



South West
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Test and Learn Findings from the Longitudinal Evaluation 2015-2017: Cross Site Synthesis

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Executive Summary

Introduction

Somerset is a rural county in the South West of England with a population of 549,447 recorded at the last census. The annual growth rate of the proportion of people between the ages of 65-74 is an estimated 3.5%, 5 times the national average. In response to the demands of an aging population with increasing numbers of long term conditions, Somerset health and social care providers embarked on an ambitious roll out of a model matured in the south of the county that targets older people with long term conditions. The roll out of the Symphony programme worked on a hub based model, linking a network's services across health and social care in the North East (Frome and Mendip) and the West of the county (Taunton). The collective name for the three sites 'Test and Learn Somerset', reflects a forward thinking recognition of the cycles of iterative learning and development required for the implementation of complex innovations. The overarching aims of the hubs were to develop Person Centred Coordinated Care (P3C), achieve better outcomes for patients, and improve efficiency. South Somerset, the original home of the Symphony project, began operating out of Yeovil district hospital with links to participating general practices. Input from the older person's service at the hospital was key to managing older people with the most complex needs, and their transitions into and out of hospital, using a multi-morbidity model of care. The Taunton based site operated a virtual hub through a joint venture of providers (hospital, general practice, social care) who share resources and risks with an integrated P3C care team, focusing on people with 3+ long term conditions. Mendip (Frome) began from a general practice, hospital, and strong voluntary sector alliance, collocated with health connectors (voluntary service professionals) to support people with 1+ long term condition who are house bound. The three test and learn sites share many common elements despite variances in organisational arrangements and localised operationalisation of the model, these include:

- A single personalised care plan created from a comprehensive assessment with patient access
- A united patient pathway with expert generalist input
- Interdisciplinary working and multi-disciplinary team input
- Care coordinator (managing transitions)
- Professionals working in new roles to coach, coordinate or support patients (keyworkers, care coordinator, health connectors, wellbeing advisors)
- Access to pharmacy expertise

- Use of new technologies
- Extended role for voluntary sector
- SPoA (Single point of access)
- Rapid crisis response and escalation plans
- Admission and discharge planning
- Support and coaching for patients to work towards self-management using the Patient Activation
- Measure

An evaluation of the Test and Learn programme began in 2015 and concluded in 2017. Qualitative data was collected over the course of the evaluation; no new qualitative data was collected beyond July 2017. The evaluation team regularly observed practice, collected data and fed this back to front line delivery staff, managers and commissioners over the two year period. Patient reported questionnaires were collected up until October 2017 to provide a longitudinal perspective.

Aims

The aims of the evaluation were to establish from the perspective of patients, staff, and the system if the roll out of Symphony Test and Learn to other localities in Somerset would result in improved Person Centred Coordinated Care.

Methods

The initial evaluation was set to take place over one year using a combination of open ended interviews with staff and patients, observations of care and practice, the administration of questionnaires, and the extraction of service utilisation data. This multilevel and mixed method approach was developed to bring multiple perspectives (staff, patients, carers, managers etc.) into view to provide a rounded understanding of the interventions. Due to information governance issues with service use data (CSU and NHS Digital) the evaluation team was not provided with data to conduct this analysis. The evaluation of the Test and Learn hubs has therefore been based on a rich qualitative data set and the questionnaire returns received from participants who were recruited via each hub.

The quantitative sample who returned questionnaires at both time points (n. 78) was analysed for change in scores from baseline to time 2 on Wellbeing, Loneliness and experiences of Person Centred Coordinated Care. This sample is described in the quantitative findings section. Cumulatively

113 individuals representing both staff and patients from across the test and learn sites shared their experiences with us which are presented as the data within this report.

The qualitative methods included observations of care contact (n=12) and interviews (staff =26, patients = 31) focusing on how key processes were implemented and what factors affected their completion. Cumulatively this creates a rich data set from a qualitative perspective.

Qualitative interviews and observational data were subject to a thematic analysis with emerging themes checked by an independent member of the team.

The key questions that the evaluation sought to answer are listed in box 1 below:

Key Questions (<i>Addressed through qualitative data</i>)	Key Questions (<i>Addressed through quantitative data</i>)
What are the key characteristics of the intervention delivered at each hub?	What type of individuals (age, diagnoses, frailty etc.) are referred to each hub and do they differ between hubs ?
Have the interventions been implemented as planned ?	How does the sample compare to normative data on baseline scores of experience, wellbeing, loneliness and patient activation?
If not why? What have been the barriers and facilitators to implementation?	What are the baseline levels of service utilisation (hospital/whole system) of the cohort and those consented to be part of the evaluation?
For individuals that have received care from each hub, was this experienced as person centred and coordinated ?	What organisational processes have changed since the interventions have been rolled out?
How do staff feel about the new interventions?	
What does the observational data tell us about the interventions being delivered at each hub?	

Key Findings

The qualitative and quantitative data that was collected over a period of nearly two years suggests that collectively the Test and Learn sites were meeting their specified aims of improving Person Centred Coordinated Care. Over this formative period it was understandable to hear that sometimes patient and staff expectations of the new model were not being met, and that it takes time to create a coherent and clear sense of a model and to articulate this in a meaningful way to individual patients. The overriding and general impression from the data that was collected and through interactions with staff and patients, is one of committed and passionate staff doing their best to work with patients in a different and person centred, coordinated, compassionate and empowering manner. A synthesis of the key findings that have led us to the above conclusions is presented below. A site specific report has also been delivered to each Test and Learn site.

Establishing and delivering the model(s): Referral and Care Pathway

The three Test and Learn sites shared common aims and processes in the establishment and delivery of their model but exercised flexibility in deciding which patients to target. Frome utilised a broad patient eligibility criteria focused on adults with complexity, South Somerset targeted people with 1+ long term conditions and Taunton targeted people with 3+ long term conditions. South Somerset patients could enter the service via their GP or via the Hospital whereas Taunton and Frome patients typically came from GP or community services. For this reason South Somerset patients were typically more unwell than those from the other two sites. Sites reviewed admissions data or used lists provided by the Clinical Support Unit, complemented by team discussions, to decide who to target.

When a patient was referred to a Test and Learn service, some common processes that were put into action at each site were observed. These typically involved a meeting between professionals, where a discussion about the patient would help determine the next steps in the care pathway. This was commonly based on a discussion of the known needs and issues, arising from a range of informational sources. This could include consideration of a person's frailty score (Taunton) or a symphony scale score (SS). Taunton would often proceed with identifying pressing social or other issues and utilise early signposting to address these before tackling more serious long term problems. Frome staff would typically review medical records and discharge summaries to build information, with similar processes followed at South Somerset. Depending on the complexity or severity of the issues identified the sites would then allocate appropriate input from a range of professionals. This included medical professionals such as Extensivist (SS), GPs (Taunton/Frome), long term conditions nurses/practice nurses/community care planning nurses (all). Care

Coordinators supported social input and coordination in South Somerset. In Frome Health Connectors would perform this role, along with signposting and preparation for care planning. In Taunton Wellbeing Advisors would typically perform these tasks, with a Care Coordinator (now removed from the model) supporting the management of complex cases. The long term conditions nurse and GPs in Taunton would be brought into the care planning exchange via the Wellbeing Advisor.

Care Planning and Shared Decision Making: Establishing a person's narrative and their goals (what is important to them)

In Taunton care plans were used to structure the conversation with the patient to discuss person centred goals and outcomes, medications and self-management, along with a person's social situation and how this might interact with health related issues. In Frome the Community Care Planning Nurse would similarly meet with the patient and seek to understand pressing problems, discuss upcoming medical visits/interventions, discuss self-management strategies and interventions, and build a holistic picture of the person in their social environment. At this stage signposting would also take place to direct the person and his or her family to appropriate support within their community through statutory and non-statutory services. At the South Somerset the complex hub first contact by the key worker would gather important information from the patient about pressing concerns. This would then be followed up by a care planning visit by the Extensivist and the Care Coordinator where a similar process to that followed by Taunton and Frome would commence with a focus on patient priorities and the Extensivist tackling medical issues. Following this care would be appropriately tailored. If the patient was referred from the Hospital the Extensivist and Care Coordinator would meet the patient on the ward and go through a similar process, but this would focus on smoothing the transition from hospital into the community. A common aim across the various incarnations of this process in all three sites was to establish a connection with the individual and identify what matters to them when addressing improvements in their health and wellbeing. All the professionals that were observed or interviewed were committed to this collective aim.

Transitions and Coordination

Across all three sites practitioners and managers put significant energy into improving transitions of care and the coordination of patient care over the period of the evaluation. These two important aspects of care for people with long term conditions and multiple long term conditions were facilitated by a number of different component processes. For example, at Taunton the Wellbeing Advisor's person centred and comprehensive knowledge of the person and their situation functioned to prevent inappropriate discharges and facilitate earlier referrals to appropriate

services. Improved coordination was also achieved by sharing knowledge across the whole team involved in care. Furthermore, Wellbeing Advisors built up considerable knowledge of community resources and fostered good working relationships which further enhanced coordination.

South Somerset had invested in building relationships with a range of other services in the statutory and non-statutory sectors. Extensivist GPs were engaging in partnership working with social care and voluntary sector organisations, whereas in their previous roles as GPs they reported that this was rare. This resulted in treatment decisions that were made much more quickly and with less delay to patients.

Frome practitioners recounted how care plans had evolved to garner input from hospital specialists via the hub line. This functioned as a tool for coordination due to its ability to share important knowledge about the person across the system. The hub line also served to aid coordination more generally at Frome by working as a 'Single Point of Access' specifically for Test and Learn patients, operated through Frome medical practice. The hub line bypasses the surgery switch board and provides a rapid response for patients and professionals with call takers identifying which professional is best suited to deal with the enquiry.

Care Plans

Each site used care plans with patients over the course of the evaluation. South Somerset began using Patient Knows Best but subsequently dropped this because it was found to be both cumbersome for staff and difficult for many patients who did not have internet access. Taunton's My Life Plan underwent modifications over the course of the evaluation to make it more user friendly and reduce its length. Frome also adapted the My Life Plan to make it more streamlined and to enable the information to be captured on an electronic tablet. Care plans commonly contained person centred information (i.e. a person's preferences and goals) along with other key practical information, such as lists of appointments, escalation plans, medication reviews, and letters from health professionals.

Early on during the process patients would often struggle to acknowledge the relevance and importance of care plans, which could sometimes be neglected if left in the responsibility of the patient. However, at follow-up more positive accounts of care plans being useful as objects to facilitate coordination and communicate patient preferences were given. Where patients had engaged with care plans these were viewed as useful. From a service perspective care plans were most useful when electronic components were shared across teams and when they garnered input from different disciplines. Importantly, care plans were also ways in which to surface and disseminate previously unknown medical issues across the teams involved in providing care. They

were also used in multidisciplinary team meetings to help frame the discussion. Care plans at Frome were co-designed with patients, and across all sites they were used to record and monitor patient goals. Other useful information was also contained in the care plan including advanced care planning information and carer details. Care plans worked when they had been iteratively developed with patients and when their purpose and aims were communicated clearly to patients. Electronic interoperability was also a facilitator for successful use.

Multi-disciplinary Team Meetings

Multi-disciplinary Team Meetings were common across all three sites over the course of the evaluation. Observations of MDT meetings were conducted and their use was explored in interviews with staff. MDT meetings were adapted over the course of the evaluation to make them more effective and to maximise the chances of involving as many different professional groups as possible. Extensivists from the South Somerset complex care hub would often feed input into MDT meetings from the range of professionals that they interacted with in relation to their work with specific patients. MDT meetings were viewed as important for problem solving, bringing a multidisciplinary perspective, and for coordinating person centred priorities. Once refined, and with appropriate attendance from a range of services, MDT meetings were viewed as effective and integral to delivery of the model. MDT meetings were viewed as critical for coordination by staff and are likely to be one of the mechanisms by which coordination was improved. This finding was corroborated by the patients who completed the P3CEQ. This is also likely to be related to the enhanced use of care plans as objects for care coordination.

Self-Management & Social Engagement

In the staff and patient follow-up data collected from South Somerset there were positive stories of how self-management was beginning to improve in some patients. Early first steps for these fairly unwell patients were indicated by a greater recognition of when to contact the complex care hub. Staff at South Somerset also recounted how PAM scores were improving for some patients across their sites. South Somerset staff also reported that some patients had reengaged with social activities and had increased their levels of confidence and self-esteem.

Patients who were part of the Frome Test and Learn site were offered advice and signposting to Health Connections and other community groups during care planning visits with the Community Coordinator Practice Nurse. Suggestions and advice were tailored to the situation and what mattered to the person. In some cases this was a befriending service, in others it might be a support group or gym. Network mapping was a tool used in care planning visits, both with patients in hospital and with those in the community, and was directly used to identify gaps and areas of need.

Barriers to Delivery of the Model

Patients' willingness, understanding and expectations of their role and what the service provided

In all three sites, some of the patients that were interviewed for the evaluation were resistant to help, either because they didn't want to feel a burden or because they felt the service would be better suited to people in a worse situation. Some patients and carers also had expectations that were not met by the service and there was a sense in some cases that this was related to a lack of understanding around patient and carer roles. This issue frequently surfaced around how frequently patients were followed-up and it emerged that patient and carers did not perceive that it was their responsibility to initiate contact with the service early on in the care pathway. This perception shifted once patients and carers began to expect to take more responsibility. A similar finding was noted at Frome where some patients were resistant to taking a more empowered role in the care relationship. This could also be an issue when attempting to get patients to engage in goal setting work. For some patients it took time to tease out and identify goals and this often related to their unfamiliarity with person centred working. Furthermore, some patients reported feeling confident to self-manage, but this was often not confidence to self-manage in a proactively preventative fashion. There was frequently a confusion between the notions of 'coping' and 'actively managing' and was common across the sites.

GP resistance

It was noted at South Somerset that a lack of understanding of the complex care model early on may have influenced the reluctance of GPs to engage with the model. However, this was addressed with the implementation of the continuum model, which placed GP practices more central to care delivery.

A lack of Clarity about Roles and Ongoing Change

At sites which were undergoing evolution of the model, or significant change, a lack of certainty around roles and responsibilities sometimes caused Practitioners to experience change negatively. It would appear that these uncertainties settled once the new models matured. This was a common finding at both Taunton and South Somerset.

A Common IT System

Practitioners were frustrated in some sites with the lack of a common information technology platform to share patient records and care plans. Taunton also found the lack of a centralised or interoperable computer system a continued problem, particularly when working across different GP systems.

Resourcing and Limited Staff Capacity

Staff at all three sites were worried about resources, most typically the available professionals, with many practitioners feeling like they were stretched too thinly when covering their roles and responsibilities. Both Frome and Taunton acknowledged resource barriers in relation to the limited capacity of partner organisations. For Frome more district nurses were required and for Taunton limited availability in social care organisations was a problem. Frome made use of service user led organisations where possible to fill this resource gap. Staff from Frome and Taunton articulated concerns about the long-term future of their models and acknowledged the requirement of long term CCG investment for continuation.

Training

Staff and Taunton specifically talked about the need for more training using real life scenarios, particularly focusing on Dementia.

Facilitators to Delivery of the Model

Electronic Systems – Information Sharing and Networking

Perceived facilitators across the three models were similar, with access to electronic systems, support for the development of these, networking, and information sharing all viewed as important for the smooth delivery of the model.

Communicating in a Different Way with Patients

Communicating with patients in a way that makes sense to them and involving them in care plan checking and development helped patients to feel more involved in the pathway of care. Staff at Frome underscored the importance of asking patients what they wanted rather than telling them what to do. They also recognised the importance of knowing the person and understanding their backstory. This was all facilitated by 'active' listening. Frome's use of the 'Bubble Tool' (a way to probe for unmet need) was directly helping to identify unmet need or goals. Assisting patients to fill out paperwork helped also to build rapport and to get to know the person. Frome also reported that regularly reviewing patient goals, discussing why some had not been accomplished, and celebrating achievements were important to ensure active engagement of patients.

Escalation Plans and Hub Lines Reduce Avoidable Care Contacts

Well-developed escalation plans were considered important for avoiding unnecessary hospital admissions in South Somerset. In Frome the hub phone line was considered important in reducing unnecessary admissions as all those with care plans and LTCs had direct access. They also felt that the hub line was instrumental in reducing GP demand for those patients. Joint visits with health

connectors and other staff helped to coordinate care and prevented patients from having to duplicate information.

Training

Ensuring that keyworkers and health coaches were provided with the same level of training was considered important for delivering a consistent model at South Somerset.

Recognising the Needs and the Role of the Family and Carers

Frome emphasised the importance of recognising the role of the carer and targeting care towards the carer early on in the process if this was needed. Staff felt that this functioned as a preventative measure, ensuring the needs of both patient and carer are met. In this way families and carers were often part of the care partnership from very early on in the process and would feed into care planning activities.

Engaged GPs and Team thinking

At Taunton increased engagement from GPs was considered to be a direct facilitator to the model. Taunton also highlighted the important of 'team thinking' across boundaries, with promotion of a good shared understanding of the model. Demonstrating the value of the model helped bring GPs on board.

Cross-site analysis of patient reported data

Across all three sites (Taunton, South Somerset, Frome) a combined improvement in care coordination was found, with small and non-significant decreases in the more interpersonal components of person centred care. There was no change in mental-wellbeing, but an observed increase in loneliness.

Person Centred Coordinated Care

Person Centred Coordinated Care was measured using the Person Centred Coordinated Care experience questionnaire (P3CEQ). The P3CEQ asks questions covering a range of topics related to person centred care and care coordination. Changes in question responses were examined for each site and represent whether score responses were more positive or negative.

Across all three sites, patients reporting having to repeat themselves less often. At follow-up, two out of three sites had improved care plan existence, care plan availability, care plan usefulness, care plans being followed, and care being 'joined up'. All items related to coordination increased in at least two sites.

T-tests (used to compare mean scores) were conducted to identify if there were statistically significant changes across all evaluation participants in the level of person centred care and care coordination. Although person-centred care has decreased, the decrease was minor and not statistically significant. There was a statistically significant increase in the coordination of care ($p < 0.02$) between time 1 and 2 suggesting that Test and Learn had a positive effect on care coordination (see appendices for charts). This represents an increase in just under 1 point between baseline and follow-up in the same group of individuals. The cross-site trend towards stronger care coordination is also present in the qualitative data.

However, there are cross-site reductions in the level of person-centred care. This may be due to a number of reasons, such as people moving away from more familiar healthcare structures or staff whilst adjusting to the new scheme. The qualitative data found that some individuals expected more contact from staff and it is quite possible that as coordination improved contact may have decreased due to increased expectations around self-management. These experiences may be driving the slight dip in perceptions in person centred care between baseline and follow-up.

Involvement of friends/family was rated as worse at follow-up at all three sites. Discussing what matters most, involvement in decision making, being considered a 'whole person', involvement of friends/family, and support to self-manage were scored lower at 2 out of 3 sites, but in most cases the drop in score was less than 0.5 of a 1-5 point scale. No single item related to person centred care improved in more than a single site. It should be emphasised that these changes are not statistically significant. Sites also made a number of changes to care in response to feedback, therefore this data does not necessarily reflect the current state of Test and Learn care.

Mental Wellbeing

Mental wellbeing was assessed at each site using the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS). Across sites and across time mental wellbeing was consistent, this suggests that during the evaluation period, Test and Learn did not significantly reduce or increase peoples' wellbeing. However it must be noted that in an aging population with LTCs, no observable drop in Wellbeing levels over the course of the evaluation could be considered a good finding.

Loneliness

Loneliness appears to have increased (but not significantly so) at both the South Somerset and Frome sites. The reason for this increase is unclear, but it may be related to dips in service contact in the group as a whole. Loneliness levels at the Taunton site appear relatively stable, although they were elevated in comparison to other sites at baseline.

Conclusions

While trying to improve care for their patients, South Somerset has focused on developing its model, responding to change and creating a service that will work better for practitioners and for a broader range of patients, not just those with the most complex issues. The evaluation has been able to track some of these changes but most of the data in this report was collected from patients and staff in relation to care delivered through the complex care hub. We have however attempted to detail how the model has changed over the course of the evaluation from feedback gathered from staff. The qualitative patient experiences collected in relation to South Somerset were varied, as interviewees had experienced the service in quite different ways. Very strong accounts were given which showed that when the complex care team were able to deliver the service how they wanted to deliver it, the service was positively valued by the patients who were interviewed.

There are many positive accounts from staff and patients, but it is of course important to recognise where there have been problems and unaddressed needs, and to acknowledge that the service had already identified these and were seeking to address them through an evolution of the model. As with all systems undergoing change this can be frustrating for both staff and patients. Now that the new model is up and running the team are able to work more collaboratively with GPs and social care staff, and have also improved links with secondary services. This has lifted staff morale and improved the service. Due to small sample sizes we emphasize caution in drawing any widespread conclusions about the service from this report. We do however suggest that there is learning potential from even a small number of peoples' experiences, and many opportunities for celebration in the ambitious and innovative change that the Symphony teams have embarked on to improve the experiences and outcomes of the population of South Somerset.

Unlike other sites, Taunton's strengths primarily lay in catering for less complex patients and its approach to addressing social problems. Their Wellbeing Advisors were playing a pivotal and highly valued role in their practices and in individuals' care. They appeared to be providing an interactional bridge between the patient and their wider health care. In addition, the time taken to develop rapport and listen to the patient in a non-medicalised way was leading to greater disclosure and improved coordination within the practice and with hospital teams. It was interesting to find, that unlike other sites, patients appeared to be more engaged in goal setting work, despite practitioners concerns with this activity. It may be the case that some of the success of the one-on-one work between the patients and the practitioners was due, in part, to the non-medical background of the Wellbeing Advisors.

Where Taunton appeared to be struggling, it concerned engaging and providing care to patients with complex needs. These types of patients also seemed to be less likely to make contact with services or act on information provided. With the service struggling to follow up patients and constantly under pressure to enrol new patients, there was perhaps concern that these patients were passing under the radar.

The Taunton sites did acknowledge these strengths and weaknesses and in the final feedback session with the site, the evaluation team was informed that the model would be changing in response to their own self-reflection of the service. The Care Coordinator role was removed from the model, instead Wellbeing Advisors were being upskilled and a new Wellbeing Advisor Coordinator position was to be put into place. There was a plan to become even more integrated into primary care and to begin to revisit cases that may not have been followed up on for a while. There was still an ambition to re-engage with the PAM measure and make it a more prominent aspect of the evolved model. They planned to elevate its role by keeping hold of the data it generated and making it a tool for tailoring care as well as form of aggregate outcome measurement. The major change in the model's focus was that they were no longer planning to develop a complex (medical) arm of their model. Instead, they would focus on delivering "quick fixes" to what are, primarily, social issues. This would involve dealing with end of life care and complex care issues, but in a preventative form rather than reactive manner. Preparing patients for the difficult choice and issues they will face in the future was considered of prime importance.

The Mendip Symphony service incorporated Frome and several other sites that came on board later. The Test and Learn evaluation data was collected primarily from Frome, but due to a later initiation with the evaluation, the amount of follow up data available within the timeframes was less than that collected from the other sites. In spite of this rich data was collected about the Frome model and how it has been implemented. Frome initiated an innovative and ambitious project to provide Person Centred Coordinated Care by incorporating voluntary sector services using a social prescribing model. Using network mapping the Frome model also sought to increase social capital and community resources and improve palliative care.

Frome has benefited from the close locality of the hospital and the Health Connections team, who offer an enormous amount of support to the hub, being based within the Frome Medical Practice. In addition, their model was up and running before the Test and Learn evaluation began. This has meant that while changes have been made there has not been a substantial evolution of the model during the service, unlike other services. This has allowed the team at hub to benefit from a sense of stability and an existing shared objective, which they are passionate about.

Referral processes and the organisation of the service appeared to be very efficient. However, there was only one community care planning nurse at the time data was collected, which could mean that she was stretched quite thinly. Like many new models we noted excellent and passionate practice but also acknowledged that some aspects of the care planning processes still perhaps need to be refined. However, these areas for refinement are issues that all sites are facing, e.g. the format of, and patient engagement in care plans and goals, and communicating and establishing expectations.

By focusing on Frome the picture of Mendip Symphony is unlikely to be representative of the wider Mendip Symphony sites, and it would have been interesting to have explored the implementation of Test and Learn in more rural areas where co-locality, community involvement and resources may have not been as extensive.

Recent, reported changes to the model, since data was last collected are:

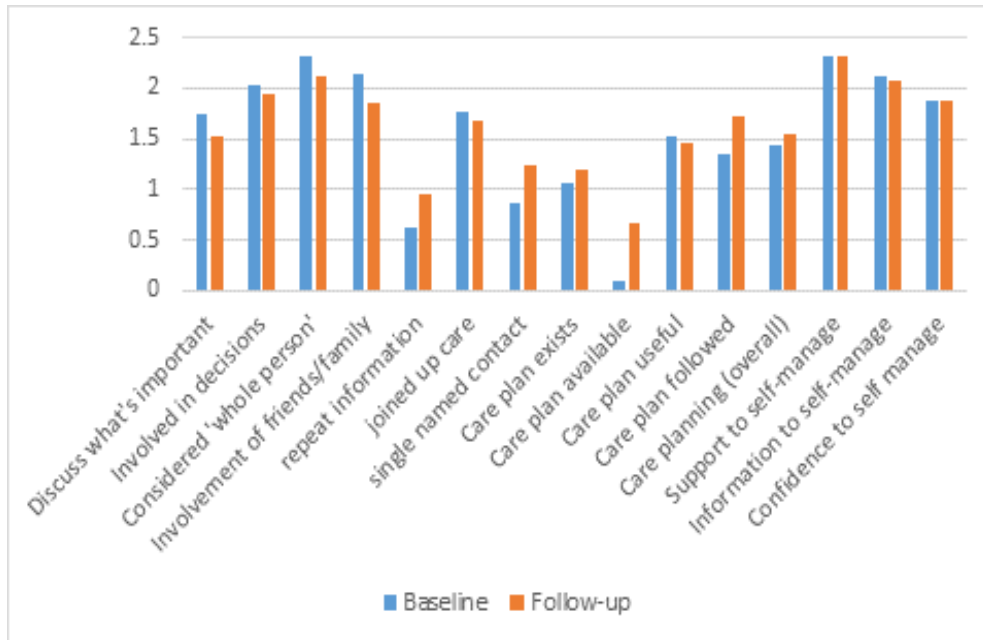
- There are now Hubs developing across Mendip with Health Connectors far more integrated into the practices.
- The Health Connector who was based at the hospital is now no longer working in the hospital, but is working with people who have been discharged from hospital.
- Their earlier number of 201 Community Connectors has now risen to over 350. They include trained Asda staff, care workers, park rangers, town councillors, people who go to peer support groups, taxi drivers and hairdressers
- Now more integrated, and are working on a shared care plan that practices and Health Connectors can input on. Their remodelled EMIS system is facilitating this
- Previous localities that have been slow to come on board are now working well with the model

The findings from quantitative patient reported measures demonstrate that coordination has improved at group level across the sites, a finding also reported through the qualitative data and feedback to practice sessions. Care plans and multidisciplinary teamwork, with successful engagement of social care, voluntary sector, mental health, and secondary care, appear to be contributing to this finding. This is a significant achievement as coordination is commonly one of the most difficult problems to address. It involves significant personal energy from individual staff members, who often have to 'think outside the box' to make connections and build relationships to improve coordination. Furthermore it also requires team commitment and energy. The fact that coordination improved with only minor and non-significant drops in the interpersonal aspects of care across the sites should be celebrated. It is also worth noting that current levels of the

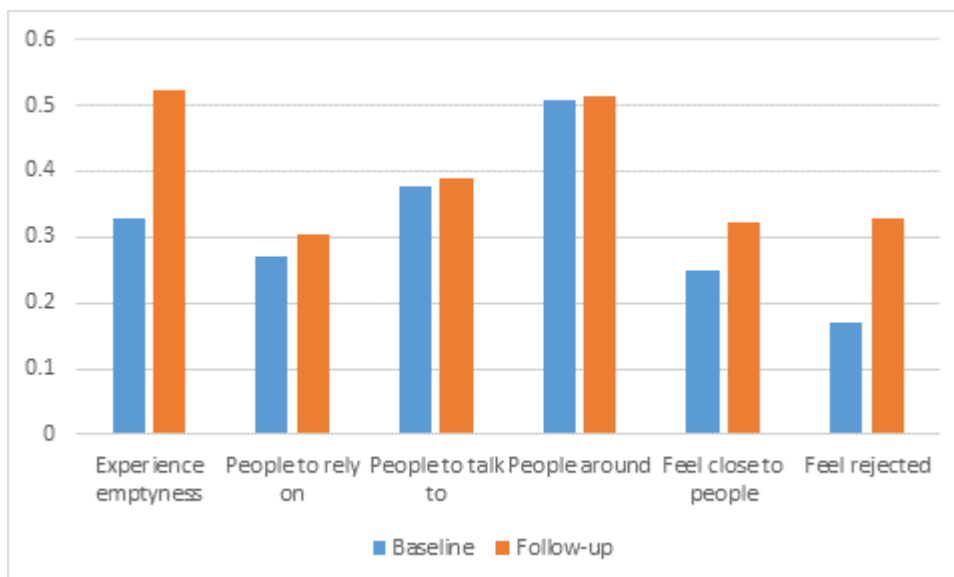
interpersonal aspects of care are relatively good. It would appear from both the qualitative and quantitative data that was collected over nearly a two year period that the Test and Learn sites were collectively meeting their specified aims of improving Person Centred Coordinated Care. Over this formative period it was understandable to hear that sometimes patient and staff expectations of the new model were not being met. It was learned that it takes time to create a coherent and clear sense of a model and to articulate this in a meaningful way to individual patients. The overriding and general impression from the data that was collected and from interactions with staff and patients, is that of committed and passionate staff doing their best to work with patients in a different and person centred, coordinated, compassionate and empowering manner.

Appendices

Person Centred Coordinated Care: Score Changes in Question Responses between baseline and follow-up Across Test and Learn Sites



Loneliness Scores across Test and Learn Sites from Baseline to Follow-up



Mental Wellbeing Scores at Baseline and Follow-up across All Test and Learn Sites

