of stakeholders who participated in the workshops together with additional local stakeholders considered relevant to the initiative. These steering groups were created to design and implement improvement plans, that is, sets of improvements that apply to local, site-specific priorities. Each steering group agreed to implement their plans over the 18-month period from autumn 2016 to spring 2018. In each initiative, implementation progress and outcomes were monitored by SUSTAIN partners using a multiple embedded case study design, in which each initiative was treated as one case study (Yin, 2013). A hallmark of case study design is the use of several data sources, a strategy which also enhances data credibility (Creswell, 2009). SUSTAIN partners therefore used a set of qualitative and quantitative data collection tools (see Annex 1), allowing us to collect data from different data sources, being: surveys to users, surveys to professionals, interviews with users and carers, professionals and managers, care plans/clinical notes, field notes, notes of steering group meetings, and templates to collect efficiency data from local services, organisations or registries. Data were collected at agreed and specified times during the 18-month implementation period, using the same procedures and tools for all initiatives. In addition to a core set of data collection tools applied in all initiatives, sites were being encouraged to select site-specific tools tailored to their site-specific context and improvement priorities.

Data were analysed per site, guided by the principles of case study design. There were three steps in our analyses: 1. all data sources were analysed separately using uniform templates for analysis which were generated through a discussion among research partners; 2. for each data source, data were reduced to a series of thematic statements (qualitative data) or summaries (quantitative data); 3. an overarching site-specific analysis was done, in which all qualitative and quantitative data were coupled and underwent a process of pattern-matching across the data. This is the approach of choice for evaluating complex community-based interventions which are context bound and noted for their differences in application and implementation (Billings and Leichsenring, 2014; Craig et al., 2008). In order to be able to do a site-specific overarching analysis, we created an analysis framework which was used by all SUSTAIN partners in order to create uniformity of approach. Data were analysed against the propositions and analytical questions presented in Table 1.

Proposition 1	Integrated care activities will maintain or enhance person-centredness, prevention orientation, safety, efficiency and co-ordination in care delivery.
Proposition 2	Explanations for succeeding in improving existing integrated care initiatives will be identified.
Analytical question 1	What seems to work, in what kind of situation, and with what outcomes when making improvements to integrated care?
Analytical question 2	What are the explanations for succeeding and improving integrated care initiatives?
Analytical question 3	What are the explanations for not succeeding and improving integrated care initiatives?
Analytical question 4	Are there any factors that are particularly strong in the analysis that could be seen as having an impact on integrated care improvements?
Analytical question 5	What factors can be identified in the analysis that could apply to integrated care improvements across the EU, and be transferable?

1.3 SUSTAIN sites in the United Kingdom

This report is dedicated to the SUSTAIN sites from the UK. The SUSTAIN project cooperated with two integrated care initiatives in Kent in the South-East of England. Reasons for including these sites are reported elsewhere (de Weger and Billings 2016). The first case study described in this report is called Swale Home First. This initiative represented efforts to improve integrated care for older people returning from Medway hospital to their home in Swale, north Kent. A 'discharge to assess' project was designed in 2016 in collaboration with the SUSTAIN team, and new processes for hospital discharge, a home-based assessment of needs and the provision of integrated health and social care at home were initiated in February 2017.

The second case study is called the Over 75 Service and is based in Sandgate Road Surgery, which is a General Practice (GP) centre, in the South of Kent. This project was designed to provide integrated health and social care for people over the age of 75, who are frail and housebound, in order to improve their wellbeing and maintain their independence. A pathway was developed based on an initial assessment of frailty and described the services and organisations involved in meeting users' and carers' health and social care needs. SUSTAIN partners supported the development of the project which has been operational since April 2017.

In Chapter 4, the main lessons learned from Swale Home First are presented. Chapter 5 introduces the second care site, called Sandgate Road Surgery, Over 75 Service. Here, the site, its characteristics and the aims of the improvement project are described. Chapter 6 presents the main findings from this site, including what seems to work for whom and explanations for why it was successful and unsuccessful in integrating care. Chapter 7 presents the main lessons learned from the Sandgate Road site. In Chapter 8, the lessons learned from both case sites are discussed together. The chapter highlights the implications of the SUSTAIN project for integrated care in the UK and suggests recommendations for both policy makers and service providers.

1.4 Reader's guide

Chapter 2 introduces the first case site, called Swale Home First. It describes the characteristics of the improvement project, introduces the site and outlines the aims and objectives. Chapter 3 discusses the main findings from Swale Home First, in terms of what seems to work for whom, and explanations for why it was successful and unsuccessful in integrating care.

PART 1
Swale Home First

2. SWALE HOME FIRST: CHARACTERISTICS AND IMPROVEMENT PROJECT

2.1 General description of the site

Swale is the third most deprived district within Kent and is ranked 70 out of the 326 districts in England, with the majority of the most deprived areas on the Isle of Sheppey – a small island off the northern coast. Swale has the lowest life expectancy in the region. Inequalities are high within Swale too; there is almost a 10-year gap in life expectancy between the wards with the highest and lowest life expectancy rates. In 2015, there was an estimated 142,000 people living in Swale (Public Health England, 2018).

In Kent, the county council is responsible for social care services and provides formal care services in residential care homes and in people's own homes. Kent County Council (KCC) manages the Kent Enablement at Home (KEaH) service, which is county wide, and which provides up to 3 weeks' support at home for people returning from hospital. KEaH staff work with users to learn or re-learn important skills they need for everyday life, such as regaining confidence following a fall. KCC also employ care navigators who help older people to stay independent in their own home. KCC has a statutory responsibility for improving the health of its citizens and for providing local health improvement services (such as support with lifestyle changes or mental wellbeing). Swale is also served by Swale Borough Council, which is one of 12 lower-tier district councils in the county. It is responsible for housing and planning, amongst other things, and provides help and advice for older people dealing with repairs, adaptations and home safety issues to help them to stay in their own home (the service is called 'Staying Put').

Health care services are planned and commissioned by local NHS Clinical Commissioning Groups (CCGs) - clinically-led statutory NHS bodies. Swale CCG is one of seven within the KCC area. It commissions urgent and emergency care, community health services such as district nurses and rehabilitation services, primary care services, planned hospital care, and mental health services. Swale CCG currently (since September 2016) commissions Virgin Care to provide Adult Community Nursing Services. Medway Maritime Hospital, managed by Medway NHS Foundation Trust, is one of the key hospitals in the area.

To design and implement this improvement project, a commissioning manager from Swale CCG has worked with:
• A clinical nurse lead at Medway Hospital.
• Service managers at KCC.
• Social workers (case officers and a team manager) from KCC's integrated discharge team (based in the hospital).
• A locality manager from KCC's KEaH service.
• Clinical leads (therapists) from Virgin Care's Rapid Response team.
• A manager from Swale Council's 'Staying Put' service, and
• a representative of HealthWatch (the independent national champion for people who use health and social care services).

A manager from the local Age UK branch was involved in initial discussions, and was informed throughout, but unfortunately was not able to attend more than one steering group meeting.

2.2 Rationale for improvement project

Delayed transfers of care (DTOCs), particularly for older people, are a policy priority in England (Department of Health, 2017). They occur when a patient is ready to leave a hospital or similar care provider but is still occupying a bed. Longer stays in hospital can lead to worse health outcomes

and can increase people's long-term care needs. Delayed transfers of care can also affect waiting times for NHS care, as they reduce the number of beds available for other patients. If delayed transfers of care are reduced, system flow may be improved, enabling patients to access urgent care at the time they need it.

For people who no longer need to be in an acute hospital, the completion of health and social care assessments and the setting up of care plans, arranging of care packages and introduction of physio and/or occupational therapies could be delaying their prompt return home. The improvement project sought to address this by shifting these activities to the home setting following a more prompt transfer home.

2.3 Aims and objectives of improvement project

Swale Home First was based on a 'discharge to assess' model described by NHS England and partners (NHS England, Department of Health, & ADASS, 2016). This model made 'going home' the default pathway, with alternative pathways for people who could not go straight home. The model focused on discharging users from acute and community hospitals as soon as they were medically fit, with care coordinators supporting users and their families throughout the discharge process, and care packages and in-house reablement and rehabilitation services put in place to support the user in their own home (Monitor, 2015; The Health Foundation, 2013).

The Swale Home First improvement project targeted the shifting of previously hospital-based activities – assessment, arrangement of a care package and initiation of physio- and/or occupational therapy – into the home setting. One key aspect of the project therefore was to conduct a comprehensive, 'context-specific' assessment of an older person's health and social care needs upon their return home. A second key aspect was to ensure coordinated, person-centred 'wraparound' support was available to enable individuals to recuperate and to regain/maintain their independence at home.

2.4 Explanation of the improvement project

The intervention required a change in the pathway, ensuring that patients deemed suitable for Home First were placed on a 'fast-track' discharge process. This process was familiar to staff at Medway hospital, since a Medway Home First program (for patients returning to their homes in Medway) had already been implemented. The aim, therefore, was to replicate as far as possible the Medway model for Swale patients. The 'ideal' service user for Home First was deemed to be someone who: has additional care needs that can be safely met at home; is identified as

medically fit but further support is required; is deemed safe between visits at home; and needs support and/or rehabilitation. For these service users, staff at Medway hospital were asked to forgo conducting care assessments or initiating certain therapies which were deemed more appropriate upon the user's return home, and instead to refer them to Home First. To enable this process, the improvement project team needed to:
- Identify clear and simple criteria for referral and a tool for risk screening use in hospital
- Identify the process for referral (single point of access, ideally same as for Medway Home First).

Clear communication was required to enable hospital-based staff to shift their thinking to 'home first' and to promote independence for older people with ongoing health and care needs. In this case, the benefits for service users and for the system needed to be clearly articulated to hospital staff, who also needed a good understanding of the Home First process following referral so that they could make sound decisions based on an assessment of risk. The Home First team needed to develop a number of communication tools for the wards – posters, pathway diagrams, and launch events – to highlight the potential benefits for users of the Home First service.

The intervention also required a change in the health and social care needs assessment process, so that full assessments took place at home rather than on the ward. In order to reduce the potential level of risk to the service user, the aim of the service was to conduct the assessment within two hours of the service user's return home, in line with NHS England guidance on discharge to assess services (NHS England et al., 2016). This meant the hospital staff could be assured that the person's care needs would be assessed and met quickly. The improvement project team needed to identify a tool for a single assessment of ongoing care and support needs, at home, that would be acceptable to both health and social care providers. They also needed to identify the assessment process – who the service user would be assessed by, at what stage, and how assessment information would be shared.

In order to ensure sufficient and appropriate support was available to users on their return home, the project team needed to identify the process for care package arrangement, and to ensure there was sufficient capacity amongst wraparound/enablement service providers to respond rapidly. They also needed to ensure there was a process to escalate issues with getting appropriate support arranged in good time.

A summary of the key aspects of the improvement project, and key requirements for implementation, is shown in figure 1 below:

Prompt discharge
- Criteria for referral and risk screening tool
- Process for referral (including fast-tracking discharge processes)
- Excellent and ongoing communication to ward staff

Home-based assessment
- Single, agreed health and social care assessment form
- Process for assessment (within 2 hours of arrival home) that satisfies all providers, and process for sharing of assessment information

Support at home
- Process for speedy care package arrangement (and quick provision of equipment)
- Sufficient capacity amongst community service providers to respond rapidly
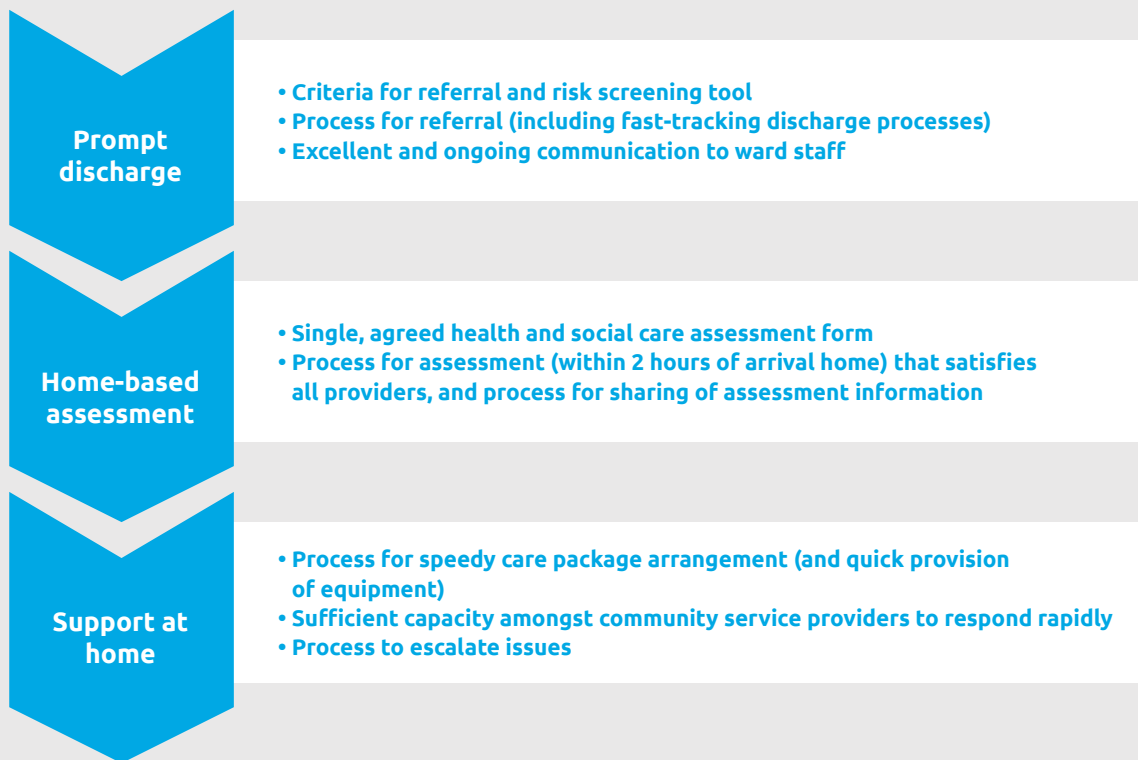- Process to escalate issues

Figure 1 - *Key aspects of improvement project and requirements for implementation.*

3.   FINDINGS OF THE IMPROVEMENT INITIATIVE IN SWALE HOME FIRST

3.1 Introduction

Researchers worked with the project team from October 2015 to identify the stakeholders, form/support a steering group, specify the improvement project and plan its implementation. On 1st February 2017, a restricted/partial version of the improvement project was launched enabling up to one patient per day (Monday to Friday) to be transferred home via Home First. From April 2017 to April 2018, SUSTAIN researchers collected data in order to monitor and evaluate progress and outcomes of the improvement project. Table 2 below provides an overview of the quantity of data collected per data source. More information about the different types of data collected can be found in Annex 1.

In terms of participant demographics, half of the ten users were male, six were in the 75-84 years age bracket (two were 65-74 and one was 85 or over), and half had a low educational level (completed schooling up to age 16). Four of the ten users were living at home alone, which is consistent with the growing number of single-person households across Swale. The average number of medical conditions was 3.5 (range 0-6). The most prevalent condition was persistent back pain. All carers were spouses, so they were all in the 65+ age category, and all lived with the user. They all felt it was not possible to quantify the number of hours they spent caregiving, as opposed to helping their partner as part of a usual relationship. This is despite the fact that one of the carers (an 85+ year old male) was supporting a wife with a high level of health and social care needs including dementia (she was not eligible to be interviewed as part of this study). None of the carers had had a needs assessment for their own needs, and just one had their own care plan, related to ongoing considerable healthcare needs.

Of the six managers in our sample, five were female. Only one reported being under 45 (in the 25-34 years bracket).

Two worked for a health care organization – one as commissioner and one as a provider team manager; four worked for social care/local government. All six had permanent contracts, and all but one worked full time. Of the eight professionals in our sample, all were female, and all were between the ages of 25 and 54 (four were between 25 and 34). All participants were on a permanent contract, and all but 1 worked full time. Two of the sample were administrative officers (one senior). Four were case officers working for local government social care, but within the acute hospital setting. One was an occupational therapist working for a community healthcare organisation, and one was a clinical lead working in the acute trust.

Ethical approval for this study was obtained from the NHS Health Research Authority (REC reference: 16/IEC08/0045).

3.2 What seems to work?

Home First Swale experienced significant challenges in implementation, described further in section 3.4. Despite these challenges, aspects of integrated care were occasionally supported through Home First.

Co-ordination

In interviews with health and social care professionals, it was suggested that those involved in transfers home from hospital were now working better together, as a result of being involved in Home First. By improving communication amongst themselves, various providers were able to develop a better understanding of each other's services, requirements and capacity issues, which led to better collaboration. This manager from Rapid Response talked about the sharing of information between teams:

Table 2 - *Summary of data collected for Swale Home First.*

Data source (Professionals & managers)	N	Data source (Service users & informal carers)	N
Manager/Professional Demographics	14	User Demographics Carer Demographics	10 5
Team Climate Inventory (TCI)	Baseline 7 Follow-up 4	Interviews users and carers	6 users 1 carer 4 dyad
Interviews managers and professionals	10	Person-centered coordinated care questionnaire (P3CEQ)	10 users
Minutes of and reflective notes from steering group meetings	15	Perceived control in health care questionnaire (PCHC)	5 users
Field notes	1 document with notes taken throughout (Dec 2015 – April 2018)		

"I would say myself and KEaH … [and] ourselves and the Integrated Discharge Team at Medway, because we do liaise with them quite a lot about referrals that they send through and also the Social Services OTs [occupational therapists] because we've had to liaise because of sharing a rota and it meant we did all meet, so that we could put faces to each other and know who to ask and I didn't want their OT to feel like she wasn't supported at all so, you know, she spent time with some of my OTs going out, doing the visits, so she knew who she could contact. So definitely we've built more links that way as well." (Manager 1)

The new assessment form introduced as part of Home First reduced duplications of assessment between NHS therapists and social care workers since the therapist was completing a goal sheet, identifying a package of care, then handing this over to a KEaH officer, who was then accepting and taking on those goals with the service user.

From a user's point of view, there were signs that different service providers communicated with each other, often in the background, or within paperwork left in users' homes. However, the P3CEQ results suggested that users generally didn't have a single professional (or several professionals) taking responsibility for coordinating care across the services they used. This chimed with interviews, where respondents reported a number of people coming in and out of their home, without any sense of a key person or coordinator. In the words on one service user, *"It all seemed as if the right hand doesn't know what the left hand's doing"* (User 8). Responsibility for co-ordination of care at home shifted more onto the user, and it was unclear whether they knew the implications of this, or received the support required to enable them to do this. Of the five users who completed the PCHC, two were in control of their own care, and two took joint control with family/friends. All participants had family members and/or a close friend who 'stepped up' and provided more help with co-ordination when care needs were highest. Interview and survey data suggested that users sometimes didn't know where to look

for more support at home, and were not aware of who was responsible (other than themselves) for co-ordinating care. For half the users that participated in the evaluation, this was less of an issue since they were mostly being cared for by their spouse.

Whilst Home First users sometimes received more co-ordinated support from Rapid Response and KEaH, some users still felt the organisations operated independently, rather than together, and the staff from each service worked in quite different ways. Moreover, there was difficulty getting quick access to other support or 'wraparound' services from voluntary sector organisations.

Person-centredness

Home-based assessments were potentially more contextually relevant and therefore more personalized than those conducted in hospital. One carer described the home assessment:

"And she went through everything we'd got in the house that would aid Mary, and she checked the hand rails and the handles, and we said about the toilet so Mary could push herself up, and she said, 'Well, I will get one of my assistants to drop them out this afternoon', which they did, and they came in and put them up and that was it, wasn't it?" (Carer 10)

An occupational therapist explained from her perspective:

"I think it gives you more of a real reflection of how they're actually going to manage at home. In hospital, someone can say to you 'I can cook my meal', but if you're not, when you're in their home, if you can see that actually they haven't got a microwave and they've only got a really low oven and they can't lift things, they can't just say to you, 'Well, I manage', because you're going to say, 'Well, actually, you're never going to get things in and out of that oven.' But it's little discrepancies like that that when you're in the home and you can see their home environment, you're able to realise." (Manager 1)

However, users were sometimes too tired after the transfer process (and sometimes a lengthy journey via patient transport) to be subjected to a full assessment within a few hours.

Whilst a care manager said in interview that clients *"get what they want in the sense of they want to be at home, so they get home a lot quicker"* (Manager 5), this perception was not supported by user/carer data. Rather, data from users suggested that patients sometimes felt "pushed" out of hospital (User 2) (*"because they want to get rid of you don't they"* User 7) before they were fully prepared:

> *"I was shocked because I didn't know, no-one told me, or this other lady, and the ambulances just turned up and they said we're taking you home now … I didn't even know I was going home … It must have been about 10 o'clock of a night [when I arrived home]."* (User 11)

Once home, the emphasis on self-care and enablement can be empowering. However, it can also be difficult for some users, particularly when they have just returned from a stay in hospital and may be feeling anxious, exhausted and in need of being looked after a little. Data from user interviews suggested that there sometimes appeared to be a lack of compassion amongst staff working to 'enable' self-care, and users were sometimes missing the 'softer' aspects of a care visit, such as the offer to make a cup of tea, help with washing in the shower, or holding their hand whilst talking about how they are feeling today. A few users, in interview, described the enablement service as uncaring, unhelpful and bullying, as they talked about being told to make their breakfast when they were exhausted, or being watched while they showered themselves or struggled with putting socks on, as the following quote highlights:

> *"And there's one who come and said to me "I'm not doing anything today, I'm going to watch you." … Christ, bloody mad, I was. I was upstairs, trying to get a stocking off. "I'm not going to help you", she said. I said "Well, I've had enough. I can't." She said "Yes you can! I'm just watching today."* (User 1)
> Interviewer: *"How did that make you feel?"*
> *"Terrible."* (User 1)

In steering group meetings it was acknowledged that it was difficult to get the balance right between doing things for people, and enabling them to do it for themselves, but that this largely relied on the individual staff member to respect the user's dignity and to respond in a caring and compassionate way. This issue was discussed in a steering group meeting in November 2017, when an occupational therapist suggested that goal planning can really help to manage expectations and improve understanding of the enablement service. However, in the discussion, members highlighted that *"it is necessary to stand and watch someone have a shower if there is a risk they won't be safe. But there are ways of making it less embarrassing for the user, e.g. by getting on with a task"* (Steering group member 1). Also, *"KEaH would do things like getting a user to make her own breakfast, because they want to push her and see what she can (and can't) do."* (Steering group member 2).

Prevention and safety

Occupational therapists seeing the user in their own home had quick(er) access to a range of support, including equipment, a health technician, and physiotherapy. However, beyond this, the support available to Home First service users at home was quite limited. Users without spouses living with them felt scared, weak and vulnerable:

> *"Well I was fragile coming home from hospital and especially being on my own here. [Sighs] I just needed someone to hold my hand [very upset]."* (User 8)

> *"I was frightened of falling."* (User 11)

Similar feelings were expressed about care being scaled back before users were ready.

Users interviewed received very little personal care (most essential only and usually based on a user's needs on a good day), at particular times (for instance, help with getting to bed at 5pm), or provided by a limited range of carers (usually not including the voluntary sector). If users didn't have good self-support or family support strategies, this sometimes left the user (and sometimes carer) vulnerable and struggling to cope. In addition, data suggested that when out of hospital, some aspects of users' health care – such as medication review and adherence – might not be a focus. This could be exacerbated when (as some user interviewees suggested) GPs might be quite inaccessible to the service user (due to high demand/low capacity).

Some people may be more receptive to input once they are in their home environment. For example, in a steering group meeting, one of the earliest service users benefiting from Home First was described:

> *"This man was very keen to get home, and didn't want input, although he had multiple complex (health and social care) needs. He self-discharged before input, but was picked up in the discharge lounge. [Case Officer] saw him and referred him to Home First. [Occupational Therapist] conducted his home visit and identified a range of support (including ordering a bed and instructing him on how to get up off the sofa), which the client was happy to accept now home. He was connected to Staying Put, who arranged support to help him stay at home".* (Extract from steering group meeting minutes, March 2017).

Occasionally people were transferred via Home First when it was not appropriate to do so (e.g. more preparation was necessary to make the home setting suitable for safe recuperation). People were sometimes discharged on the understanding that they would have an assessment the same day, but arrived home too late for this to take place. Three such service users spent the night on a sofa or in a chair, as this user describes:

> *"I come home, it was about eight o'clock at night I come home … I was in my nightie, a hospital nightie and that, and I come in, I went straight on this chair and stayed here all night and wouldn't go anywhere because I felt so dirty, I wanted a shower like, you know, and I was waiting."* (User 3)

Efficiency

A shared objective to reduce DTOCs, and a project that focused minds on this objective and enabled improved co-ordination between providers in hospital and in the community, enabled some medically optimised patients with low ongoing care needs to be discharged sooner, perhaps by 24-36 hours. However, the referral process involved lots of to-ing and fro-ing between different teams to identify whether the patient was suitable, and whether there was sufficient capacity in the community to meet that service user's needs, which meant the maximum potential for reducing the delay was sometimes lost. Moreover, the lack of capacity in the community services – exacerbated by the extreme pressure on services over winter periods (called 'winter pressures') – meant that delays crept back into the processes. The added value of Home First, over and above a normal discharge via the KEaH service, was not always clear.

For Home First service users, there was a reduced input from hospital-based occupational therapists, and there could be less over-anticipation of a person's needs and more appropriate packages of care arranged from the start, which complemented the users' own self-support and family support strategies. However, the referral/discharge process required more time to be spent by KCC case officers, and staff in the community sometimes wasted time waiting for a Home First service user to arrive home or to start a care package only to find that their transfer did not happen that day, or that they did not need the care package after all. Whilst it was not possible to collect quantitative data on efficiency, qualitative data suggested that the Home First improvement did not lead to more efficient processes.

3.3 What are explanations for succeeding and improving integrated care initiatives?

Ongoing pressure from a strategic level systems resilience group[1], a supportive policy environment, and consistency and links with a wider 'transformation process' (across national, regional and local levels) geared around improving urgent and emergency care, ensured the improvement project had to press on with implementation.

The discharge to assess model was endorsed by NHS England, and the principles underpinning it were widely shared and promoted. TCI scores suggested that the steering group members were in strong agreement of Swale Home First objectives, and felt that the objectives were worthwhile to the organization. In meetings, members showed real persistence, commitment and willingness at every level to make it work. The group met frequently and consistently. Having the right people on the group (including both operational and senior management staff), and a flexible membership so that new people could come in, meant that the group could understand the issues

and challenges, and ensure a good fit with wider context. They could also both take issues 'up' to other managers where required, to help improve situations affecting or related to Home First implementation, and take a 'deep dive' look at individual service users to try to identify learning for further improvements.

Leadership from the University of Kent in the early phase (up to month 6) helped to keep a focus on integrated care. Following that, there was shared leadership across three key organisations (KCC, Swale CCG and Virgin Care), which ensured joint organisational responsibility. Leaders demonstrated and talked about the importance of a 'can do' attitude, which sometimes involved taking a risk or acting at the edges of their role boundary, as this manager described in an interview:

> "… I've said that we can do this and we will do it because there's no other way of taking it forward. And sometimes I've sort of taken the risk really." (User 9)

There was evidence during the steering group meetings of much inter- and intra-organisational collaboration going on; there was lots of information sharing, identification of problems, and thinking through improvements or solutions. Indeed, TCI scores suggested that there was a positive climate for teamwork and innovation. Interviews with professionals also described how Rapid Response and KEaH team members in particular were getting to know each other, developing trust between each other, and developing a better knowledge of each other's services.

A change in provider for community health services in 2016 (Virgin Care won the contract in January and started provision in September) was hugely disruptive, but it did perhaps offer an opportunity to explore new or different ways of doing things. Moreover, the relative flexibility and responsiveness of Virgin Care (perhaps not so hampered by 'clunky' structure and procedure as large public sector bodies) was deemed by one interviewee to be an advantage to the improvement project.

Central government support in the form of 'High Impact Change' money (released late 2017 and specifically focused on reducing DTOCs) and additional funds to help cope with winter pressures, enabled KCC to increase their staffing capacity both in KEaH and in community based occupational therapy. The additional occupational therapist shared the Home First rota for initial visits, thereby releasing a bit of pressure from Virgin Care's rapid response team.

3.4 What are the explanations for not succeeding in improving integrated care initiatives?

Swale Home First experienced significant challenges in implementation, due largely to a lack of funding, weak capacity, and (throughout 2016) the upheaval caused by the change in provider for community health services.

[1] Systems resilience groups include representatives of local providers, commissioners and social care organisations. They are headed by CCGs and aim to cut waiting lists and ease winter pressures.

One of the most important barriers to progress for this improvement project was a lack of financial investment, coupled with already weak capacity particularly in the community services (due in part to staff vacancies, difficulties in recruitment, and the change in provider contract). Capacity was tested even further during one of the worst periods of 'winter pressures' the stakeholders had known; the local health and social care system spent much of winter 2017/18 at the highest 'operational pressures escalation level' (OPEL), indicating that organisations were unable to deliver comprehensive care and that extensive support and intervention was required (NHS England & NHS Improvement, 2016). In addition to the increased demand on services, the high OPEL status triggered frequent systems calls (teleconference calls for updates and accountability), demands for information, and requirements to cancel anything not deemed to be urgent, which is disruptive to new improvement initiatives.

The improvement project relied on adequate capacity within the community services to be able to respond quickly to the needs of discharged patients. Whilst the CCG hoped the project could be achieved by just getting existing staff to work in a different way, capacity in the community was already too weak. The option to move staff from one part of the system to another proved too difficult because of shortages of capacity right across the system, and due to differences in expertise/skills. However, KCC were able to help support weak capacity in Rapid Response, which sometimes entailed making compromises in the project plan:

> *"We still realised that with the capacity and what we were trying to achieve we needed that first response to be there, which Virgin community health couldn't always guarantee because they're, you know, their staffing levels. So that's when I went back to our management and said 'Can we use KEaH to try and support', obviously we're not going to be as reactive with the two hour response time but ..."* (Manager 16)

The pressure from the higher-level strategic group was not coupled with corresponding financial support. The CCG were in financial deficit and were therefore unable to commit any resources to it. The lack of additional finances for Home First meant that teams already pushed to the limits were expected to do more or work differently. There was no creation of a single team, or a shared space or computer systems. They couldn't simply buy in a private provider to provide the wraparound support (as was the case elsewhere), and they couldn't assign a dedicated project leader/manager with the time to lead (as happened for Medway Home First). Resource issues often dominated the agenda such that many actions the group identified as necessary to implement the improvement project were not followed through.

Moreover, ongoing financial cutbacks across the public sector were harming the ability of the voluntary sector to be involved, and were leading to the loss of some services that could contribute to 'wraparound' care. Voluntary sector providers were not involved in the improvement project, although Age UK noted the value they could add, and users often noted that they lacked the kind of services such organisations provide, such as befriending and support with shopping or making meals.

Whilst financial constraints affected both health and social care, they felt more acute for health service providers. The lack of investment from either the CCG, the hospital or Virgin Care, and the already weak capacity meant that health service providers were not able to lead the project, and were insufficiently integrated into Home First wraparound care. The shortage of capacity in the community significantly hampered the objective to discharge the patient then assess their needs; the objective to provide a comprehensive wraparound service; and the objective to have a health-led active recovery team. It also lessened the difference between Home First and normal discharge. The injection of funding in late 2017 by central government boosted capacity in social care but not health care, which arguably sidelined the health organisations' involvement still further.

The steering group often discussed the need for a dedicated and strong lead, with relationships with the hospital trust and community staff, and with the responsibility to drive the project forward. Instead, leadership had to come from various different people running their own services, which could cause difficulties as they tended to see their own pressures and *"lacked the helicopter view of what would streamline the process"* (UK1M005C). The focus of the improvement project was lost over time. As highlighted in section 3.2, as the priorities of individual services sometimes over-rode the priority of the integrated care intervention, there were sometimes less than satisfactory outcomes, particularly related to person-centredness, co-ordination and efficiency. Governance was also not as robust as it could have been – professionals interviewed pointed to a lack of joint governance across health and social care.

Aspects of geography and location relevant to Swale were also seen to influence the progress of integrated working. The key organisations involved in the improvement project do not share geographical boundaries with each other, and service provision is highly fragmented. Swale is one of 12 districts in Kent, and due to its location it has tended to fall or be passed between the traditional 'east/west' locality groupings. In addition, Swale residents make up a minority proportion (about 30%) of patients treated at Medway hospital (which is outside of the KCC area). Whilst a representative from Medway hospital attended the steering group, their attendance was sporadic, and not at a sufficiently senior level to push for change or commitment within the hospital. Several key barriers to effective implementation of the improvement project needed to be addressed at the hospital level. In addition, the Swale team were not permitted to 'piggy back' on Medway Home First (in terms of using its single referral number), and had instead to create new processes and systems which increasingly created difference between the two models; staff on the wards understandably found this confusing.

The awarding of the contract for provision of adult community health services to Virgin Care in 2016 prompted a long period of upheaval as the new provider moved in and scrutinised the large and complex contract. Some staff chose not to transfer to Virgin Care, adding to the vacancies in the area. Previous alliances (e.g. with Age UK) were affected, and some services were altered or removed.

The progress of the improvement project was significantly affected, as there was a long period of distraction and uncertainty, where key decisions could not be taken.

The referral of patients to Home First depended on ward staff understanding and trusting in the project. Interviews with professionals alluded to aspects of culture change that were required in the improvement project. Therapists in the hospital were described as inherently quite risk averse, and might have been reluctant to see patients discharged without them doing a full assessment. There is a tendency to move older people straight from hospital to long-term care, and one social care manager in particular pointed to the change that needs to happen in hospital with regards to promoting independence and reducing the tendency to remain a 'patient' (in bed, in a gown, and dependent).

Some factors influencing the success of Home First were to do with its design. It was tricky finding the 'ideal' service user: some were too straightforward to benefit, others were too complex for that pathway. Professional interviews highlighted that different people interpreted suitability in different ways, and it seemed difficult to get everyone's agreement on what was and wasn't appropriate. Given the steering group were unable to deal with various key constraints, the project was ultimately adapted to operate around those constraints. This made it somewhat complicated and different to the Medway model, which created confusion on the wards. An effective communication strategy was not implemented due to lack of finances. Moreover, there was no user/carer involvement, and very little voluntary sector involvement in the improvement design or planning.

Some factors influencing the success of Home First were to do with the complexity of the processes for hospital discharge and community referrals. Within these processes - which included board rounds, discharge notes, communication with ongoing providers and the service user and family, organisation of medications, arranging of transport, etc. - there were many opportunities for delay. As one manager interviewee said:

> *"I think there's so many different elements to getting that patient discharged that, if they all come together at the same time, it's a flipping miracle, to be honest."* (Manager 20)

This points to the difficulties of making improvements by changing the parameters without also changing the wider structures, processes and systems which can impede improvement.

4. MAIN LESSONS LEARNED FROM SWALE HOME FIRST

4.1 Working towards integrated care improvements that could have impact

The Swale Home First case study highlighted the difference between working together to achieve a set of objectives, and integrated working focused on individual people and their needs. It demonstrated success in that people within different teams worked together to implement a version of Home First – their knowledge and understanding of each other appeared to grow; they shared information, highlighted issues and worked together to resolve or find ways to work around those issues. They appeared, too, to achieve some success with regards to aspects of person-centred care at least for a sub-set of users. For example, older people with someone at home to help look after them, and who felt ready and were keen to return home from hospital, received a more appropriate needs assessment and were quickly provided with equipment and support to help them recover at home. Ultimately though, the staff remained in different organisations working separately, and they tended to be pushed and pulled by their respective organisational pressures, processes and cultures. Often, the 'bigger picture' was lacking, preventing system feedback and unintended consequences from being addressed, and preventing other possible changes/actions – perhaps with significant potential impact – from being seen. The steering group, whilst they were very solutions oriented, and worked well together to identify and address problems, were only really able to achieve a 'tinkering at the edges'.

For example, the pressure faced to free up a hospital bed, or to cut back on care visits, and the difficulty in finding capacity to visit a service user within two hours of returning home, or picking up a client at short notice, could sometimes mean that person-centredness, prevention orientation and safety were compromised. The focus on enabling independence, coupled with the shortage of capacity in Rapid Response, the lack of involvement of the voluntary sector, and the culture of care in hospitals (that could do more to actively promote independence and active recovery), could contribute to a lack of recognition of the need for a short period of personal care prior to enablement. This can leave older people struggling to cope. These examples show the interconnectedness and intransigence of some of the key issues related to the case study context.

The lack of funding was a clear theme in the data and could be seen to impact on the improvement project in a number of ways. But it was the lack of funding coupled with the already weak capacity, further stretched by winter pressures that made such an impact on this particular project. Features of the wider context – particularly of financial cut-backs in the public sector, the growing need for services to support older people, a historical lack of local investment despite evidence of high need, and local difficulties in staff recruitment and retention, particularly in the community sector – were extremely important to address. In a short-term improvement project, response to such deep-seated issues is usually limited and short-term in nature – such as buying in extra capacity through contracting with a private provider. However, such responses do require additional finances, of which Home First had none.

Other features of the context that were particularly important included the constant and large-scale change (particularly, in this case with the community health contract) that was so disruptive to progress, continuity and relationships, and the continued separation of health and social care in the community.

4.2 Working towards integrated care improvements that could be transferable across the EU

Drawing from the Home First case study site, it is possible to see that small-scale local projects can serve a purpose in terms of focusing attention on the importance of person-centred co-ordinated care, improving aspects of local practice, and improving relationships between different individuals, teams and organisations – perhaps so long as they have clear, shared objectives that are consistent both with local organisations' priorities and with policy. However, their success is highly dependent on key contextual conditions – particularly related to resources, timing, individuals, leadership and relationships. One potentially transferable aspect of this project is the sustained effort to ensure different service providers from different organisations meet, talk, and get to know each other. The opportunity to discuss cases together, and to explore what went well and what might have been improved and how, enables stakeholders to understand each other's services, perspectives, and requirements, and to identify ways of making incremental improvements. Another potentially transferable aspect is the use of a single shared assessment form that can be used by any provider to assess health, social care and other needs at the point of transfer from one care setting to another. The form used in Home First was developed as part of another improvement project in a different part of Kent, but was instrumental in reducing duplication of assessment when it was adopted into the Home First improvement project.

4.3 Methodological reflections

In the Swale Home First case study, the improvement project was implemented in a limited form, with tight restrictions and misunderstandings both affecting the number of service users referred and accepted. This limited our ability to recruit participants for interview and questionnaire completion. It was challenging to ascertain whether or not the improvement project enhanced integrated care at the level of the service user. This is partly because it was difficult to tease out 'the improvement project' from both 'service as usual' and from other aspects of the constantly changing context. User-related outcomes were likely to be influenced by a long chain of interacting variables, and improvements in practice were likely to take some time to translate into improvements in outcomes. Home First is a very short-term process designed to improve the transfer home from hospital, and to improve the way immediate support is arranged to enable older people to recuperate at home. It was not possible, in this case study, to obtain before and after measures of user-related outcomes in order to detect change following 'exposure' to the service. Therefore, data was collected from users at just one point – usually two to five weeks after returning home from hospital.

The collection of user-related outcomes data included two questionnaires – one focused on patient perceptions of quality and coordination of care and support, and another focused on perceived control in care and support of older people – and semi-structured interviews. These methods were geared towards examining service users' experiences of the care they received from health and social care. Some questions focused on co-ordination and communication between different service providers. However, several of the users in our sample had no need for social care support and limited need for ongoing health care support. Ward staff were reluctant to discharge patients via Home First unless they knew they had a low level of needs, just in case there was insufficient capacity in the community to support them. Some participants found questions relating to the co-ordination or provision of more complex care irrelevant or difficult to answer. Other participants found the contents of the two questionnaires and the interview guide repetitive. On reflection part way through data collection, we decided not to prioritise the perceived control in health care questionnaire since it generated data that was less pertinent to the improvement project. In addition, it was not possible to collect and analyse care plans for research participants in Swale Home First. Rather than a single care plan, the different providers each had records of assessments at different time points. It was not feasible to collect all of these for the purposes of this analysis.

The staff involved in Home First implementation found it impossible, with their staff shortages, to keep an up to date record of the efficiency indicators we had agreed to collect. Data collection activities involving professionals and managers were due to take place at a time when they were just emerging from a winter that had placed unprecedented pressure on services. Staff who had been declined annual leave over the winter period had booked long chunks of time off to ensure they used their quota before the end of March. Whilst it was not possible to organise a focus group discussion with professionals, as planned, it was possible to arrange one-to-one interviews instead, which provided very rich data.

4.4 Overall reflections and keypoints

On the one hand, the story of the Home First improvement project was one of frustration, since it was so hampered by the lack of capacity and the lack of any additional funding, and since progress was impeded for so long by the change in provider contract at a key point. It demonstrated just

how vital adequate capacity is to service improvement, and to delivering person-centred coordinated care. In the Home First case, staff capacity was short, particularly in community services, which meant the existing staff were stretched thinly and sometimes lacked the time to deliver genuinely person-centred care. Also, service capacity in the community was limited largely to the enablement service and rapid response. There wasn't always capacity to provide immediate, short-term, hands-on help and support to older people who felt vulnerable, anxious or lonely after their stay in hospital.

The findings with regards to respect and dignity of the service user were troubling; several users felt strongly (and quite negatively) about the enablement service. This was sometimes about the approach of individual staff members, perhaps under a lot of pressure. It could also be that, when service users are being discharged earlier, enablement might not be the first service they need. They might benefit from a short period of active help/ support at home before enablement begins, or alongside enablement. This could be the kind of service that voluntary sector organisations are able to provide. Alternatively (or in addition), it might be that the jump from high dependence in hospital to independence at home is too great, and that there is more that hospitals could do to prepare their patients for the transfer. (This resonates with a national campaign to 'end PJ paralysis', which is a campaign to get patients up, dressed in their own clothes and moving to boost their recovery.)

However, on the other hand, Home First was also a story of promise. The core steering group members never wavered in their commitment to this improvement project, and shared an understanding of the importance of its objectives. Individuals from different organisations were committed to improving the way they work together, and there were many examples of jointly identifying solutions to problems, and ways of supporting one another. At times of sometimes significant pressure, when it is easy for relationships amongst staff in different teams to be under strain, the evaluation found very few instances of tension between individuals or teams. Staff seemed to gain in both trust and understanding of each other as they worked together to implement the service.

PART 2
Sandgate Road Surgery, Over 75 Service

5. SANDGATE ROAD SURGERY, OVER 75 SERVICE: CHARACTERISTICS AND IMPROVEMENT PROJECT

5.1 General description of the site

Sandgate Road Surgery is a General Practitioner (GP) Medical Centre in Folkestone in the South East of England. Folkestone is a coastal town in the district of Shepway. The district has pockets of high deprivation with Folkestone being one of the most deprived areas. There is a high dependency ratio which represents a higher proportion of older people than the UK as a whole. The surgery had 12,000 registered patients. The target group for the Over 75 Service were: people aged 75 and over; frail, housebound and vulnerable; living alone or with a spouse with limited social or family support; complex health and social care needs and at high risk of hospital (re) admission.

The Over 75 Service was commissioned by South Kent Coast Clinical Commissioning Group (SKC CCG) although GP practices largely operate as independent organisations. The Over 75 Service has a core team based at the surgery consisting of a Lead GP, Senior Nurses called 'Practice Matrons', a paramedic practitioner and administrative staff. There is a wider multidisciplinary team from health, social and voluntary sector organisations including Kent Community Health Foundation Trust (KCHFT), Kent Social Services (KCC), Age UK, Crossroads Carers, and Medicines Management (SKC CCG).

As a result of this extensive team, a range of services are delivered including medical and nursing care, social care, health training, independence co-ordination, care navigation, carer support and medicines management. People also have access to wider services which are not formally part of the Over 75 Service such as falls prevention and housing services.

5.2 Rationale for improvement project

In 2015, NHS England introduced the "Enhanced Service" (ES) programme which was designed to enable GP practices to reduce avoidable unplanned hospital (re)admissions and A&E attendances by improving services for vulnerable service users and those with complex needs (NHS England 2015a). Locally, SKC CCG decided to use the ES funding to enable the surgery to develop the Over 75 Service.

"There was a recognition that a lot of people were going into hospital unnecessarily and it may well be because services or education were not in place for that patient or their wider circle of acquaintances to avoid that. The "Over 75" was also a recognition that the housebound are a particularly vulnerable group because they are often only seen when they are ill. They are never seen in order to prevent illness." (Manager 1)

5.3 Aims and objectives of improvement project

The overall aim of the service was to establish clear multidisciplinary care pathways for frail, older people and provide them with care that was person-centred and integrated in order to improve their health and wellbeing and maintain independence. Specific aims and objectives were focused on themes of person-centredness, prevention-orientation, safety and efficiency.

Person-centredness:
- To improve users' independence by providing more co-ordinated and streamlined care.
- To improve users' wellbeing.
- To provide enhanced and person-centred care.

Prevention-orientation:
- To improve users' self-management skills by developing person-centred care plans that can be shared with other services when required (and with users' consent).
- To improve users' health outcomes.
- To prevent crises/hospital admissions.

Efficiency/safety:
- To reduce polypharmacy.
- To reduce duplication between services by implementing a trusted assessor model and sharing the Over 75 Service initial assessment if onward referrals are required.

5.4 Explanation of the improvement project

The Over 75 Service steering group agreed a definition of frailty according to the Rockwood or commonly called the Dalhousie frailty screening tool (Rockwood et al, 2005). Following a scoping exercise by the SUSTAIN research team of available screening tools including the Tilburg Frailty Indicator, for example, Dalhousie was selected as it recognised social and environmental influences on frailty, not just clinical indicators. It was also very simple to use which was important as all staff in the Over 75 Service would be applying it – some of whom were not health or social care professionals but voluntary sector workers without any advanced education or training. Voluntary sector organisations were closely involved in the delivery of the Over 75 Service. Age UK is a national charity which offers advice and support for older people and aims to enable independence and combat loneliness; Crossroads Care provides practical and emotional support for carers in the region. Care navigators are employed by a range of both voluntary and professional organisations including Age UK and KCC. Their role is to help users and carers find and access services in the complex health, social and voluntary care system. A pathway was developed, based on the Dalhousie frailty screening tool, which described the services and organisations to be involved according to the users' level of frailty (see Figure 2: The Over 75 Service Frailty Pathway).

In summary, any health, social care or voluntary sector worker who has contact with an older person in the community, applies the Dalhousie frailty screening tool if they have any concerns about that person's frailty status. If this score is <4 (mild frailty) practitioners consider referring to Age UK, Health Trainers, Care Navigators and Crossroads Carers, as appropriate. If users score 4 (moderate frailty) or higher, practitioners will refer to the Practice Matrons at the surgery who conduct an in-depth assessment of users' needs. If onward referrals are necessary, this assessment is shared (with the users' consent) with relevant services in an effort to reduce duplication – therefore a 'single trusted assessor' model operates. If users score 8 or 9 (severe frailty or end of life), the Practice Matrons complete an advanced or anticipatory care plan with the user, in line with SKC CCG's End-of-Life Care strategy, which is shared

electronically across relevant teams through the MiG (Medical Information Gateway). The use of this pathway aims to meet the needs of users across the spectrum of mild to severe frailty, and employs a pro-active and preventative approach to support people to remain independent at home for as long as possible. For those with mild to moderate frailty, care is primarily provided by voluntary sector organisations who provide care navigation, help with claiming government financial benefits, a befriending service and support for carers, for example. For those with increasing frailty and more complex needs, Practice Matrons play a central role in terms of managing referrals and co-ordinating care.

Step 1: Start
Older person (75+) presents with frailty related issues at any service within locality
(i.e. GP, District Nurses, Social Workers, Health Trainer, Care Navigator,
Age UK Personal Independence Co-ordinator, Crossroads

Step 2:
Practitioner at service conducts *Dalhousie frailty screening tool* to identify presence/severity of frailty

Initial assessment & care plan with review

Person scores 1-2 on Dalhousie
(managing well and mostly active) referral to Personal Independence Co-ordinator

Person scores 3 on Dalhousie
(managing but not regularly active): referral to Health Trainers, Care Navigators, Personal Independence Co-ordinator

Person scores 4 or more on Dalhousie
(vulnerable and limited activity): referral to Practice Matron for initial assessment & care plan

Anticipatory care plan for follow-up

Person scores 5-6 on Dalhousie
(moderately frail) possible referral to District Nurses and share initial assessment & care plan

Person scores 6-7 on Dalhousie
(moderately/severely frail): possible referral to social care & share initial assessment & care plan

Person scores 8-9 on Dalhousie
(very severely frail/end-of-life) complete anticipatory care plan and follow End of Life Care strategy

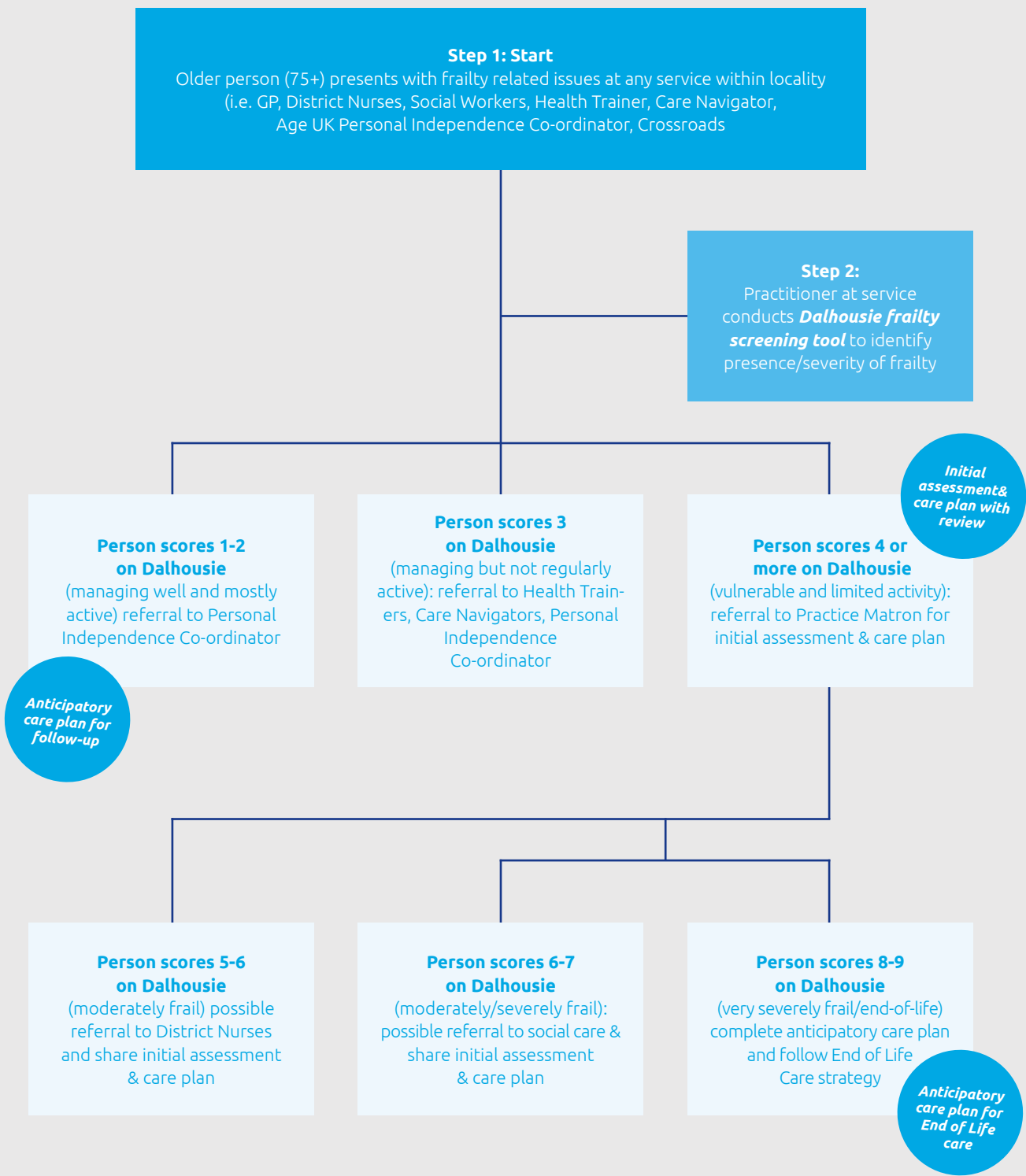*Anticipatory care plan for End of Life care*

Figure 2 - *The Over 75 Service Frailty Pathway.*

6. FINDINGS OF THE IMPROVEMENT INITIATIVE IN SANDGATE ROAD SURGERY, OVER 75 SERVICE

6.1 Introduction

Researchers worked with the SUSTAIN project team in the UK from October 2015 to identify the stakeholders, form and support a steering group, specify the improvement project and plan its implementation. The service was implemented on April 1st 2017. From April 2017 to April 2018, SUSTAIN researchers collected data in order to monitor and evaluate progress and outcomes of the improvement project. Table 3 provides an overview of the quantity of data collected per data source. More information about the different types of data collected can be found in Annex 1.

In terms of participant demographics, ten of the fifteen users were female, eight were in the 85 years and over age bracket (five were 75-84 and two were 64-74), and ten had a low educational level (completed schooling up to age 16). Seven of the fifteen users were living at home alone; six were living at home with their spouse/partner. The average number of medical conditions was 5.2 (range 1-11). The most prevalent condition was cancer. One user had a live-in (resident) paid carer, which is unusual in the UK system. All other carers (N=4) were spouses, and they were in the 75-84 years category (N=3) and 85 and over (N=1), and all lived with the user. The spouses/partners felt it was not possible to quantify the number of hours they spent caregiving, as opposed to helping their partner as part of a usual relationship. The full-time paid-for carer spent more than 50 hours per week on caregiving. One of the carers had had a needs assessment for their own needs, but none had their own care plan.

Of the eight managers in our sample, all were female. All were in the 45-54 years (N=4) or 55-64 years (N=3) age brackets except one (who was 35-44). Two worked for a health care organization; three worked for social care/local government, and three for other organisations. All eight had permanent contracts, and all worked full time. Of the thirty professionals in our sample, twenty-five were female. Eleven were 55-64 years of age; 10 were 45-54; 4 were 35-44; 5 were 25-34. 94% were on a permanent contract, and 81% worked full time. Fifteen of the sample were social and community workers, five were administrative and clerical staff, five were nursing, four were allied health professionals, 1 was medical, and 1 was 'other'.

Ethical approval for this study was obtained from the NHS Health Research Authority (REC reference: 16/IEC08/0045).

6.2 What seems to work?

Co-ordination
There was better care co-ordination as the Practice Matrons were the central point of information for users, carers and the other organisations involved in delivering the Over 75 Service. This made communication easier. Better care co-ordination resulted in reduced duplication of services between the Practice Matron and District Nurses, for example, in end of life care:

> *"End of Life things was a duplication at some points because they [Practice Matrons] may have gone in and done something and we're not aware of it and then we've gone in and done it all over again, and the patient and the relatives are kind of looking at us, 'we've already done this with the Matron' and we're like 'oh okay', whereas that's completely stopped now. They'll refer to us and say 'oh by the way we've been in and we've done an end of life care plan and we've left that in the house', so things aren't getting duplicated."* (Professional 6)

Table 3 - *Summary of data collected for Sandgate Road, Over 75 Service.*

Data source (Professionals & managers)	N	Data source (Service users & informal carers)	N
Manager/Professional Demographics	38	User Demographics Carer Demographics	15 5
Team Climate Inventory (TCI)	Baseline 17 Follow-up 25	Interviews users and carers	15 users 5 carer
Interviews managers and professionals	6	Person-centered coordinated care questionnaire (P3CEQ)	15 users
Minutes of and reflective notes from steering group meetings	16	Perceived control in health care questionnaire (PCHC)	8 users
Field notes	1 document with notes taken throughout (Dec 2015 – April 2018)		

However, social care also had care managers so some users were not sure who co-ordinated their social care.

Communication occurred on a personal level with professionals having face-to-face or telephone communication. This was particularly apparent between the different health services and the voluntary care organisations. There was a perception amongst staff and users that social care was not as fully integrated with health care with more limited sharing of information. For example, care plans were not shared between health and social care.

Person-centredness

In terms of person-centredness, users in the Over 75 Service developed close, personalised relationships with a designated Practice Matron at Sandgate Road Surgery who was their key contact, particularly for health care services. At an initial assessment, the Matrons undertook detailed needs assessments in the users own homes and this extended appointment was highly valued by users and carers. One user commented:

"She asked me what I'd had wrong with me, why I was in this state that I am, can't move about. She just asked me what illnesses I'd had recently but just general conversation about things. She was very, very pleasant and very, um, you felt you could talk to her. She wasn't in a rush." (User 11)

Over time, this relationship developed over a number of contacts either at the user's home or by telephone. Users were given a telephone number, which they could use to contact the Matron directly which enhanced this personal relationship. Medical and nursing staff visited users at home if they were unwell or unable to get to the surgery. Also, reception staff accepted medication prescription requests by users and carers over the telephone - unusual in primary care, where most GP surgeries require the user or carer to make the request in person. This was valuable to both users and carers and helped ensure that users' needs were met in a timely way and without further stress

and anxiety at a time when they were most vulnerable. However, due to high demands for services across health and social care, users felt, at times, that there was a lack of timely follow-up so they would ring the surgery to find out test results and the outcomes of referrals, for example.

Prevention and safety

The nursing teams supported independence by providing services that aimed to prevent admission to hospital such as giving preventative medication such as antibiotics and flu vaccinations and referring to occupational- and physio-therapists and disabled services. The comprehensive needs assessment carried out by the Practice Matrons meant that preventative interventions including pressure area care and nutrition and hydration support could be instigated at an early stage. As a result there was a clear focus on prevention-orientation.

A range of professionals including District Nurses, Care Navigators, Social Care workers and Personal Independence Co-ordinators (PICs) provided equipment such as beds, raised toilet seats, commodes, and walking aids, based on an assessment of need. Whilst this might have resulted in some duplication of services, there was no evidence of this from the data. Rather, it meant that users had a needs assessment at the first contact with any of these professionals. As a result, all users in this case study had equipment installed to support them to live independently. PIC workers may have prevented increasing frailty by supporting users to be more active. A befriending service helped prevent loneliness and social isolation. Volunteers enabled users to attend day care services, gave reassurance, built confidence and offered support based on the users' goals and abilities. As a result, the social contact provided by the volunteers was highly valued. One social worker commented:

"The PIC workers, having access to them is really useful, to be able to phone them up and say 'we've got this patient that we feel would benefit from your service' and then

them going and actually preventing people from becoming frail because they've got someone that they can go out for coffee with or pop in and have a chat with them, it makes them less isolated and lonely as well." (Professional 4)

As well as the provision of equipment, which aimed to promote independence and maintain user and carer safety, a medication management service carried out medication reviews, which aimed to support medication adherence and reduce the risks associated with polypharmacy. These reviews took place in the user's home, which enabled a more complete understanding of how users managed their medication in practice.

6.3 What are explanations for succeeding and improving integrated care initiatives?

There were effective governance arrangements exercised through the development of terms of reference, clear accountability and risk management arrangements. The Senior Practice Matron was the clearly identified leader of the Over 75 Service, as they were the designated lead for the service within the surgery and therefore best placed to co-ordinate care across sectors. This decision was agreed upon and supported by steering group members at the start of the project. Effective leadership was demonstrated by good engagement of colleagues and a collaborative approach to decision-making. In addition, personal qualities helped facilitate implementation:

"Because I'm very positive about the Over 75 Service and I think that, that rubs off because if you're positive and you're enthusiastic then you aim to, you strive to impart that positivity and enthusiasm to other people." (Manager 1)

Although there were many staff changes throughout the implementation period, both within the steering group and the wider operational team, this had limited impact on the service due to clear direction and shared aims and objectives.

Key decisions were made early on in the design of the service, particularly the use of the Dalhousie frailty screening tool which provided a focus for the improvement and enabled a shared understanding of frailty. The decision to include users who were mildly frail through to those at end of life meant that the service was available to all users, and had a preventative element as well as targeting those with complex health and social care needs. This also meant that voluntary organisations, who are generally seen as more peripheral to health and social care services, came to play an important role in the delivery of the Over 75 Service. The steering group focused on delivering key elements of the service, rejecting interventions and other initiatives that were peripheral to the overall aims and objectives. For example, the steering group were invited by the CCG to become 'ambassadors' for another person-centred initiative (called ESTHER), which was considered but then declined.

The support of SKC CCG, the commissioners of the service, was also important in terms of funding and ongoing support. In March 2017, the CCG invested in Dalhousie frailty screening training for the staff delivering the service which was important for implementation as it was the final element to be put in place before the service became operational. In December 2017, there was a national policy requirement to record an electronic frailty score. Due to the experience of using the Dalhousie frailty screening tool across a range of health, social, and voluntary care providers in the Over 75 Service, SKC CCG selected this same screening tool to be rolled-out across the region. This meant the service was now more aligned to national and local policy, which led to greater engagement by KCHFT – the provider of the community nursing service - as recording Dalhousie became a policy requirement.

Collaboration and multidisciplinary teamworking was facilitated by effective multidisciplinary team meetings, which provided a mechanism for establishing personal contacts, sharing information, promoting understanding of individual roles and responsibilities and increasing knowledge of the services that are available, particularly in the voluntary sector. There was a culture of inclusiveness with all agencies valued equally for their contribution and a perceived lack of competition. The selection of service users to be discussed at the meetings was based on the users' needs rather than the demands of the surgery. This was achieved by the staff at the surgery knowing their service users and their families well. A member of staff from the carers organisation noted:

"And it's not just the patients, the team here are very aware of the family situation and quite often they refer to me to give the husband, the wife, the son, daughter, whoever, a bit of a break because they are the main carer, so it's knowing the whole situation at home and being able to share that information so you're not going in cold, you actually know the background." (Professional 28)

Positive interpersonal relationships have been key to the success of the service. Professional and non-professional staff were seen as equally important and staff valued the direct, personal contact they had with each other. In particular, social care staff felt equal partners with health because of a shared vision of promoting independence in frail, older people and felt comfortable discussing issues and concerns within the team. One professional commented:

"It's so much easier when you can just speak to someone and you can just say, right, this is the situation. We've got that good working relationship, you can speak more freely and if you're trusting what they're saying and they trust what you're saying." (Professional 4)

Organisational structures supported the development of close working relationships and collaboration. Single individuals from the District Nursing team, Age UK (the PIC), the Care Navigator and the Medication Management Support team were assigned to patients registered at Sandgate Road Surgery. This meant that the Practice

Matrons were a single point of contact, not just for users but also for professionals and voluntary sector staff, as they were able to share information about users and their families and were a source of advice and support. The District Nurse described this:

"If you've gone in to a patient and you think "oh God, I don't know what to do", you know that you have got them at the end of the phone or you can pop into the surgery and see them and kind of run it past them and get their advice." (Professional 6)

The exception to this highly localised, organisational structure was the social work team, where different users had different care managers. The effect of this is discussed in Section 6.4. However, despite this challenge, social services worked more closely with health care services than previously, due to a high level of commitment by representatives on the steering group and at the multidisciplinary team meetings:

"I think definitely social services have been very pivotal and have been so engaged as well and really wanted to make it work and considering their pressures on their time and the whole kind of what's social care, what's health, you know… they have the least vested interest in it because there might not have been perceived to be any benefit to them by engaging in it but they have been absolutely pivotal." (Manager 1)

6.4   What are explanations for not succeeding and improving integrated care initiatives?

Short to medium term funding contracts awarded by the CCG to a number of service providers created uncertainty amongst staff in terms of their own employment, difficulties in recruitment and fears about the ability to continue to provide services in the near future. In all cases, funding was confirmed just a few weeks before the services were to be de-commissioned. In March 2017, the Enhanced Service money was withdrawn nationally and Sandgate Road surgery applied for and were awarded further funding by the CCG, for a period of 12 months. This was then renewed for a further 18 months in April 2018. Similarly, Age UK and Crossroads Carers services were working on 6 monthly contracts. Funding cuts at KCC meant that the health trainer service, which was providing lifestyle and self-management support to users, was withdrawn. Medicines management became unable to provide aids for medication adherence (Dosette boxes) due to budget cuts. Uncertainty over the ability to continue to provide services was described as immoral:

"I personally think it's quite immoral to allow people to set up something like an Over-75 Service and just withdraw it, because you create a safety net for people and then take it away and I don't think that's, personally I think that's quite immoral." (Manager 1)

Increasing demand and a lack of capacity to deliver services was highlighted by the staff hours data, which showed an increase in the number of hours staff spent delivering the service coupled with a reduction in the number of staff. The reason cited for the lack of involvement of mental health professionals was lack of capacity due to high demand. Changes in the wider health and social care economy also created increased pressure in the system. The closure of a neighbouring GP surgery created pressure on Sandgate Road as they were required to take on extra patients. Due to this increasing demand, in January 2018, the lead GP decided that the service needed to become time-limited, with users able to access the service for a maximum of 12 weeks. However, the Practice Matrons have aimed to reduce the impact of this on users by establishing 'work-arounds' - users are able to self-refer back into the service and those with the most complex conditions are not discharged as they have ongoing needs. Pressure on services over the winter meant that there were delays in making referrals to other services and the Practice Matrons needed to undertake visits to urgent care patients, who were not necessarily part of the Over 75 Service. This compromised their ability to carry out the more pro-active, preventative work that was a key feature of the service.

Another significant barrier to integrated services were problems with accessing Information Technology (IT) and Information Governance (IG) issues. Concerns about data protection, access to data and unwieldy processes for changing IT systems hindered information sharing. However, some progress was made with NHS email accounts being made available to non-NHS staff and social care staff were eventually able to access their own records on mobile devices. There were two information systems in operation – CIS which was the record system held by KCHFT and MiG which was a new electronic patient record accessible by all health and social care providers across Kent, in theory. CIS became available to the Practice Matrons but with read-only access, and was not accessible at all to any other provider. MiG was not accessible due to technical and ongoing IG issues, which at this moment in time, seem to be impossible to resolve. As a result, the single trusted assessor model whereby full assessments, including care plans, were to be shared across organisations had not been implemented successfully due to organisational boundaries and the lack of a shared IT system. Somewhat paradoxically, this may have promoted direct communication between individuals either face-to face or over the telephone, and the development of trusted relationships which enabled faster response times in meeting users' needs. The District Nurse said:

"[Practice matrons] will phone us directly and will give us the heads up that a referral's coming through. I had one a few weeks ago where they phoned me directly and said 'oh this patient's end of life, can you go and see him?' I got a phone call from our admin to say that a referral had come through and I said 'oh I'm actually already there'." (Professional 6)

Care plan templates could not be accessed on mobile devices in the users' homes and so had to be completed by staff once they had returned to the office, before they could then be given to the user. They also could not be edited electronically but needed to be re-written in their entirety. This represented inefficient use of staff time and did not support person-centredness as users were less involved in the development of the care plan and there was be a considerable time delay in users receiving their care plans. This was apparent from the user and carer interviews and the P3CEQ which indicated that care plans were of limited usefulness to users.

On an operational level, in contrast to other services, there was a lack of personalised contact between social services and other team members due to the way social care was organised:

> "Social Services are a bit more difficult because every patient has a different care manager. That can sometimes be a bit more disjointed because sometimes trying to get hold of their care manager can be a bit difficult because they might not be in the office or we'll leave a voicemail for them and they don't get back to us. So sometimes it is a case of phoning them regularly but we generally get through to them eventually." (Professional 6)

This finding was consistent with data from user and carer interviews where there was a perception that health and social care were less integrated than other services. One paid carer commented:

> "Information is shared within the surgery but not with outside social care agencies – I always need to repeat things. I act as a sort of co-ordinator." (Carer 6)

However, from April 2018, an organizational restructure within KCC meant one social worker will be assigned to service users at Sandgate Road Surgery, which will bring it in line with other services that operate at this local level. Finally, tensions over ongoing funding for the service have resulted in some lack of transparency between staff at the surgery and the commissioners where there is some unwillingness to share some performance data. There is also a question over the 'ownership' of the Over 75 Service as there may be a business opportunity in rolling-out this model to other GP surgeries.

7. MAIN LESSONS LEARNED FROM SANDGATE ROAD SURGERY, OVER 75 SERVICE

7.1 Working towards integrated care improvements that could have impact

The Over 75 Service case study has highlighted that integrated care can be achievable at a local level, when there is a clearly defined target population and clear aims and objectives. The ability to maintain this focus despite considerable change both within organisations and in the wider arena helped maintain momentum and sustain the initiative. Key to maintaining this forward momentum was effective leadership and a spirit of collaboration rather than competition where members of the multidisciplinary team were respected and equally valued for their contribution. This meant that voluntary sector workers who were not health and social care professionals were supported to 'fill the gaps' between services so that more person-centred care could be provided. Lead individuals were employed solely to run the Over 75 Service at Sandgate Road, which was important as they could devote their time to developing and delivering the service. They fulfilled a key role as the main co-ordinators of care and provided a focal point for users, carers, and staff as well as acting as a conduit for information sharing.

Collaborative working was enabled by positive interpersonal relationships, which took time and commitment to develop. However, once achieved, the benefits were clear in terms of enhanced communication, which facilitated better care co-ordination and reduced duplication in services. In this case study, communication was frequently direct through face-to-face meetings or telephone conversations. This helped to foster trusting interpersonal relationships. Organisational structure was highly localised with one individual from each provider assigned to service users registered at Sandgate Road

surgery. Essentially, this meant that even though the number and size of the organisations involved was relatively large, in fact communication was confined to a small number of people who were well-known to each other and an in direct, personal contact. This structure also meant that users were cared for by individuals who were known to them. This is a good example of relational continuity, where there is *"a therapeutic relationship between a patient and one or more providers that spans various healthcare events and results in accumulated knowledge of the patient and care consistent with the patients needs"* (Burge et al, 2011). Where organisations were not structured in this way but were more centralised (social care), care was less person-centred and communication between staff members was more difficult.

Other factors that impacted on the initiative were the awarding of short and medium-term financial contracts for services, which resulted in job insecurity and concerns about whether users could access services in the future. Increasing demand and lack of capacity resulted in the withdrawal of some services (health trainers) and the need to time-limit the Over 75 Service. Inaccessible IT systems and information governance concerns limited electronic sharing of information between organisations and created inefficiency in terms of staff time. This meant that not all the aims of the Over 75 Service were able to be met such as the single trusted assessor model and shared care plans. However, the impact of this on integrated care may be limited in this context where there is a defined and localised initiative with good interpersonal relationships and a high degree of direct communication.

7.2 Working towards integrated care improvements that could be transferable across the EU

Findings from the Sandgate Road Over 75 Service case study demonstrate that features of organisational structure, leadership and the involvement of a wide range of professionals and non-professionals are key elements which can be transferred to community care settings across the EU. Organisational structures which align individual professionals to small, specific patient populations enable better communication between professionals and better integrated care. Given that health and social care operates within a system of continual and often rapid change, clear aims and objectives and a shared vision are needed, which can be adopted by new members of staff joining the service. An effective leader with dedicated time to develop and maintain the initiative supports sustainability. The inclusion of voluntary sector organisations enables more person-centred care and can meet the needs of users and carers that would not otherwise be met by more traditional, professional services. In order to achieve this, non-professionals must be equally valued for their care contribution. The maxim "think local, act personal" (Think Local Act Personal (TLAP) Partnership) seems to provide a narrative for person-centred, co-ordinated care in this community setting.

7.3 Methodological reflections

In the Sandgate Road Over 75 Service, recruitment of users and carers was challenging due to a number of service-related factors. Firstly, the inclusion criteria for data collection specified that users (and carers) needed to be cognitively able to give informed consent to participate. This meant that it was necessary to exclude a large number of users with dementia, which represented a significant proportion of the Over 75 Service caseload. Secondly, the data collection period coincided with a period of high workload for staff at Sandgate Road surgery – namely, the delivery of annual flu vaccinations and subsequent winter pressures. This meant that staff were, at times, unable to prioritise recruitment of participants for SUSTAIN. In an attempt to boost recruitment, social services, district nurses and Age UK workers were also asked to identify potential users and carers but his was not successful perhaps because these services played less of a central role in the delivery of the service and so were less committed.

It was not possible, in this case study, to obtain before and after measures of user-related outcomes in order to detect change following implementation of the service since it would be unlikely that actions resulting from any referrals made as part of the Over 75 Service would have been completed over this short time period. Therefore, data was collected from users at just one point, usually 12 weeks after being registered for the service. The collection of user-related outcomes data included two questionnaires – one focused on patient perceptions of quality and coordination of care and support, and another focused on perceived control in care and support of older people – and semi-structured interviews. Some questions focused on co-ordination and communication between different service providers. However, some users in our sample had no need for social care or other services. This may have been because users were recruited by the Practice Matrons at Sandgate Road surgery, rather than via other service providers, which may have resulted in these other services being less well represented.

Some participants found the contents of the two questionnaires and the interview guide repetitive and questions about goal setting were generally difficult for users to answer. On reflection part way through data collection, we decided not to prioritise the perceived control in health care questionnaire since it generated data that was less pertinent to the improvement project. Care plans were accessible for all users so it was possible to include comprehensive care plan analysis. However, these were accessed via Sandgate Road surgery rather than in the users homes as intended as there was often a delay in sending the care plans to the users once they had been completed. The improvement project did not include sharing care plans between different service providers, therefore, this analysis reflects the contents of the health care plans developed by the Practice Matrons so were less useful in determining care co-ordination and information sharing.

The efficiency data was incomplete as some staff did not provide the required information, presumably due to work pressures. Also, it was difficult for some staff to determine how many 'extra' hours they spent on the improvement project as most staff were assigned to work with users registered at Sandgate Road surgery so the Over 75 Service represented a significant but undefined proportion of their workload. TCI data was generally comprehensive and all the main service providers took part either in the staff focus group or individual interviews. However, it was not possible to receive feedback from a member of the CCG, which would have been useful in terms of representing an external agency. This was due to an organisational re-structure within the CCG, which meant that the individual who was most involved with the service was no longer in post.

7.4 Overall reflections and keypoints

On reflection, the Over 75 Service did establish a multidisciplinary care pathway for frail, older people and provided care that was person-centred and integrated, to a significant degree. Members of the steering group and the operational multidisciplinary team worked together in such a way to put the user at the heart of the service as organisational and professional boundaries became less rigid. The single trusted assessor model, where care plans and comprehensive assessments were shared across

organisations, was not implemented for two reasons. Firstly, the lack of a compatible IT system and information governance concerns, but more importantly, personal communication was very highly valued and the team much preferred to 'pop-in' to see each other or call each other on the telephone to discuss problems and find solutions between them. Even established referral systems were often bypassed by people simply picking up the telephone. It is therefore questionable whether there was any real commitment to improving electronic communication. The involvement of the voluntary sector services was critical in giving the Over 75 Service a preventative focus. As a result, users and carers received support that they would not otherwise have been able to access through traditional health and social care organisations. Ongoing funding remained problematic and the awarding of short term contracts meant the service was not really secure even on a month to month basis, which threatens its sustainability.

PART 3

8. OVERALL (NATIONAL) REFLECTIONS

8.1 Introduction

Folkestone and Swale are similar in terms of populations, with Swale having a higher level of deprivation that Folkestone. Both have high levels of need in terms of health and social care. Both Swale Home First and Sandgate Road Over 75 Service were initiated as a direct result of a national policy to reduce pressure on acute hospitals, with the recognition that older people with complex conditions are better cared for at home.

For Swale Home First, the aim was to enable early discharge from hospital; for the Over 75 Service, the aim was to prevent admission to hospital in the first place. However, the impact of integrated services on hospital admissions is just one outcome, and both improvement projects aimed to understand the context within which integrated care operated and other user- and service-related outcomes. For the Over 75 Service, integration occurred within a community setting (what we might think of as horizontal integration), whilst Home First attempted to integrate services both within the community and across hospital and community settings (what we might think of as both horizontal and vertical integration).

In terms of the methodology, recruitment of users and carers was challenging at both Swale Home First and Sandgate Road Surgery Over 75 Service, largely due to unprecedented workload pressures within both services. There was some lack of complexity of care needs due to the nature of users within the service (Swale) and possibly the method of recruitment (Sandgate) which may have resulted in some limitation of the discussion of care co-ordination between health and social care services. Efficiency data on staff hours was incomplete and likely to contain some inaccuracies due to difficulties in establishing the number of additional hours dedicated to the improvement projects.

This Chapter further brings together some of the lessons learned from both sites, looking at similarities and differences, and aims to make recommendations for policy makers and service providers.

8.2 Implications of SUSTAIN for integrated care in the UK

There has been much recent work on understanding both the prevention of hospital admissions and the reduction of DTOCs for older people in the UK (Edwards, 2017; Purdy, 2010; Purdy et al., 2012; Steventon et al., 2018). The experiences within both case study sites support and contribute to a growing body of evidence.

The Sandgate Road Over 75 Service represents a good example of a localised, community-based integrated care service which could be transferable to other GP practices in the UK. In particular, the use of designated Practice Matrons to ensure relational continuity with frail older people, and to improve co-ordination and reduce duplication, and the use of Personal Independent Co-ordinators who, together with a range of different service providers, can support older people to live well, independently. The Home First service, by contrast, is one example of a 'discharge to assess' model that has been rolled out already in many areas in England. However, Swale Home First highlights the significant challenges associated with implementing this model at local level when there are very limited resources, multiple organisations with different geographical boundaries, and complex processes involved in transferring and referring service users. Lessons from both sites add to the evidence base in terms

of what worked in what context for older people, and in particular the need to understand the context within which integrated care is operating. Whilst each case study was small-scale, there are some general lessons that can be identified that are relevant on a national level.

Both UK improvement projects highlighted the importance of secure and sufficient funding and adequate capacity to enable improvements in integrated care to be made. Funding in the UK has historically been biased towards secondary care services, to the detriment of primary care services, and towards health care to the detriment of social care. There are current efforts in England, as part of a national drive to improve integrated care, to bring NHS organisations and local authorities together to develop 'place-based plans' for the future of health and care services in their area (NHS England 2015b). The SUSTAIN projects described in this report highlight the importance of considering funding and capacity at 'systems' levels (e.g. across a locality or region), rather than organisational levels (e.g. within hospitals or community health providers). However, the experience in Swale Home First highlighted that it is difficult for organisations to shake off their 'fortress mentality' (Ham & Alderwick, 2015) – particularly when extreme financial pressures tend to make organisations more inward looking, and focused on securing their own future.

In the Sandgate Road case study, SUSTAIN partners were asked to provide evidence of the value of the services as part of both Sandgate Road and Age UK's application for funding. The involvement of SUSTAIN, therefore, had a direct impact on continuation of the Over 75 Service. Similarly, the planning, monitoring and evaluation of Home First, and the comprehensive analysis of outcomes and implications of improvements for service users and providers, helped to provide a case for all stakeholders to persist with Home First implementation in Swale, even if additional investment couldn't be found. The Home First project highlights to others the importance of identifying additional investment for dedicated project leads, particularly where staff are already over-stretched.

In both sites, the importance of communication and collaboration was also apparent. Time, over a sustained period, for the different stakeholders to work together, to get to know each other, to establish trust and to understand each other's capacities and constraints, was an important part of being able to examine problematic situations and identify incremental improvements. In the Over 75 service, the culture of inclusiveness, with all agencies valued equally for their contribution, was identified as being an important facilitator for improvement, whereas in Home First, the lack of inclusion of voluntary sector organisations was identified as being an important barrier. In national efforts to improve health and care, there is an emphasis on organisations collaborating to respond to the challenges facing their local services. However, a key factor that disrupts collaboration is change. Unfortunately, as demonstrated in the two SUSTAIN case studies, change is almost constant in health and social care in the UK – organisations are continuously transforming

to identify 'efficiencies' and work within tighter budgets; providers are frequently changing as services are recommissioned (or de-commissioned) and contracts are awarded on a competitive bidding basis; insecurity of long-term funding breeds change, as staff move between organisations to ensure employment. There is both a focus on *competition* within the health system, particularly following the Health and Social Care Act 2012, and a need for *collaboration*, particularly to face the clear challenges of growing need and reducing funds – the two make uncomfortable bed-fellows.

The SUSTAIN project, through its in-depth case studies, took a comprehensive approach to considering outcomes and implications of improvement projects in different contexts. By researching the perspectives and experiences of different stakeholders involved in integrated care, and focusing on service users' perceptions of quality and coordination of care and support, the SUSTAIN evaluation shone a light on the complexity of the situations, and demonstrated the importance of examining interrelationships between different parts of the whole. SUSTAIN emphasizes the importance to policy makers, practitioners and researchers involved in improving integrated care, of using models and tools that allow us to fully depict and deeply understand complex and dynamic scenarios.

8.3   Policy recommendations

It is an important time for the development of integrated care in England, as new 'integrated care systems' are evolving and taking the lead in planning and commissioning care for their populations and providing system leadership. Experience in Sandgate Road Over 75 Service supports the notion that community interventions, particularly delivered by appropriately trained personnel in an environment that allows sufficient time to assess and manage service users, can help to support the independence of older people and prevent unplanned hospital admissions (Crede et al., 2017; Purdy, 2010). Experience in Swale Home First highlighted the value of frontline staff embracing and driving change, but emphasized the support that is needed (particularly in the form of resources) to enable staff to do things differently. It is recommended that leaders of new area-based partnership forums put more support into local innovations at community level.

With regards to reducing DTOCs, experience in Swale supports the notion that "there are issues within the local health and social care economy as a whole that drive the level of delays and so the focus ought to be on the performance of the system rather than individual organisations within it" (Humphries, 2017). Whilst, as Humphries (2017) acknowledges, it is not all about money, the underinvestment in primary and community NHS services threatens to undermine the policy objective of supporting older people to remain at home and avoid admission to hospital and residential care (Humphries et al., 2016). This work, therefore, supports a policy recommendation to national policy makers to make additional investments in

primary and community care.

Whilst it is clear that there are significant opportunities for improvements in internal processes within different organizations, there is a complex array of factors outside of each organisation's control that influence service improvement and the delivery of integrated care. Both case studies highlighted the importance of local context. This is becoming more understood in recent policy developments related to place-based planning; the need for system leadership, identified already in policy (NHS England 2015b), is clearly demonstrated in the SUSTAIN projects. Both the UK sites confirmed the need for system leadership, and highlighted how far there is to go to see this happen. In both sites, it was evident that where organisations are under considerable pressure (associated with lack of funding, weak capacity, periods of very high demand, constant change and targets), they can tend to become more inward looking, work more in isolation, and focus on 'fire-fighting'. This presents a significant barrier to improving integrated care. Policy makers at national, regional and local level should be committed to identifying these barriers and ensuring they are minimised.

8.4 Recommendations for service providers

Alongside a commitment from policy makers to minimize barriers to integrated care, innovators at local level should identify those factors outside of their control that impede improvement, and bring them to the attention of regional and national policy makers. This might include working with researchers and others to ensure improvements and evaluations build on understanding the complex realities in different real-world situations.

The UK case studies have illustrated the importance of effective leadership. Therefore, a recommendation to health and care service managers would be to agree a project leader/manager with dedicated time and the personal characteristics to engage others and drive the project forward. The right people at the right level of seniority are necessary to instigate change – in Home First and the Over 75 Service, representation from the CCG, senior management and staff working at an operational level were all important in order to identify barriers and work through solutions. It is recommended that this team structure of managers, commissioners and operational staff is built early on in the improvement process.

The aims and objectives of the project need to be clear, widely shared and consistent with the values of individuals and organisations. Furthermore, there needs to be a clear communication strategy to ensure all stakeholders are aware of the existence of the service. In the Over 75 Service, the withdrawal of national funding meant there was an assumption by other GP practices, members of the CCG and hospital staff that Sandgate Road no longer operated an Over 75 Service. In Swale, there was an assumption by the hospital that the Home First pilot study had ended and so patients were not referred. Remedial action and further 'marketing' was then required at both sites, which might have been avoided. It is recommended to managers and professionals that a clear communications strategy, including marketing the initiative where necessary, is developed to ensure effective communication with internal and external stakeholders.

In the Over 75 Service, the number of users who met the eligibility criteria rapidly increased which necessitated a restriction in the time users were able to stay in the service. In Swale, the actual number of patients able to be discharged via Home First was arguably too small, given the high proportion of people with complex needs and excluding those who required little if any health or social care input at home. A recommendation to managers and professionals is to clearly define the target population and have realistic expectations of what can be delivered. This could be achieved through the development of a logic model or similar organisational tool.

Voluntary sector agencies were integral to the Over 75 Service, however, in the Swale site, the energies of users, carers, citizens and local community partners including the independent and voluntary sectors were not harnessed as effectively as they could have been. This seemed to be due in part to the importance the respective CCGs placed on these services. The experience at Sandgate Road demonstrates that the contribution of Age UK and the carers organisations, for example, supported emotional well-being and promoted independence. In designing an integrated care service, it is recommended that managers and commissioners undertake a scoping exercise of the range of services available in the locality, not just focusing on the traditional, statutory health and social care services. It is also recommended that system leaders ensure local innovations engage all relevant stakeholders in their local community.

Operational staff delivering integrated care need to be committed to the project and there needs to be a willingness to change along with considerable perseverance. Professionals need to think and act 'outside the box' working at times on the very edge of professional and organisational boundaries. A 'can do' attitude and trusting relationships are therefore needed. For managers, recruitment of professionals which these values and characteristics is the ideal (so called 'values-based' recruitment). Furthermore a culture of positive change should be fostered. Related to this is the recommendation to managers that a clear risk management strategy is developed.

8.5 Conclusion

In general, the Swale Home First improvement project demonstrated that it is possible to improve the process of transfer home from hospital in terms of user experience and reduced delays by means of implementing a 'discharge to assess' service. The service did, in a few cases, expedite appropriate hospital discharge, and reduce duplication and unnecessary time spent by people in the wrong

place – but only for people with few health/social care needs. The case study demonstrated, however, that even the implementation of a small-scale, evidence-informed improvement project (that has in fact been rolled out in many different localities already) can be extremely challenging in some contexts. The identification and referral of suitable patients for Home First was affected by communication issues, trust between hospital and community care providers, and capacity in the community services. The adoption of a single assessment was affected by health and social care organisations' procedures and information and governance structures. The processes for quick assessment and the arrangement of care packages were affected by capacity
in provider organisations and the poor relationships between statutory providers and voluntary sector providers. The lack of additional money and shortage of staff dominated the agenda, such that other key issues (like engaging meaningfully with older people and carers in the implementation process) became lost. In addition, the case study demonstrated that in pursuing some benefits, others were put in jeopardy. For example, in the pursuance of reduced length of stay in hospital, some patients felt 'pushed' out of hospital before they were fully ready. In the effort to 'enable' people to be more independent, some felt that their basic human need for care and comfort were ignored.

The Over 75 Service improvement project demonstrated that care for frail, older people can be more person-centred and better co-ordinated at a local level when there is a clearly defined target population, clear aims and objectives, a strong, dedicated leader, and good engagement across different professionals and organisations. The service helped to put the user at the heart of the service, and by working closely with voluntary sector organisations, took a preventative approach to frail older people's care. This case study also demonstrated the complexity of implementing some elements of the improvement project. For example, the lack of compatible IT systems hindered the sharing of assessments conducted by a single trusted assessor. The professionals' value in human relationships and personal communication affected the extent to which automated electronic communications were focused on.

The case studies also highlighted the challenges around determining 'what works' in improving integrated care, given the inter-related and interdependent factors involved and the multiple constrasting perspectives on situations. It is important to think strategically about service improvement, and look beyond single cause-effect relations. In both sites, the degree of uncertainty and the array of factors contributing to the problem (or influencing the improvement) were underestimated. This work has highlighted the importance of devoting further work to understanding how best to measure performance in integrated care improvements.

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10. ANNEXES

10.1 Practical measures for monitoring outcomes and progress of the implementation of the improvement plans.

Item	Data collection tool	Short description
DEMOGRAPHIC INFORMATION		
Socio-demographics of older people (users)	Demographic data sheet – older people, administered to older people	Survey developed by SUSTAIN researchers requesting information on age, gender, education, marital status, living situation and self-reported medical conditions
Socio-demographics of informal carers	Demographic data sheet – carers, administered to informal carers	Survey developed by SUSTAIN researchers requesting information on age, gender, education, marital status, relationship and distance to older person (user), paid work and caregiving activities
Socio-demographics of professionals	Demographic data sheet – professionals, administered to professionals	Survey developed by SUSTAIN researchers requesting information on age, gender, nationality and occupation
Socio-demographics of managers	Demographic data sheet – managers, administered to managers	Survey developed by SUSTAIN researchers requesting information on age, gender, nationality and occupation

Item	Data collection tool	Short description
OUTCOMES		
Person-centredness		
Patient perceptions of quality and coordination of care and support	The Person Centred Coordinated Care Experience Questionnaire (P3CEQ) (Sugavanam et al., under review), administered to older people	Survey measuring older people's experience and understanding of the care and support they have received from health and social care services
Proportion of older people with a needs assessment	Care plan template (in case sites do not work with care plans, information will be retrieved from clinical notes or other documentation)	Template developed by SUSTAIN researchers for predetermined content analysis of care plans of older people
Proportion of care plans actioned (i.e. defined activities in care plan actually implemented)		
Proportion of care plans shared across different professionals and/or organisations		
Proportion of informal carers with a needs assessment and/or care plan		
Perception and experiences of older people, informal carers, professionals and managers with person-centredness	Semi-structured interviews and focus group interviews with older people, informal carers, professionals and managers	Interview and focus group schedules developed by SUSTAIN researchers including interview items on perception and experiences with receiving person-centred care
Prevention orientation		
Perceived control in care and support of older people	Perceived Control in Health Care (PCHC) (Claassens et al., 2016), administered to older people	Survey addressing older people's perceived own abilities to organise professional care and to take care of themselves in their own homes, and perceived support from the social network
Proportion of older people receiving a medication review	Care plan template (in case sites do not work with care plans, information will be retrieved from clinical notes or other documentation)	Template developed by SUSTAIN researchers for predetermined content analysis of care plans of older people
Proportion of older people receiving advice on medication adherence		
Proportion of older people receiving advice on self-management and maintaining independence		
Perception and experiences of older people, informal carers, professionals and managers with prevention	Semi-structured interviews and focus group interviews with older people, informal carers, professionals and managers	Interview and focus group schedules developed by SUSTAIN researchers including interview items on perception and experiences with receiving prevention-oriented care

Item	Data collection tool	Short description
Safety		
Proportion of older people receiving safety advice Proportion of older people with falls recorded in the care plan	Care plan template (in case sites do not work with care plans, information will be retrieved from clinical notes or other documentation)	Template developed by SUSTAIN researchers for predetermined content analysis of care plans of older people
Perception of older people, informal carers, professionals and managers with safety	Semi-structured interviews and focus group interviews with older people, informal carers, professionals and managers	Interview and focus group schedules developed by SUSTAIN researchers including interview items on perception and experiences with receiving safe care, and safety consciousness
Efficiency		
Number of emergency hospital admissions of older people Length of stay per emergency admission of older people Number of hospital readmissions of older people Number of staff hours dedicated to initiative Costs related to equipment and technology or initiative	Care plan template (in case sites do not work with care plans, information will be retrieved from clinical notes or other documentation); template to register staff hours and costs	Template developed by SUSTAIN researchers for predetermined content analysis of care plans of older people; template developed by SUSTAIN researchers to collect data on costs and the number of staff hours from local services, organisations or registries
Perception of older people, informal carers, professionals and managers with efficiency	Semi-structured interviews and focus group interviews with older people, informal carers, professionals and managers	Interview and focus group schedules developed by SUSTAIN researchers including interview items on perception and experiences with receiving efficient care, and finances
IMPLEMENTATION PROGRESS		
Team coherence of improvement team (professionals)	Team Climate Inventory – short version (TCI-14) (Anderson and West, 1994; Kivimaki and Elovainio, 1999), administered to professionals	Survey measuring vision, participative safety, task orientation and experienced support for innovation of the improvement team
Perception and experiences of professionals	Focus group interviews with professionals and minutes from steering group meetings	Focus group schedule developed by SUSTAIN researchers including interview items on experienced factors facilitating and impeding outcomes and implementation progress Minutes cover progress, issues and contextual issues impacting on outcomes and implementation progress
Perception and experiences of managers	Semi-structured interviews with managers and minutes from steering group meetings	Interview schedule developed by SUSTAIN researchers including interview items on experienced factors facilitating and impeding outcomes and implementation progress Minutes cover progress, issues and contextual issues impacting on outcomes and implementation progress

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care for older people in Europe

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